Uniformed Firefighters Association of Greater New York

Health & Welfare Plan Document and Summary Plan Description

For members of the Security Benefit Fund (SBF) and Retired Firefighters Security Benefit Fund (RFSBF)

Effective January 1, 2026

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Quick References

Most of the information that you might need to understand the Uniformed Firefighters Association ("UFA") of Greater New York Health and Welfare Benefits Program can be found in this Summary Plan Description ("SPD")

Name/Web Address	Phone
Security Benefit Fund ("SBF") and Retired Firefighters Security Benefit Fund ("RFSBF") UFA: **ufanyc.org**	
For forms and more information • Visit **ufanyc.org/retirees/forms** • Email **sbfstaff@ufanyc.org**	**212-683-4723** (Fax) **212-683-0693**
Death Benefit — SBF/RFSBF	**646-839-6503**
Surviving Spouse — Medical Coverage (One Year)	**212-683-4723**
Beneficiary Changes Retirees	**929-436-4836**
Death Notifications (Retirees & Article 1 Retirees)	**929-436-4868**
Address/Bank (EFT) Changes	**929-436-4838**
Prescription Drug Coverage	
CVS/Caremark **caremark.com**	**866-832-0563**
SilverScript **silverscript.com**	**866-412-5373**
Dental Coverage	
MetLife **metlife.com/UFAdental**	**866-832-5756** (Dental PPO) **800-880-1800** (Dental HMO)
Hearing Coverage	
General Hearing Services (Hearing Aid Services) Group #7530H Security Benefit Fund ("SBF") and Retired Firefighters Security Benefit Fund ("RFSBF") UFA	**800-480-0558** **212-683-4723**
Vision Coverage	
Optical Providers **ufanyc.org/optical-providers**	
General Vision Services ("GVS")	**855-653-0586**

Welcome

We are pleased to present to you the Uniformed Firefighters Association (“UFA”) of Greater New York Health and Welfare Benefit Program (the “Plan”) document and Summary Plan Description. This combined document is known as the “SPD” and will be effective beginning January 1, 2026.

This document provides important information about your benefits. In addition to the information in this SPD, you can find the certificates of coverage and other booklets describing the benefits offered under the Plan in the “***Rights and Administrative Information”*** and the “***Appendix”*** sections.

The Plan is maintained pursuant to a collective bargaining agreement between the UFA, Local 94, I.A.F.F. AFL-CIO, and the City of New York (the “Employer”). Plan benefits are funded through the Security Benefit Fund (“SBF”) for active members and their covered dependents, as well as the Retired Firefighters Security Benefit Fund (“RFSBF”) for Medicare-eligible retired members and their covered dependents.

The Plan is intended to satisfy all applicable requirements of the Internal Revenue Code of 1986, as amended (the “Code”) and the Patient Protection and Affordable Care Act of 2010 (the “Affordable Care Act”) and the regulations promulgated thereunder along with other applicable federal laws. Nothing in this Plan should be construed as requiring compliance with Code or any other federal or state law provisions that do not otherwise apply.

Using Your SPD

Here's a summary of what's inside the major sections of this SPD:

- **Benefit Basics —** Information about eligibility, enrolling in and making changes to your benefits, and other facts related to your benefits.
- **Prescription Drug, Vision and Hearing Benefits —** Descriptions of your health plans.
- **Additional Information about Your Benefits —** How to continue health care coverage through COBRA and more.
- **Qualifying Change in Family Status Guide —** An overview of benefit changes to consider when you experience a qualifying change in family status.
- **Rights and Administrative Information —** Information about your rights under federal law; how to submit a claim, what to do if it's denied and how to appeal a claim decision; the review process for Plan benefits and other required information.
- **Appendix —** Information about the Dental and Life Insurance plans provided by the vendors that support them.

How the Uniformed Firefighters Association May Communicate with You

At times, the UFA as well as the Security Benefit Fund, the Retired Firefighters Security Benefit Fund, or the Plan Administrator, may need to communicate with you about your benefits. We'll use your home address, personal phone, or email address on file. **Please be sure your contact information is kept current — both as an active and a retired member.** Update it by visiting **ufanyc.org** and then download and submit the change of address form.

About this SPD

We encourage you to refer to this SPD whenever you need information about your health and welfare benefits provided under the Plan. Because this document is available online, the current online version may differ from and supersede any prior print versions or prior online versions you may have.

This SPD describes prescription drug, dental, vision, and hearing benefits (collectively, "health benefits"), along with life insurance. The benefits described in this SPD are applicable to all eligible active and retired members ("members") of the UFA and their benefits-eligible dependents.

We've made every effort to ensure that the information in this SPD accurately describes the terms outlined in the applicable benefit plan documents, dental HMO agreements, and insurance contracts and certificates of coverage. Benefit plan documents, dental HMO agreements, insurance contracts, and certificates of coverage control the administration and operation of the Plan. If there are inconsistencies between this SPD and the underlying benefit plan documents, dental HMO agreements, or insurance contracts and certificates of coverage, the latter document(s) will control.

The information included in this SPD does not supersede applicable state or federal law.

The SBF and RFSBF Fund Administrator is the Plan Sponsor and the Fund Administrator appoints the Plan Administrator, who is responsible for the operation of the SBF and RFSBF

benefits program (see ***"Discretionary Authority"*** in the ***"Rights and Administrative Information"*** section.) The Plan Administrator may delegate this authority at its discretion to a third party, such as a claims administrator, to carry out the day-to-day responsibility for administration of benefits.

For any of these benefits, the claims administrator or other entity to which the Plan Administrator has delegated authority may interpret and apply the terms of the Plan regarding eligibility, benefit payments, or other provisions of the Plan. This includes determining whether individuals are entitled to benefits under the Plan and determining benefit payments. Any determination made by the Plan Administrator or its delegate is final and binding, subject to the claims and review procedures described in this document.

For additional details on the administration of the Plan, see the ***"Rights and Administrative Information"*** section.

If you have questions about your coverage, please see the ***"Quick Reference"*** section on page 4 for a list of important contacts.

Benefit Basics

This section provides an overview of your UFA benefits. It contains basic eligibility and coverage information under the Plan.

Who Is Eligible?

Active Members

Active members covered by an agreement between the Employer and the UFA, Local 94, I.A.F.F., AFL-CIO (the “Union”). Active members of the Union receive benefits through the Security Benefit Fund of the UFA, Local 94, I.A.F.F., AFL-CIO.

Retired Members

Retirees are covered by an agreement between the Employer and the Union. Retired members of the Union receive benefits through the Retired Firefighters Security Benefit Fund of the UFA, Local 94, I.A.F.F., AFL-CIO.

Retired Firefighters and Fire Marshals, who retired on or after January 1, 1971 (July 9, 1993, for Wipers), and their eligible dependents, including duly registered domestic partners and their dependents, receive benefits. Retired Marine Engineers and Pilots as of January 1, 2012 also receive benefits.

Dependents

If you are enrolled for coverage, you may enroll your eligible dependents. Your eligible dependents include your spouse or domestic partner, and your dependent children up to age 26. Your dependents cannot be covered under the Plan as both a dependent and a member.

Your Spouse

Your spouse is the person to whom you are legally married as determined under applicable state law. To be eligible for coverage as a dependent, your spouse cannot be in the military of any country or subdivision of any country or be covered under this Plan as a member. A former spouse may not be covered.

Your Domestic Partner

Your domestic partner means someone who is at least 18 years of age and with whom you are living in a current, continuous, and committed relationship, although not related by blood to you in a manner that would bar marriage in New York State. More details concerning eligibility and tax consequences are available from your agency or the Office of Labor Relations Domestic Partnership Liaison Unit at **212-306-7605**. References to a spouse throughout this SPD also apply to a domestic partner, unless otherwise noted.

To be eligible for coverage as a dependent, your domestic partner cannot be in the military of any country or subdivision of any country or be covered under this Plan as a member.

To enroll your domestic partner for coverage, you must provide such information showing domestic partner status as the Plan Administrator may require and complete and sign an affidavit attesting to the existence of an insurable interest in each other’s lives. You must follow the Domestic Partner Checklist available on **ufanyc.org**.

Tax Considerations of Covering Your Domestic Partner

The taxable value of the UFA's contributions toward your domestic partner and/or your domestic partner's dependent children's coverage is considered imputed income. The UFA reports this income to you and the IRS. You must pay taxes on the imputed income amount in addition to your after-tax contributions for domestic partner health coverage.

This imputed income amount will change from year to year. You should consult your tax advisor for questions regarding taxation related to domestic partner coverage. It is the UFA's goal to comply with all federal, state, and local taxation laws.

This information is only a summary of the tax provisions governing the tax status of a domestic partner (or their child(ren)) for health coverage purposes. It is not intended, nor should it be relied upon as legal or tax advice. Due to the complexity of these tax rules and potential impact of any imputed income you may incur, you should seek advice from a competent tax professional before filing your tax returns.

If you have questions regarding the taxability of your domestic partner's benefits, please contact the NYC Office of Labor Relations ("OLR") at:

Domestic Partner Information Line: **212-306-7605**

Retirees: **212-513-0470** or email **brianna.oxley@olr.nyc**

Coverage for Your Dependent Child

Your dependent child is your child under age 26, whether married or unmarried and who is one of the following:

1. Your natural child;
2. A child for whom a court has accepted a consent to adopt and for the support of whom an employee has entered into an agreement;
3. A child required to be covered under a qualified medical child support order until the court order expires, at which time the child may continue to be eligible for coverage under (1) or (2) above;
4. A child for whom a court of law has named the employee as legal guardian; or
5. Any other child who lives with an employee in a regular parent/child relationship and is the employee's tax dependent. A child is the employee's tax dependent if the employee claims the child on his/her income tax return as a dependent.

Coverage for a dependent child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical disability, as determined by a licensed medical doctor selected or approved by the Plan Administrator. Proof of disability must be sent to the plan within 31 days after the date the child attains the age limit and at reasonable intervals after such date as may be required by the Plan Administrator in its discretion.

Unmarried, disabled children age 26 and older, who cannot support themselves, are eligible for continued coverage if the following criteria are met:

- The disability occurred before the age at which the dependent coverage would otherwise terminate; and
- The proof of disability was approved by the health plan at least 31 days before the date the dependent reached age 26.

Note: The eligibility for such dependents only applies to current employees whose disabled dependent children reach the age limitation while covered by a New York City health plan. New employees with disabled children, already over the age limitation, may not include such children as dependents on their City health plan coverage. In addition, employees may not add disabled dependent children to their health plan coverage if the child is already over age 26.

For the purposes of determining who may become covered for benefits, a dependent child does not include any person who:

- Is in active military service of any country or subdivision of any country; or
- Is covered under this Plan as a member.

If Your Employment Status Changes During the Year

You may continue to be covered under the SBF's benefit plans depending on your specific circumstances.

If You Leave the UFA and Are Rehired Later

If you leave the UFA after you become eligible for benefits under one of the following conditions and return to employment, the effective date of your benefits is provided below:

- If you leave and are rehired within 30 days in a benefits-eligible position, you'll be eligible for benefits on the day you return to full-time employment and will automatically be enrolled in the same benefits and level of coverage you had before you left. A change in coverage will be allowed only if you have had a qualifying change in family status during your time away from the UFA.
- If you leave the UFA and are rehired outside of 30 days, you will continue to be eligible for benefits on the day you return to full-time employment. Eligibility for benefits on the day you return to employment with New York City assumes that you satisfied all eligibility requirements for benefits before you left New York City employment.

If You and Your Spouse/Domestic Partner Are Both Members of the UFA

If both you and your spouse/domestic partner are eligible under the Plan as UFA members, you have options in how you choose benefits coverage for yourself and your eligible children.

Either you or your spouse/domestic partner can choose to be covered as a member. You can be covered as a dependent instead of a member for health benefits under your spouse/domestic partner's coverage. However, neither of you can be covered as both a member and dependent. Eligible dependent children can only be covered by one of you.

- If both you and your spouse/domestic partner enroll for coverage, you may each choose coverage for yourself (“you only”), or one of you may choose coverage for yourself and cover the other as a dependent (“you and one dependent”). In the latter case, the individual being covered as a dependent would choose “no coverage” when making elections as a member.
- If you are also covering eligible children, one of you can enroll as a member and choose the appropriate coverage level to cover all your children (for example, “you and your spouse/domestic partner and two children”); the other person can choose “no individual coverage.” Or you may each enroll as a member and cover one or more of your children, as long as no one in your family is covered twice.

No person may be covered as a dependent of more than one member. To cover eligible dependents, you must be either (1) already enrolled in the Plan; or (2) enrolling in the Plan at the same time you are enrolling your dependent(s). You may enroll eligible dependents when you are first eligible for coverage as a new hire, during an annual enrollment period, or if you have a qualifying event. More information about qualifying events can be found on page 61.

When Coverage Begins

You are eligible for UFA benefits on the date you become an eligible member as defined previously under ***“Who Is Eligible”*** in this section.

You should be aware of the following rules about when coverage begins:

- You must be actively at work for your coverage to become effective. If you are not actively at work when your coverage would otherwise take effect, it will not go into effect until you return to work (full time) for one full day.
- Your dependents’ (spouse/domestic partner and children) coverage will go into effect when yours does if they are eligible dependents and you enroll them when you enroll.
- In some cases, you may be able to add coverage for yourself or eligible dependents during the year because of a change in family status if you make a timely election. If you change your coverage because of the birth, adoption or placement for adoption of your child, medical coverage takes effect on the date of the birth, adoption or placement for adoption.

When Coverage Ends

Coverage for you and your dependents ends as shown here:

- On your New York City employment termination date.
- When you or your dependents no longer meet the eligibility requirements described under ***“Who Is Eligible”*** in this section or any new eligibility requirements the UFA establishes: For example, your child’s health benefits coverage ends at 11:59 p.m. on the last day of the month in which the child reaches the age limit (age 26 unless otherwise extended).

- If your dependent is the unmarried child of a domestic partner and is a full-time student and graduates or fails to enroll in school, coverage will end on the last day of the month before the new semester begins.
- On the effective date of your change in family status or on your initial eligibility date if you drop coverage during your election period.
- When the UFA terminates the Plan, or any applicable underlying benefit plan or insurance policy.

You are responsible for notifying the UFA when a dependent is no longer eligible for coverage. This includes notifying the UFA of a divorce, dissolution of a domestic partnership, death, or a child reaching the age limit for coverage and/or a change in your domestic partner's child's student status.

You or your dependents may be eligible to continue health benefit coverage (prescription drug, dental, vision, and hearing benefits) after losing eligibility under the Plan's terms (for example, if you are no longer employed or a dependent reaches the age limit for coverage).

See ***"COBRA Continuation Coverage"*** in the ***"Additional Information about Your Benefits"*** section for more information about rights to continued health plan coverage in some circumstances.

Disability and Leaves of Absence

Continuation of Coverage at the Plan Sponsor's Option

The Plan Sponsor (SBF) has elected to continue coverage by paying contributions for members who cease active work in an eligible class for any of the reasons specified below. If your coverage is continued, coverage for your dependents may also be continued.

Provided you pay for your coverage, coverage will continue for the following periods:

1. If you cease active work due to layoff, for a period in accordance with the Plan Sponsor's general practice for a member in your job class.
2. If you cease active work due to any other Plan Sponsor approved leave of absence, for a period in accordance with the Plan Sponsor's general practice for a member in your job class.
3. If you cease active work due to injury or sickness, for a period in accordance with the Plan Sponsor's general practice for a member in your job class.

The Plan Sponsor's general practice for members in a job class determines which members with the above types of absences are to be considered as still covered and for how long among persons in like situations.

At the end of any of the continuation periods listed above, your coverage will be affected as follows:

- If you resume active work in an eligible class at the end of the continuation period, you will continue to be covered under the Plan.
- If you do not resume active work in an eligible class at this time, your New York City employment will be considered ended, and your coverage will end, unless you qualify for

coverage under the RFSBF or you are otherwise eligible for continuation of benefits and pay for the coverage.

If your coverage ends, your dependents' coverage will also end.

How to Enroll

New Hire Enrollment and Effective Date of Coverage

Member is enrolled automatically in benefit plans on the effective date of hire. Coverage begins immediately. Coverage will continue upon retirement from employment with the City of New York.

Cost of Coverage

Except for supplemental life insurance and Accidental Death & Dismemberment ("AD&D") coverage, there is no cost to members for UFA-sponsored benefit plan participation.

If You Have a Change in Family Status

If you have a change in family status, you must change your coverage within 31 days of the status change. You must supply the required documentation of all changes. Depending on the benefit being considered, coverage may be retroactive to the date of the change in family status event (for example, the day your child was born) or the first day of the month after your election change.

Changing Your Benefit Elections During the Year

The benefit elections you make when you initially enroll as a newly eligible member will remain in effect throughout the year unless you elect to change them. You may add or drop dependents at any time, but dependents cannot be covered until you add them to your coverage, including newborns and adopted children. To ensure your dependents are covered, be sure to add them promptly upon marriage, birth, adoption, etc.

Documentation Required

The UFA reserves the right to request documentation for any coverage changes. When you submit a request for changes, the UFA will request documentation at that time. If documentation is not received within 31 days, the changes will be cancelled, reverting to the coverage in place before you reported the qualifying change in family status.

If you misrepresent a change in family status or fail to submit required documentation, the UFA reserves the right to cancel the change.

If the change impermissibly added coverage, the UFA would cancel coverage retroactively to the earliest date on which you and any individual covered on your behalf became ineligible for coverage, to the extent permitted by law, and take other appropriate action. In that case, the UFA and the Plan each has the right to recover, and you and any ineligible individual each have the obligation to restore to the UFA or the Plan, any benefits or other expenses paid by the UFA or the Plan on behalf of an ineligible individual.

You may also be liable for civil action and reasonable attorney fees to the extent permitted by law, and you may be subject to disciplinary action, up to and including termination of your employment.

More detailed information regarding allowed changes and documentation required for such changes is included in the ***"Qualifying Change in Family Status Guide"*** section.

Special Enrollment Rights for Prescription Drug Coverage

To ensure individuals have additional access rights to health care coverage, Congress enacted the Health Insurance Portability and Accountability Act ("HIPAA"). Under the special enrollment provisions of HIPAA, you may be eligible to enroll in a UFA prescription drug plan during the year, even if you previously declined coverage.

These special enrollment rights extend to you and all eligible family members as defined by HIPAA.

- You may enroll in prescription drug coverage if you or your dependents have lost coverage under another plan because:
  - SBF contributions to the plan stopped (this will apply even if the covered individual continues receiving coverage under the prior plan by paying the amount previously paid by the employer);
  - There was a loss of eligibility for any of these reasons: divorce, legal separation, cessation of dependent status (e.g., reaching the age limit to be eligible as a dependent under a plan), death, termination of employment (and employee is not otherwise covered as a retiree), a reduction in hours to part-time status that affected benefits eligibility, the covered individual no longer lives or works in an HMO service area, or the plan no longer offers benefits to a class of individuals that includes the previously covered individual;
  - Your or your dependents' COBRA coverage under another plan is exhausted; or
  - The plan was terminated.
- If you experience one of the above events and you want to change your prescription drug coverage, **you must contact the UFA within 31 days of the event**.
- HIPAA allows you to enroll in prescription drug coverage or to change your prescription drug coverage if you gain a dependent during the year as a result of marriage, birth, adoption or placement for adoption. To make any changes to your prescription drug coverage, you must contact the UFA within 31 days of the event. For example:
  - 31 days if you got married or you're enrolling in an insured option.
  - 31 days from birth, adoption or placement for adoption if you are enrolling in a self-insured benefit plan.
- Under the Children's Health Insurance Program Reauthorization Act of 2009, you also have a special enrollment opportunity if:
  - You or your eligible dependents become eligible for Medicaid.
  - You or your eligible dependents lose eligibility for Medicaid or CHIP.
  - For the above special enrollment rights, you may request enrollment **if you notify the UFA within 60 days of the event**.

Time Limits for Making Mid-Year Election Changes

You should make timely changes whenever you have a change in family status. The applicable benefit changes described earlier should be made within the timeframes shown below.

Change in Family Status	Deadline for Changing Your Benefit Election
You or your eligible dependents gain or lose Medicaid or CHIP eligibility	60 days
You or your eligible dependents become eligible for COBRA coverage	60 days
You have a baby, adopt a child, or a child is placed with you for adoption	31 days
All other changes in family status	31 days

Medical Privacy Rights

HIPAA also includes provisions relating to the privacy practices of group health plans, such as those offered through the UFA. These provisions specify how your protected health information will be handled. For details, see ***"HIPAA Notice of Privacy Practices"*** in the ***"Rights and Administrative Information"*** section.

Prescription Drug Benefits

A big part of maintaining good health is following your health care provider's recommendations for taking prescription drugs — whether it's for ongoing, chronic conditions like heart disease or more acute health problems like an infection.

How Prescription Drug Coverage Works (**not** Medicare-eligible)

Currently CVS Caremark is UFA's prescription drug partner for non-Medicare-eligible active and retired members and their dependents. The New York City's PICA (Psychotropic, Injectable, Chemotherapy and Asthma) Prescription Drug Program includes coverage for chemotherapy and injectables, among other medications that are not covered under the UFA's prescription drug plan for non-Medicare eligibles. See ***"PICA Prescription Plan"*** further down in this section for details.

Prescription Drug Benefits: What You Pay

The amount you pay for each prescription depends on a number of factors, including:

Retail vs. Mail Order	In general, you save money on recurring prescriptions (such as for chronic conditions like high blood pressure) when you purchase them through mail order, which allows up to a 90-day supply of a prescription, or through CVS Caremark's retail pharmacy network designated to dispense up to a 90-day supply of a prescription to treat chronic conditions. **Mandatory Maintenance Choice** Mandatory Maintenance Choice enables you to fill medications you take regularly for chronic conditions — for example, diabetes, asthma, and high blood pressure medications — for a minimum of an 84-day supply up to a 90-day supply at participating retail pharmacies or through CVS' Caremark's mail order pharmacy After the original fill and two grace fills for a 30-day maximum supply of a maintenance medication at a retail network pharmacy, the plan requires that these medications be filled for a minimum of an 84-day supply up to a 90-day supply at a select participating retail pharmacy or at CVS Caremark's mail order pharmacy. The Maintenance Choice program includes the following select participating pharmacies: • Costco and their mail pharmacies; • Kroger affiliated pharmacies and their mail pharmacies; • CVS affiliated pharmacies; • CVS Caremark® Mail Service Pharmacy; and • Select independent pharmacies.

Brand	You generally pay much less for generic medications than you do brand-name medications. When your doctor is prescribing a new medication, ask your doctor if there's a generic equivalent that will offer the same therapeutic effects as a brand-name drug at a lower cost.
Formulary Brand vs. Non-Formulary Brand	The formulary is a list of medications the plan covers at a preferred discount rate. The plan also pays for non-formulary brand medicine, but it pays less. Your cost share is lower for formulary brand drugs, compared to non-formulary brand drugs. Visit **caremark.com** to see the list of medications.

SBF Pharmacy Benefit Plan Prescription Drug Cost Share for Eligible Active Members and Staff and Their Dependents and Widows	**Family Maximum: Up to $10,000 of prescription drug expenses per year (UFA member and eligible dependents combined)**	**Prescription drug expenses at $10,000 or more per year**
For retail — 30-day maximum supply per fill		
Generic	$8	35% ($5 minimum)
Preferred Brand	25% ($20 minimum, $75 maximum)	35% ($5 minimum)
Non-Preferred Brand	40% ($50 minimum, $140 maximum)	40% ($5 minimum)
For mail order 84 — 90-day supply per fill		
Generic	$15	35% ($12.50 minimum)
Preferred Brand	25% ($50 minimum, $190 maximum)	35% ($12.50 minimum)
Non-Preferred Brand	40% ($125 minimum, $350 maximum)	40% ($12.50 minimum)
Annual Out-of-Pocket Maximum for 2026 — Individual: $10,600/Family: $21,200		

The plan pays 100% of your prescription drug costs for the remainder of the year after the Annual Out-of-Pocket Maximum has been reached.

SBF Pharmacy Benefit Plan Prescription Drug Cost Share for Non-Medicare eligible Retired Members and their Dependents and Widows of Retired Members	Up to $6,000 of prescription drug expenses per year family maximum after which there is no additional coverage for the remainder of the year
For retail	
Generic	35% ($5 minimum)
Preferred Brand name	35% ($20 minimum)
For mail order	
Generic	35% ($15 minimum)
Preferred Brand name	35% ($60 minimum)

Members and their dependents using non-participating pharmacies can obtain up to a 30-day supply and may be reimbursed up to the in-network contracted ingredient cost plus dispensing fee, minus copay by submitting a completed claim form and receipt(s) to Caremark. Reimbursement claim forms can be obtained by calling CVS/Caremark at **866-832-0563**.

Prescription Drug Coverage Management Programs

CVS Caremark's clinical and utilization management programs help control rising drug costs and provide you with medically appropriate coverage. These programs determine how your prescription drug plan will cover certain medications. Some medications are not covered unless you receive pre-approval or prior authorization. Clinical and utilization management programs also may include quantity limits on certain medications and step therapy, which require a member to try a lower-cost medication in the same therapeutic drug class before a higher-cost medication is approved. **This is not a complete list of affected medications; all medications and programs described below are subject to change.**

Penalty for Selecting Brand When a Generic Equivalent Is Available

If you or your physician requests a brand name medication when a therapeutically equivalent generic medication is available, you will pay the brand copay plus a penalty, which is the cost difference between the brand name medication and the generic equivalent at the time the brand name medication is dispensed.

Maintenance Choice

If you are taking medication for a chronic condition (e.g., high blood pressure and high cholesterol), you will be required to enroll in the mail order program. You will be allowed one original fill and two grace fills at a retail network pharmacy for up to a 30-day supply. After that, you will pay the full cost of the medication at a retail pharmacy if you do not have the medication dispensed at a mail order or designated retail pharmacy that fills medication under the plan for up to a 90-day supply.

CVS Caremark Compounds

Compounding is a practice in which a pharmacist combines, mixes, or alters ingredients of a drug. Compound prescriptions can include ingredients not approved by the FDA. To ensure plan participants are being prescribed safe and effective medications, some compounded drugs are excluded from coverage, while others may have dollar or dosage limits. Compounded drugs are limited to one claim per month and require prior authorization from CVS Caremark.

About the CVS Caremark Specialty Drug List

The CVS Caremark Specialty Drug List is updated quarterly.

For the most up-to-date list of drugs subject to the guidelines for Generics First, compound prescriptions, and specialty therapies, visit cvsspecialty.com.

Specialty Drugs

Generally, specialty drugs are developed through breakthroughs in biotechnology that improve treatment and outcomes for patients with rare and complex conditions, such as hemophilia, cancer, and multiple sclerosis, to name a few. This type of drug therapy helps many patients enjoy an improved quality of life with fewer disease symptoms and sometimes results in cures for diseases that previously were uncurable.

Certain specialty drugs are included in the prescription drug benefit administered by CVS Caremark through its specialty pharmacy. However, coverage of specialty drugs under the SBF plan is limited to **non-injectable, non-infused** drugs. Injectable and infused specialty drugs may be covered under PICA or the member's medical plan or, if a member is eligible, through the World Trade Center Health Program.

CVS Caremark Specialty Pharmacy's clinical staff is trained in the use, side effects, and appropriate dosage of specialty drugs. The pharmacy clinicians can help members overcome medication side effects, provide confidential and empathetic care, assist with insurance and financial coordination, and more. Specialty medications are limited to a 30-day maximum supply per fill; copays and coinsurance are the same as for non-specialty medications filled at a retail pharmacy.

Coverage for specialty medications is only available through a CVS Specialty Pharmacy where required and allowed by law. If you fill a prescription for a specialty medication through any other means, it will not be covered.

To fill a specialty drug prescription, please visit **cvsspecialty.com** or call Specialty Customer Care toll-free at **800-237-2767**.

The Specialty Generics First Program promotes lower-cost generic equivalents or alternatives when appropriate. It requires you to try a generic form of a drug before the plan covers the brand name. For a current list of these drugs, please visit **cvsspecialty.com** or call Specialty Customer Care toll-free at **800-237-2767**.

Note: CVS Caremark updates the approval criteria used for specialty medications as new clinical information becomes available, or marketplace dynamics change.

Specialty Guideline Management (SGM)

The Specialty Guideline Management (SGM) program supports safe, clinically appropriate, and cost-effective use of specialty medications. Programs are based on FDA-approved labeling, compendia use, current medical literature, and nationally recognized guidelines.

The CVS Caremark clinical team proactively works with your physician's office to obtain the required clinical information. If you meet the guidelines, CVS Caremark will determine if the specialty medication is approved and, if approved, will notify your doctor. Medication will be shipped to you. If you don't meet the guidelines, CVS Caremark will send a denial letter to you and your doctor.

Prior Authorization

Prior authorization requires that you obtain pre-approval of a prescription drug through CVS Caremark's coverage review. This review will determine whether your prescribed medication will be covered based on medical appropriateness. **Prior Authorizations include but may not be limited to the following <u>Non-Specialty</u> Medications:**

Isotretinoin Products	Ivermectin (oral) PA with limit
Amphetamines (Age 19 and older)	Opzelura PA with limit
Methylphenidate (Age 19 and older)	Fabior
Strattera (Age 19 and older)	Endometrin
Tazorac	Crinone
Nutritional Supplements (Infant formulas)	Prochieve
Nutritional Supplements (Malabsorption)	Evista
Nutritional Supplements (Renal dysfunction)	Xifaxan
Nutritional Supplements (Tube feeding)	Winlevi
Differin	Oral Weight Loss Medications
Tretinoin Products	Rezdiffra
Qelbree	Eohilia
Azstarys	Zoryve
Kerendia	Voquezna

Prior Authorizations include but may not be limited to the following <u>Specialty</u> Medications:

Sensipar [Cinacalcet] SGM	Tavalisse SGM	Multiple Sclerosis Ponvory SGM
Adempas [Riociguat] SGM	Jynarque SGM	Bylvay SGM
Orenitram SGM	Epidiolex SGM	Livmarli SGM
Opsumit SGM	Galafold SGM	Tavneos SGM
Ventavis SGM	Firdapse SGM	Tarpeyo SGM
Austedo, Austedo XR SGM	Inbrija SGM	Cibinqo SGM
Ingrezza SGM	Oxervate SGM	Pyrukynd SGM
Tikosyn [Dofetilide] SGM	Spravato SGM	Camzyos SGM
Esbriet [Pirfendione] SGM	Multiple Sclerosis Maysent SGM	Ztalmy SGM
Ofev SGM	Multiple Sclerosis Mavenclad SGM	Vijoice SGM
Kalydeco SGM	Mulpleta SGM	Jesduvroq SGM
Orkambi SGM	Duopa SGM	Sohonos SGM
Pulmozyme SGM	Doptelet SGM	Vjuvek SGM
Promacta, Alvaiz SGM	Arikayce SGM	Rebyota, Vowst SGM
Hemo Stimate SGM	Rinvoq SGM	Velsipity SGM
Otezla SGM	Wakix SGM	Joenja SGM
Xeljanz, Xeljanz XR SGM	Trikafta SGM	Opfolda SGM
Ocaliva SGM	Multiple Sclerosis Vumerity SGM	Zurzuvae SGM
Cerdelga SGM	Zeposia SGM	Skyclarys SGM

Procysbi SGM	Fintepla SGM	Tascenso ODT SGM
Cholbam SGM	Dojolvi SGM	Agamree SGM
Orfadin, Nityr [Nitisinone] SGM	XYWAV SGM	Daybue SGM
Ravicti SGM	Mulpleta SGM	Liqrev SGM
Endari SGM	Evrysdi SGM	Filspari SGM
Nuplazid SGM	Multiple Sclerosis Kesimpta SGM	Fabhalta SGM
Hetlioz, Hetlioz LQ [Tasimelteon] SGM	Chenodal SGM	Olpruva SGM
Keveyis, Ormalvi [Dichlorphenamide] SGM	Zokinvy SGM	Diacomit SGM
Symdeko SGM	Orladeyo SGM	Thiola SGM
Litfulo SGM		

Generic Step Therapy

Generic Step Therapy is designed to save money for both you and the Plan, while providing quality pharmaceutical therapy for patients. This program may require a treatment failure on at least one generic drug before certain brand name medications will be covered by the plan.

Medications requiring step therapy include the following:

- Long-acting opioids
- Prudoxin, Zonalon and generics
- Eucrisa
- Reyvow
- Oral CGRP products
- Minolira, Solodyn
- Acanya, Aczone, Amzeeq, Benzaclin, Cleocin-T, Clindacin ETZ, Cindagel, Evoclin, Klaron, Neuac, Onexton

CVS Caremark Coverage Review Process

For prescription drugs that need special authorization, you, your doctor, or your pharmacist may initiate the review by calling CVS Caremark at **855-559-1385**.

CVS Caremark will send your doctor appeal forms to complete and mail or fax back to CVS Caremark. CVS Caremark will contact you and your doctor by phone or letter within 15 business days from receiving the necessary information — 72 hours for urgent care claims — to let you know if coverage has been approved or denied.

If coverage is approved, you pay the applicable coinsurance/copay for the medication — after you've met any annual deductible. If coverage is not approved, there may be an alternative drug that would be covered. Otherwise, you must pay the full cost of the medication.

Note: You have the right to appeal the decision. Information about the appeal process will be included in CVS Caremark's notification letter. See also ***"Appendix A"*** for additional information on the claims appeal process.

Quantity Limitations

To comply with FDA guidelines and to encourage the appropriate use of certain medications, your prescription drug coverage may have quantity limits. This means for some medications, your plan may cover a limited quantity for a specified days' supply. A coverage review may be necessary to approve additional quantities of these medications covered by your plan.

Medications subject to quantity limitations include the following:

- Lidocaine Topical Products
- Opioids

Exclusions

The following medications are currently **excluded** from coverage:

Medications covered through PICA	Vimovo and generic	Gimoti
Injectable products	Xerese	Soaanz
Diabetic Drugs and Supplies	Zipsor and generic	Treximet
IUD and Implant Contraceptives	Zyflo	Vuity
Medical Devices	Absorica	Yosprala
Truvada and Descovy	Ergomar	Clemastine syrup
Aplenzin	Pennsaid	Metformin 625 mg
Duexis and generic	Forfivo	Allopurinol 200 mg
Jublia	Rayos	Methocarbamol 1000 mg
Kerydid and generic	Fortamet and Glumetza	Zolpidem 7.5 mg capsules

Nascobal	Cambia	Pokonza POW 10 MEQ
Sitavig	Dartisla	ACA medications and Opioid Treatment Drugs are excluded from select plans

The following medical devices and other products are **excluded** from coverage:

Category	Examples of Excluded Products
Artificial Saliva	• Artificial Saliva — Packet (powder packets) • Boscasal • Salivamax
Medical Devices	• Antiseborrheic Products Miscellaneous (cream, kit) o Nutraseb o Promiseb • Dermatological Products Miscellaneous (solution, emulsion, cream, kit, aerosol, foam, liquid, lotion) o Epiceram o HPR Plus, o Hylatopic o Neosalus o Nuvail o Synerderm • Hyaluronate Sodium (cream, gel, foam, spray o Bionect o Hygel • Nerve Stimulators o Cefaly o Gammacore o Nerivio o Zewa • Weight Loss o Plenity • Wound Dressings (emulsion, gel, kit, sheet, pad) o Keramatrix

	o Medihoney o Wound Gel

For More Information

For more information on medication coverage, exclusions and limitations, please visit **caremark.com**, or call CVS Caremark Customer Care at **855-559-1385**.

PICA Prescription Plan

The PICA Prescription Plan is a New York City Prescription Plan covering chemotherapy, self-injectables and anti-nausea medications, among other medications. The PICA Plan is currently administered by Express Scripts. This benefit is available to both active and non-Medicare-eligible retired members, as well as their non-Medicare eligible dependents. (Once on Medicare, PICA is no longer available.) There is an annual deductible of $100 per person for injectable and chemotherapy medications. This deductible is independent of any other deductible.

PICA covers medications in two specific drug categories plus Anti-Nausea medications — Injectables and Chemotherapy.

- Injectable — Most self-administered injectables.
- Chemotherapy — Medications used to treat cancer, including infused medications.
- Anti-Nausea — Medications used to treat the side effects of chemotherapy.

PICA Prescription Drug Plan	
For retail (up to a 30-day supply)	**Copay**
Generic	$10
Formulary brand	$25
Non-formulary brand*	$45
For mail-order (up to a 90-day supply)	**Copay**
Generic	$20
Formulary brand	$50
Non-formulary brand*	$90

*If you choose a non-preferred brand drug that has a generic equivalent, you will pay the difference in cost between the non-preferred brand drug and the generic drug PLUS the non-preferred brand copayment.

- Express Scripts Customer Service Number: **800-467-2006**
- Website: **express-scripts.com**

For a full list of the medications covered under PICA, visit: **nyc.gov/assets/olr/downloads/pdf/health/2025-pica-program-drug-list.pdf**.

Important Information about the World Trade Center (WTC) Health Program

The WTC Health Program is a limited federal health care program that provides high-quality, compassionate medical monitoring and treatment for WTC-related conditions to those directly affected by the September 11th attacks in New York, at the Pentagon, and in Shanksville, Pennsylvania.

The WTC Health Program covers all prescriptions used to treat certified WTC-related health conditions, whether those prescriptions are filled through in-network retail or home delivery pharmacies. These prescriptions are covered at no cost as long as they are prescribed by a Program provider and are included on the WTC Health Program's formulary.

To be eligible for WTC Health Program pharmacy benefits, a member must have a health condition certified by the WTC Health Program. These benefits are administered and accessed through the Program's Pharmacy Benefit Manager ("PBM"), currently Express Scripts.

The Express Scripts network includes over 62,000 retail pharmacy locations nationwide, the Express Scripts Pharmacy, specialty pharmacies, and home delivery options for most members.

Once a member is certified with a WTC-related condition, Express Scripts will automatically mail a WTC Health Program Prescription ID Card and a welcome letter with instructions for how to use these pharmacy benefits.

Filling Your Prescriptions

Express Scripts has a large network of retail pharmacies and home delivery options to provide all members with their WTC-related medications. You can find participating pharmacies near you using the Express Scripts pharmacy location in the Express Scripts Member Portal online at **express-scripts.com/login**.

Please be sure to tell your pharmacy which prescriptions should be billed to the WTC Health Program. The WTC Health Program only covers prescriptions needed to treat your WTC-related health conditions and are prescribed by a Program provider.

Some prescriptions may need prior authorization to be covered by the Program. Your WTC Health Program provider should complete and submit these for you. In some cases, your WTC provider may need to submit a second prior authorization to your primary insurance as well.

Important: For Survivors, a process known as coordination of benefits ("COB") is required for the WTC Health Program to cover prescriptions at no cost to you. Survivors must make sure that the pharmacy they are using is in network for both your primary health insurance and in the Express Scripts network. Survivors must follow the steps necessary for this process in the ***"Coordination of Benefits"*** section below.

For Survivors, the Express Scripts network includes Optum and CVS/Caremark home delivery pharmacies.

There are unique pharmacy options for both responder and survivor members. Review the table below to select options available to you.

Pharmacy Options	Responder	Survivor
Retail	• Up to 90-day supply at Walgreens/Duane Reade Pharmacies • Up to 30-day supply at retail pharmacies in Express Scripts network	Up to 90-day supply at retail pharmacies in Express Scripts network AND in primary insurance network
Home Delivery	90-day supply through Express Scripts Home Delivery	90-day supply through home delivery pharmacy in Express Scripts network AND in primary insurance network
Specialty	Up to 30-day supply through Accredo Specialty Pharmacy	Up to 30-day supply at any pharmacy in Express Scripts network AND in primary insurance network

Responders who have specialty medications can get these prescriptions covered and filled through Accredo Specialty Pharmacy. Other pharmacies for specialty medications are not in Express Scripts' network and cannot be covered by the Program.

Responders with specialty medications can visit the Accredo website at **accredo.com** or call **855-540-1780** with any questions, to fill prescriptions, access plan information, and track online orders.

Coordination of Benefits

A coordination of benefits ("COB") process is required for Survivors to get their WTC-related prescriptions. COB sets the order in which different payer (e.g., private insurance, public insurance, the WTC Health Program) pay their share of costs for treatment of a Survivor's certified WTC-related health condition.

Steps for COB

1. Sign up for primary health insurance.
   - o If you already have primary health insurance, continue to step 2. If not, you must sign up for public or private health insurance offered through the UFA, Medicaid, Medicare, the Marketplace, or other options.
   - o All members of the WTC Health Program are required to have primary health insurance, including pharmacy and medical coverage. Your benefits counselor at your Clinical Center of Excellence ("CCE") or the Nationwide Provider Network ("NPN") can help you find and apply for health insurance.
2. Share your current primary health insurance information with your CCE or the NPN as soon as possible.

- You will be asked to provide your primary insurance information during each visit or phone call with your CCE or the NPN. If your insurance information changes, let your CCE or the NPN know right away. If your CCE or the NPN does not have up-to-date information, it may impact payment for your treatment or pharmacy claims.

3. Show your primary health insurance card at every treatment visit.
   - Once you begin your WTC-related care, your WTC Health Program provider must have up-to-date insurance information to process your claims and ensure that you do not receive a bill for WTC-related services.
4. Make sure that any WTC Health Program provider you see is also in your primary health insurance plan's network.
   - In order for the Program to pay for any treatment of your certified WTC-related health condition, the treatment must be received through a Program-affiliated provider. In addition, Survivors must make sure that provider is also in their primary health insurance plan's network.
   - Your CCE or the NPN will confirm the provider is in network with your primary insurance prior to referring you for treatment. If the Program-affiliated provider is not in network with your primary health insurance, talk to your CCE or the NPN about your options.
5. Show your primary health insurance card at every pharmacy visit.
   - Your WTC Health Program pharmacy must have up-to-date insurance information to process your pharmacy claims and ensure that you do not receive a bill for WTC-related prescriptions. Survivors must get all WTC-related prescriptions filled at a pharmacy (home delivery, specialty, or retail) that is both in the Program's Express Scripts network and your primary health insurance plan's pharmacy network.
   - If you need help finding an in-network pharmacy, talk to your CCE or the NPN or call Express Scripts at **800-935-7179**.
6. Follow all requirements of your primary health insurance.
   - For example, if a medically necessary procedure or prescription to treat your certified WTC-related health condition requires a prior authorization from your primary health insurance, this prior authorization must be received before the WTC Health Program can pay for your treatment.

     - WTC Health Program Survivors should NOT receive bills for treatment of their certified WTC-related health condition(s). You also should NOT pay a copay at your provider's office, clinic, or pharmacy.
     - If you receive a bill or are asked to pay a copay or coinsurance charge for a prescription or treatment of your certified WTC-related health condition, please contact your CCE or the NPN as soon as possible before paying the bill.

How Prescription Drug Coverage Works for **Medicare-Eligible** Members

The RFSBF offers a self-funded Employer Group Waiver Plan ("EGWP"), currently administered by SilverScript, which complies with all rules and regulations under the U.S. Centers for Medicare and Medicaid Services ("CMS") Medicare Part D Prescription Drug Plan for all Medicare-eligible retired members aged 65 years or older, as well as those who are on Social Security Disability. This program also applies to a Medicare-eligible spouse, dependent or domestic partner. This prescription drug plan is **not** available to active members.

This Plan has an up-front annual individual deductible of $100. After you pay your yearly deductible, you pay the following for **retail** prescriptions:

- 35% of the cost of the drug with a $5 minimum for **generics**.
- 35% of the cost of the drug with a $20 minimum for **brand** drugs.

You pay the following for **mail order** prescriptions:

- 35% of the cost of the drug with a $15 minimum for **generics**.
- 35% of the cost of the drug with a $60 minimum for **brand** drugs.

When your out-of-pocket costs (also known as True Out of Pocket ("TrOOP")) reach the maximum annual limit set by CMS, you qualify for Medicare Part D Catastrophic Coverage, at which point you pay $0 out of pocket for covered medications for the remainder of the year. For 2026, the TrOOP limit is $2,100.

Things to know about your Prescription Drug Coverage under the EGWP:

- The plan does **not** cover any prescriptions that are not on the plan formulary.
- Certain medications are subject to additional restrictions that require one or more of the following:
    - Prior Authorization.
    - Step Therapy.
    - Quantity Limitations.

For the full formulary and/or lists of medications subject to the additional restrictions outlined above, contact SilverScript.

Important Reminders about Medicare

When you become Medicare eligible, it is important that you make sure you are covered under only one plan that provides Medicare Part D prescription drug coverage. You cannot be enrolled in two Medicare Prescription plans at the same time. If you try, you risk being kicked out of both and having a lapse in coverage. Some health plans stipulate that to remain in their health plan you must use their prescription drug plan.

The PICA Prescription Plan will no longer be available once you become eligible for Medicare.

REMINDER: Please provide RFSBF with a copy of your Medicare card. On the copy, also write down the name of your health care carrier (for example: HIP, GHI, AETNA, etc.). The RFSBF fax number is **212-683-0693**.

Note: If you sign up for Social Security retirement benefits at least four months before reaching age 65, you will be automatically enrolled in Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) when you turn age 65. Other Medicare enrollment rules apply to disabled members, those with End Stage Renal Disease and other circumstances. These rules are described on the **Medicare.gov** website. If you prefer, you can receive enrollment assistance through your local Social Security office. As soon as you or your eligible dependent(s) enroll in Medicare, a copy of the Medicare card MUST be mailed to the RFSBF or if you prefer, fax it to **212-683-0693**. You should also write down on the copy what your health care carrier is (for example: HIP, GHI, AETNA, etc.).

Please note that if you have a lapse in your prescription coverage due to late or delayed enrollment with Medicare, you could potentially incur a "Late Enrollment Penalty" from Social Security/Medicare. If you don't enroll when you're first eligible for Medicare, you can be subject to a late-enrollment penalty, which is added to the Medicare Part A premium. The penalty is 10% of your monthly premium; it will apply regardless of the length of the delay and is a permanent penalty.

SilverScript Appeals Process

If you do not agree with a determination of coverage made by SilverScript, you have the right to appeal that determination. The following is a brief overview of the appeals process:

Level 1	Redetermination: SilverScript will review the claim again, including any additional documentation you submit.
Level 2	An Independent Review Entity will review the claim.
Level 3	The claim will be reviewed by an Administrative Law Judge.
Level 4	A Medical Appeals Council will review the claim.
Level 5	In the event the participant files a lawsuit in Federal Court to challenge the Medical Appeals Council's decision, the claim will be reviewed and determined by a federal court.

For More Information

For more information about coverage, including a list of medications on the formulary and medications subject to additional restrictions, contact SilverScript at **866-412-5373**.

Vision Benefits

Your Vision benefits are provided by General Vision Services (“GVS”). The following table provides your Full Benefits Summary for both active and retired members. It’s a good idea to bring this table with you to your appointment.

Vision Benefits Summary

Description	Copays
Examination*	
Includes Tonometry	INCLUDED
Frames*	
Non-Covered Frame	U&C less $130
GVS Collection — Classic	INCLUDED
GVS Collection — Metropolitan	INCLUDED
GVS Collection — Premier	$45.00 copay
Lenses*	
Single Vision	INCLUDED
Flat Top FT28 & FT35	INCLUDED
Trifocals	INCLUDED
Standard Progressive	$25.00 copay
Premium Progressive	$80.00 copay
Oversize	INCLUDED
Deluxe Progressives	120.00 copay
Materials	
Plastic	INCLUDED
Polycarbonate	$30.00 copay

Description	Copays
Polycarbonate for children 16 and under	INCLUDED
Coatings	
Cosmetic or Sunglass Tint	INCLUDED
Scratch Resistant Coating	INCLUDED
Ultra-Violet Coating	INCLUDED
Anti-reflective Standard Coating	$40.00 copay
Anti-reflective Premium Coating	$90.00 copay
Transitions Single Vision	$65.00 copay
Transitions Bifocal	$95.00 copay
Polarized	$95.00 copay
Contacts*	
Colored Contact Lenses are NOT included Fitting and Dispensing Included for the following Lenses	INCLUDED
Fitting Fee for Upgraded Lenses	$50.00 copay
Spherical Disposables — 6-month supply	INCLUDED
Non-Covered Contact Lenses	U&C less $130
Lens Benefits Copays	
Materials/Hi-Index Lenses	
Hi-Index Single Vision	$55.00 copay

*One eye exam and either: one pair of single vision, bifocal, or contact lenses (subject to providers' surcharges) annually for active members and their dependents, and every two years for retired members and their eligible dependents. Maximum benefit of $130 (includes $30 for the exam, $50 for the Frames, $50 for the Lenses, OR $100 for Contact Lenses).

Please make an appointment. Doctors' hours may vary from store hours. To find a provider, visit **ufanyc.org/optical-providers/**. Active members should enter group **7552**, and retired members should enter group **7553**. Please make sure you tell the provider that the member is with the **Uniformed Firefighters Association**. Sometimes individual stores will input the wrong union name. If there is any confusion, they can contact GVS for instructions.

For Florida locations, eye exams may have a copay.

- Any additional services that surpass the benefit are the responsibility of the patient.
- 30% discount on all optical services not listed above, including a second pair of frames.

If You Visit a Non-GVS Network Provider

Benefits will be reimbursed to members if other providers are used. You pay the expenses up front, and then the original, paid bill should be sent to the SBF/RFSBF Office (keep copies for your records). For direct reimbursement, mail the itemized, **original**, paid bill to:

Security Benefit Fund of the UFA/Retired Firefighters Security Benefit Fund of the UFA
204 East 23rd St.
Attn: 3rd floor/Optical
New York, NY 10020-4697
Or fax to: **212-683-0693**

All claims must be submitted within one year from date of service. Make sure you keep copies of everything you send!

A check will be mailed directly to the member. Please allow up to four weeks for optical claims to be processed and reimbursement checks to be mailed.

Cataract Lenses (for Retired Members and Their Dependents)

The RFSBF allows up to $150 *per eye* toward overall cost after health plans (Medicare, etc.), have paid their portion (if applicable) — for a total available lifetime allowance of $300. The original paid bill and health plan(s) Explanation of Benefits ("EOB") should be sent to the SBF Office (keep copies for your records). For direct reimbursement, mail the itemized, **original**, paid bill to:

Retired Firefighters Security Benefit Fund of the UFA
204 East 23rd Street
Attn: 3rd floor/Cataracts
New York, NY 10020-4697
Or fax to: **212-683-0693**

All claims must be submitted within one year from date of service.

A check will be mailed directly to the member.

More Information

If you need any assistance with your Vision benefits, please call **855-653-0586**. To find a provider, visit **ufanyc.org/optical-providers/** use code **7552** for active members and code **7553** for retired members.

Hearing Plan

Hearing Aid Benefit and How it Works

The UFA reimburses members and all eligible dependents up to $1,000 once every three years for hearing aids. **The UFA has partnered with General Hearing Services to offer you discounted benefits.**

What the Hearing Plan Covers

General Hearing Services ("GHS") will provide one hearing aid through a General Hearing Services Provider once every three years, up to a maximum of $1,000, upon referral from a physician or an audiologist to all eligible members and dependents.

To find a General Hearing Services Provider near you, call **800-480-0558**, or go to a provider and provide them with group number **7530H**.

The plan covers the following:

- Comprehensive hearing screening, covered in full;
- $1,000 maximum benefit once every three years, covered by the Uniformed Firefighters Association;
- A significantly discounted pricing schedule for hearing products and related services, including the latest technology, at up to 60% off the Manufacturer's Suggested Retail Price ("MRSP");
- With any hearing aid purchase, an extended three years product warranty and a one year supply of batteries for free; and
- If you or your dependent receive services from a non-participating (out-of-network) location, you will be required to pay the full cost for the hearing device and submit an itemized receipt and audiologist report to the Uniformed Firefighters Association for a maximum reimbursement of $1,000.

Process for Submitting a Claim

All claims must be submitted within one year from the date of service.

For direct reimbursement, send the **PAID** bill and the audiologist's report to:

(via email) **sbfstaff@ufanyc.org**
OR
(via U.S. mail)
Security Benefit Fund of the UFA/Retired Firefighters Security Benefit Fund of the UFA
204 East 23rd Street
Att: 3rd Floor/Hearing Aids
New York, NY 10010-4697

A check will be mailed directly to you.

Additional Information about Your Benefits

Continuation of UFA Benefits Coverage after Employment Ends

You are eligible to maintain your UFA benefits coverage as long as you elect and maintain your health coverage with the City of New York.

Surviving spouses (and domestic partners) and other eligible dependents of members who die in the line of duty: UFA will continue to pay the required premiums for the life of the spouse (and domestic partners) as well as other dependents who otherwise satisfy the general dependent eligibility requirements under the Plan.

All other surviving spouses and other eligible dependents will be automatically covered for the first year of COBRA coverage under the UFA benefit program at no cost, provided they remain eligible and timely elect COBRA coverage. Thereafter, coverage can continue if they pay the required COBRA premiums for the remainder of the COBRA continuation period. (Eligible dependents can continue coverage for as long as they remain eligible for the Plan.)

COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") is a federal law that requires many employers to allow members and certain dependents to continue group health coverage at their own expense for a period of time after employer-provided coverage ends. **COBRA coverage may be available to you and your dependents in coordination with, and at the same time as, you have coverage pursuant to the *"Continuation of UFA Benefits Coverage after Employment Ends"* section above.**

The Plan Administrator administers the COBRA coverage continuation program for the group health care benefits under the Plan. If the coverage options provided to active members change while you (or your dependents) are receiving coverage through COBRA, your (or your dependents') coverage will change accordingly. These provisions apply to the health benefits offered under the Plan (prescription drug, dental, vision, and hearing benefits).

If you are entitled to elect COBRA coverage, you will be given an election period of at least 60 days (starting on the later of the date you are furnished the election notice or the date you would lose coverage) to choose whether or not to elect continuation coverage.

The following are qualifying events for covered employees if they cause the covered employee to lose coverage:

- Termination of the employee's employment for any reason other than gross misconduct; or
- Reduction in the number of hours of employment.

For Active Members and Surviving Spouses

You may continue your elected health care coverages (through COBRA) if your coverage ends due to a qualifying event and you are not otherwise eligible for UFA-provided benefits. Your surviving spouse may apply for COBRA coverage for UFA-sponsored benefit plans and continue that coverage for as long as the required premiums are paid.

For member death other than line of duty, surviving spouses may apply for COBRA coverage for UFA-sponsored benefit plans and continue that coverage for the COBRA duration period

subject to the *"**Continuation of UFA Benefits Coverage after Employment Ends"*** **section above**.

For member line-of-duty death, SBF pays for benefit coverage for surviving spouses for the COBRA duration period.

For Your Dependents

Your covered dependents (including your domestic partner and domestic partner's children) may continue their health care coverage under the Plan through COBRA if they lose coverage due to one of the following qualifying events. Each dependent has an independent right to elect COBRA, regardless of whatever election you or any other covered dependent may make:

- You die;
- You divorce or legally separate from your spouse (or dissolve your domestic partnership);
- You become covered by Medicare;
- Your dependent child is no longer eligible under the terms of the plan; or
- Your employment with the UFA ends (except as a result of gross misconduct).

Your Coverage Options

- At the time your coverage ends, you may only enroll yourself and/or dependents who are currently covered under the benefit plan; and
- Only elect COBRA coverage under those plans in which you are already enrolled.

If Your Family Situation Changes

If while covered under COBRA (as a former member), you have a newborn child or adopt or otherwise gain legal custody of a child, you may enroll the child and coverage will be effective immediately as long as you enroll the child within 60 calendar days of the birth or adoption placement or finalization of legal custody. Dependents enrolled in COBRA under such circumstances may continue COBRA coverage for the maximum period allowed (as outlined under ***"How Long COBRA Coverage Lasts"*** in this section).

In addition to the situation described above for newborn/newly adopted children of a covered member, each qualified beneficiary may add new family members to existing COBRA coverage under the same terms and conditions as active members.

COBRA and Medicare

If you are age 65 or over, or otherwise eligible for Medicare, when your coverage terminates and you become eligible for COBRA coverage, one of the following rules may apply to you:

- If on the date you elect COBRA continuation coverage, you are already enrolled in Medicare, you can continue to have coverage through COBRA and Medicare.
- If on the date you elect COBRA continuation coverage, you are not enrolled in Medicare, when you enroll in Medicare at a later date, your COBRA coverage will end.

The chart below summarizes the above-mentioned options:

COBRA Enrollment Options for Medicare-Eligible Members (or Former Members)	
Enrollment Status as of COBRA Eligibility Date	**Post-Employment Options**
If enrolled in Medicare and UFA coverage	Eligible for both COBRA and Medicare.
If enrolled in UFA coverage and NOT enrolled in Medicare	You must enroll in Medicare (if eligible) before enrolling in COBRA in order to get both coverages. If you enroll in COBRA before Medicare, you will lose COBRA eligibility upon enrollment in Medicare.
Late enrollment penalties may apply to Medicare premiums if not enrolled within the time frame specified by Medicare.	

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second.

Notification Requirements

The UFA must inform you and any covered dependent within 14 days of your rights to continue coverage under COBRA following the end of your employment or death. This notification will contain a COBRA election form.

You or your dependent must notify the UFA if coverage for a dependent ends as a result of a divorce or a child losing his or her dependent status. The UFA must receive this notification within 60 days of the "qualifying event." **If you or your dependent fail to notify the UFA within this timeframe, COBRA coverage will not be made available.**

If you provide a written notice, your notice must be postmarked no later than the last day of the required notice period. Your notice must include both the:

- Name and address of the member covered under the plan; and
- Name(s) and address(es) of the qualified beneficiary(ies).

After you (or your dependent) have notified the UFA, you will receive a COBRA election form within the time allotted.

Making a COBRA Election

Any individual who is eligible for, and wants, COBRA coverage must make his or her election by calling the UFA within 60 days after the later of the following:

- The date coverage ends as a result of a qualifying event; or
- The date of the notice from the UFA or the COBRA administrator that coverage has ended, and that COBRA continuation coverage is available.

Your election to receive COBRA continuation coverage, if mailed, must be postmarked no later than the last day of the 60-day election period.

If a spouse is notified, that notice also applies for all other covered dependents residing with the spouse — however, each dependent has an independent right to elect continued coverage. No "evidence of insurability" (proof of good health) is required to continue coverage under COBRA.

Your right to elect COBRA will not be affected by other coverage you may have before you elect COBRA coverage (for example, if you have coverage under your spouse's plan at the time your coverage under the UFA plan ends), provided you are also enrolled in the UFA benefits at the time your employment ends. However, if you obtain Medicare or other group coverage after electing COBRA, your COBRA coverage will end, as specified under the ***"How Long COBRA Coverage Lasts"*** section below.

If you or your dependents do not elect COBRA continuation coverage, coverage will end on the date explained previously under ***"When Coverage Ends"*** in the ***"Benefit Basics"*** section.

How Long COBRA Coverage Lasts

An individual's coverage under COBRA ends as explained in the table below. In general, COBRA coverage for an individual previously covered as a member can last for up to 18 months, while COBRA coverage for a dependent who lost eligibility can last for up to 36 months.

If a member is terminated from employment for cause, that member and his or her dependents may not be eligible for COBRA coverage.

The table below shows how long COBRA coverage will continue based on various events.

For the Following Event…	COBRA Coverage Will End No Later than…	
	For You	**For Your Dependents**
Your termination	The last day of the 18-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.	The last day of the 18-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage or up to 36 months depending upon the employee's eligibility for Medicare.

For the Following Event…	COBRA Coverage Will End No Later than…	
	For You	**For Your Dependents**
Your death	N/A	The last day of the 36-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.
You divorce or legally separate from your spouse	N/A	The last day of the 36-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.
Your dependent child is no longer eligible under the terms of the plan	N/A	The last day of the 36-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage,
Non-payment of premium by the end of the grace period (see ***"Cost of COBRA Coverage"*** in this section)	Retroactive to the last month for which coverage was paid.	Retroactive to the last month for which coverage was paid.
You become entitled to Medicare (i.e., enrolled in Medicare)	The date new coverage begins (this date may vary for different individuals in the same family).	The date new coverage begins (this date may vary for different individuals in the same family).
You experience another qualifying event during the 18-month continuation period (see ***"Extended Coverage Due to Another Qualifying Event"*** in this section)	N/A	The last day of the 36-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.
You lose coverage and become disabled (see ***"Extended Coverage Due to a Disability"*** in this section)	The last day of the 29-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.	The last day of the 29-month period following the date group coverage ended, or on the date the UFA stops providing any group health coverage.

In some cases, COBRA coverage may continue for a period longer than that specified in the above table. These circumstances are described below.

Extended COBRA Coverage

The following information applies to you and/or your dependents' COBRA coverage, unless otherwise noted.

Extended Coverage Due to a Disability

If coverage was lost due to your termination of employment, you and your family members who have COBRA coverage (due to the same qualifying event) will be allowed to continue coverage under COBRA for an additional 11 months (in addition to the 18 months available) if you (or the dependent) either:

- Are disabled when your employment ends or your hours are reduced; or
- Become disabled at any time during the first 60 days of COBRA coverage.

This brings your total COBRA eligibility to 29 months. In the event of a disability, this coverage will be extended to the disabled individual and any other family members covered under COBRA.

In order to be eligible for this additional continued coverage, you must notify the COBRA administrator by contacting the UFA:

- Within 60 days following the later of the date Social Security notifies you that you are disabled or the qualifying event; but
- No later than the end of your 18-month COBRA coverage period.

You will be instructed on how to provide the required information, which must include the member's name, the name of the disabled individual as well as a copy of the Social Security Administration disability determination.

If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

You must also notify the COBRA administrator of the determination that you are no longer disabled by contacting the UFA within 30 days of receiving the determination. The additional COBRA continuation coverage (i.e., coverage beyond the original 18 months) will end if you are no longer disabled.

Extended Coverage Due to Another Qualifying Event

If a dependent has continued coverage due to your termination, and another qualifying event (such as your death or a divorce) occurs during the 18-month continuation period, the dependent will be allowed additional COBRA continuation coverage. This extension will be granted for up to a maximum of 36 months from the date COBRA coverage initially began. You must notify the COBRA administrator by contacting the UFA within 60 days of any additional qualifying event.

Extended Coverage Due to Medicare Entitlement

A special rule applies if you become entitled to Medicare benefits less than 18 months before the end of your employment.

In this situation, you are still entitled to up to 18 months of COBRA continuation coverage. However, COBRA continuation coverage for your dependents may last up to 36 months after you become entitled to Medicare. For example, if you were entitled to Medicare eight months before your employment ends, COBRA continuation coverage for your dependents can last up

to 36 months after the date of your Medicare entitlement. In this example, your dependent's COBRA continuation coverage may continue for up to 28 months after the date you enrolled in COBRA coverage (36 months minus eight months).

Cost of COBRA Coverage

You (or your covered dependents) must pay a premium for COBRA continuation coverage, unless premiums are otherwise paid by the UFA pursuant to the ***"Continuation of UFA Benefits Coverage after Employment Ends"*** section above. This premium is actuarially determined and may include:

- The amount you paid toward the cost of this coverage while you were covered as an active member; plus
- Any portion of the premium formerly paid by the UFA; plus
- A 2% administration fee.

The premium will not exceed 102% of the rate that would apply for an active plan participant with similar coverage on the date this premium was due. However, the amount charged to disabled individuals during the 11-month disability extension may be increased to 150% of the current active rate.

Each full COBRA premium is payment for a complete month of coverage. If you elect to end your COBRA coverage in the middle of a month, your premium for that month will not be prorated, and you will not receive a refund. (You may, however, pay for a partial month of coverage at the beginning or end of your COBRA eligibility if your eligibility begins and/or ends in the middle of a month.)

The premium rate will be determined at the beginning of the plan year and will apply to anyone who elects to continue coverage during that period. The premium rate will not change during the plan year, unless the UFA revises the group health care program for all participants, or continuing dependent coverage is terminated because there are no longer any eligible dependents under COBRA coverage.

COBRA Enrollment

- Within 14 business days after the UFA is notified of your loss of coverage, you will receive your COBRA election packet in the mail explaining your continuation rights, your deadline for making your election and how to make payments.
- As a reminder, you must elect COBRA within 60 days after the date you would lose coverage because of a qualifying event, or if later, 60 days after the COBRA Administrator provides you notice of your right to elect continuation coverage. A member or covered dependent who does not choose continuation coverage within the time period described will lose the right to elect continuation coverage.
- Please allow 10-15 business days to process your COBRA election and payment, whether you enroll online or by phone.
- The first payment must be made in full within 45 days from the date of the initial COBRA election.
- Your COBRA coverage will not become effective until you enroll and remit payment for your first month of coverage.

- Once your payment is posted to your account, your coverage will be reinstated as of the date you lost eligibility for group coverage through the UFA. Therefore, you will have no gap in coverage. This process will be completed within ten business days after your payment has been posted.
- If you incur eligible expenses before your COBRA coverage is activated, you may file a claim for reimbursement once your coverage is activated with the medical, dental, or vision claims administrator.

When Payment Is Due

After your COBRA coverage becomes effective, you will receive an invoice on or about the 15th of each month for the upcoming month's COBRA coverage. Your payment is due on the 1st of the month, even if you do not receive an invoice in the mail.

Although your payment is due on the 1st of each month for that month's COBRA coverage, you have a 30-day grace period to make your payment each month in order to maintain eligibility for COBRA coverage. However, your coverage will be suspended until your COBRA payment is processed to reflect that you have paid in full for the current month. This may mean that you must pay out of pocket for certain services, such as prescription drugs. If you pay for prescription expenses out of pocket and file a claim for reimbursement, the prescription drug carrier/administrator may reimburse you only the discounted amount that you would have paid if the pharmacy had processed your prescription through the prescription drug carrier/administrator (so your reimbursement amount may be less than the amount you actually paid for the prescription). Therefore, you should follow up with your pharmacy as soon as possible after coverage is activated to request the pharmacy to submit or re-submit the claim with your prescription drug insurance carrier/claims administrator. Please check with your pharmacy regarding their policy for submitting claims for reimbursement after the prescription has been filled.

Please allow ten days to process your COBRA payment. It is important to mail your payment to the correct address or submit your payment no later than the 18th of each month in order to avoid a suspension of your COBRA coverage.

If your payment is not received within your 30-day grace period, you will lose eligibility for COBRA coverage. In this case, your COBRA coverage will be retroactively terminated as of the last date for which you paid COBRA premiums. If you believe your coverage was canceled inappropriately, you can contact an EBSA benefits advisor electronically at **askebsa.dol.gov** or call **866-444-3272** for assistance.

Please read the front and back of your invoice carefully to determine the correct payment address to mail your payment, along with the payment stub included with your invoice. The address to which you should send your payment may differ depending on your situation. If you have questions regarding the correct address to send your payment, contact the UFA.

In order to ensure timely processing of your payment, you must write your COBRA ID number and your account number on your check, and you must include the payment stub from your invoice when you submit your payment. Failure to include your COBRA ID number, account number, and payment stub with your payment will result in a delay of at least ten business days in processing your payment.

Although an invoice will be mailed to you on a monthly basis, the UFA is not required to send invoices or payment reminders to you. **Therefore, even if you do not receive your invoice in the mail, you are still required to make your payment by the first of each month.**

The UFA may terminate your COBRA coverage if your premium payment is not postmarked before the end of the applicable grace period.

For More Information

Additional information about COBRA coverage will be provided to you (or your dependents) when you (or your dependents) become eligible as explained previously. You may contact the UFA with questions any time after you have received your initial COBRA election packet.

The following table is a recap of the coverage options and their availability for continuation of coverage.

Coverage Option	Continuation Rights
Health benefits (Prescription Drug, Dental, Vision, and Hearing)	You are eligible to continue coverage through COBRA if you were enrolled when you lost eligibility for coverage through the UFA. The UFA will send you a packet explaining how to elect COBRA coverage. If you do not receive a COBRA election packet within 2-3 weeks, contact the UFA.

Continuation of Coverage During an Approved Leave

If the UFA, in accordance with the federal Family and Medical Leave Act of 1993 (FMLA) (or if our Paid Family Leave (PFL) insurance carrier approves your leave request), grants you an approved family or medical leave of absence (approved FMLA leave or PFL leave), you may, during the continuance of such approved FMLA/PFL leave, continue your health care coverage under the Plan (prescription drug, dental, vision, and hearing) for you and your eligible dependents. With an approved FMLA/PFL leave, you also have the option not to continue coverage during the leave. Once you return to work, your coverage will be reinstated.

At the time you request the leave, if you continue coverage for yourself and your eligible dependents, you agree to make any contributions required by the UFA to continue this coverage as if you remained working. The amount you must pay toward this coverage will not exceed the amount an active member pays for coverage under the same plan. Contact the UFA to discuss the payment options available to you in accordance with applicable law.

If you are granted continued coverage while on an approved FMLA/PFL leave, your coverage may end on the earliest of the following:

- The date you are required to make any contribution, and you fail to do so (see below for additional info); or
- The date the program (or a particular coverage within the program) is discontinued; however, coverage for health expenses may be available to you under another plan sponsored by the UFA.

If your health coverage ends because your approved leave ends and you are unable to return to work, you may, on the date of such termination, be eligible for continuation of coverage.

If you gain a new dependent while your coverage is continued during an approved leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work (and not on an approved FMLA/PFL leave). **You should**

enroll your new dependent for coverage within 31 days of the qualifying change in family status (60 days for birth or adoption). Coverage for a dependent will not be continued under the terms of this provision beyond the date it would otherwise end.

If you return to work for the UFA immediately following the date the UFA (or our PFL insurance carrier) determines the approved leave is terminated, and you were covered on the date your approved leave terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved leave.

If any coverage being continued terminates, you will be eligible to continue coverage under COBRA. See ***"COBRA Continuation Coverage"*** in this section for more information.

Nonpayment of Health Benefit Coverage Contributions

If your coverage continued while you were on an approved leave and you are now returning to work, you will retain the same benefits upon your return to work as you had prior to your coverage ending as long as your prior coverage options remain available.

If your coverage ended for non-payment of contributions and you are now returning to work, you will be automatically reinstated to the same benefits upon your return to work as you had prior to your coverage ending as long as your prior coverage options remain available. However, the coverage will be effective from the date you return to work. This means that you will not be required to meet the Plan's eligibility rules to the extent they were met before the leave. You will be required to reimburse the UFA for its cost of providing your coverage during your leave before your coverage ended. As a result, your normal per paycheck contributions for coverage will be two times the amount listed when your elections were recorded until prior premiums are fully repaid.

If you continue coverage and then fail to return to work at the end of your leave, you may be required to reimburse the UFA for its cost of providing your coverage during your leave, to the extent permitted under applicable law. You will not be required to repay the UFA if the reason you do not return is due to a serious health condition that would entitle you to take leave under FMLA or other circumstances beyond your control.

If you experience a qualifying change in family status while on a leave of absence, you may change your elections, provided you do so within the appropriate timeframe, as described under ***"Summary of Allowable Changes"*** in the ***"Qualifying Change in Family Status Guide"*** section.

The coverage election that you make must be consistent with the qualifying change in family status that you experience, as described under ***"Summary of Allowable Changes"*** in the ***"Qualifying Change in Family Status Guide"*** section.

USERRA

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), members required to leave their job to perform military service may elect to continue health care coverage in effect under the UFA program for themselves and eligible dependents. If a military leave is for 30 days or less, the coverage may be continued at the active member rates. For longer leaves of more than 30 days, coverage may be continued for up to 24 months from the effective date of the military leave at a rate of 102% of the group rate premium. This extended leave works like COBRA and runs concurrently with any COBRA rights.

See ***"COBRA Continuation Coverage"*** in this section for information regarding the cost of coverage during this 24-month period.

Your USERRA continuation coverage will end earlier if any of the following events occur:

- You fail to pay the required contributions on time;
- You lose your USERRA rights due to a discharge status that is other than honorable or other conduct specified in USERRA; or
- You fail to report to work or to apply for reemployment following the completion of your service in the uniformed services within the time required by USERRA as described in the military leave chart shown in ***"Other Information"*** section below.

USERRA and COBRA

USERRA and COBRA coverage run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to 18 months (and for longer periods under certain circumstances) while, as noted previously, USERRA coverage can continue for up to 24 months. In addition, COBRA coverage is subject to early termination for additional reasons that do not apply to USERRA coverage. COBRA is explained in detail in the ***"COBRA Continuation Coverage"*** section.

Payment of Contributions

If you elect to continue health care coverage under USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as for COBRA coverage). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as a regular active member.

Other Information

If you leave employment to enter military service, you should contact the UFA to answer any questions you may have regarding continued coverage under USERRA and to provide notification of any changes in marital status or address.

If You Have Coverage Under Another Plan: Coordination of Benefits

Plans Other than Medicare

If you or any covered dependents are covered by more than one group prescription drug, vision, or dental plan, reimbursements are coordinated between the plans so that benefits aren't duplicated.

When you're covered by more than one plan, the plan that pays benefits first is called the primary plan. The primary plan pays its benefits without considering what the other plan may pay. The other plan (secondary plan) may pay additional benefits depending on its coordination of benefits (COB) provisions.

When the UFA Plan is secondary, your reimbursement is adjusted so that the total reimbursement you receive from both plans is not more than the amount that would have been paid if you were only covered by the UFA Plan. This means:

- If the UFA benefit payable is less than or equal to the other plan's payment, no payment is made by the UFA Plan.
- If the UFA benefit payable is more than the other plan's payment, the UFA Plan will pay the difference between what the other plan pays and what the UFA Plan would have

paid if you had no other coverage. For example, if the other plan pays $80 and the UFA Plan would have paid $85, the UFA Plan will pay $5.

You must apply for benefits under the primary plan before the prescription, vision, or dental claims administrator will consider a claim under this Plan.

How the Primary Plan Is Determined

The following rules determine which plan will pay first:

- If one of the plans has no COB provision, that plan is always primary.
- When both plans have a COB provision:
  - The plan covering the person as a member is the primary plan. The UFA Plan is primary for all covered UFA active members and as applicable, retirees.
  - If you and your spouse both cover your children, and you're not separated or divorced, the plan of the parent whose birthday (month and day) occurs first in the calendar year is primary.
- The plan covering the person as an active member, or the dependent of an active member, pays benefits before a plan that covers the person as a laid-off or retired member, or his/her dependents. If the other plan doesn't include this or a similar rule, it will not apply.

The plan covering the person as an active member, or the dependent of an active member, pays benefits before the plan that covers the person as a COBRA participant. If you and your spouse are legally separated or divorced and you both cover your children, the following rules apply:

- If a court or administrative order makes one parent financially responsible for the child's health care coverage, that parent's plan is primary.
- If the court doesn't assign financial responsibility for the child's health care through a qualified medical child support order (QMCSO), the plan of the parent with legal custody is primary. If joint custody, the plan of the parent whose birthday (month and day) occurs first in the calendar year is primary. If both parents have the same birthday, the plan that has covered the child longer is the primary plan.
- If the parent with legal custody remarries, the order of payment is:
  - The plan of the parent with custody is primary;
  - The plan of the stepparent is secondary; and
  - The plan of the parent without custody is tertiary.
- If none of these rules apply, the plan that has covered the person longer is the primary plan.

Other Plans

The term "other group medical plan" in this section includes any of the following:

- Group or group-type plans, including franchise or blanket benefit plans;
- Group practice and other group prepayment plans;

- Other plans required or provided by law, other than Medicaid; and
- No-fault motor vehicle coverage.

Other COB Provisions

Right to Exchange Information

To coordinate benefit payments, the prescription drug, vision, hearing, or dental claims administrator needs certain information. The claims administrator has the right to obtain the information necessary to apply the rules stated previously, or to give information to any other organization or individual for the same purpose. The claims administrator is not required to obtain your consent or to notify the individuals about whom such information is sought.

The covered person must give the claims administrator the information it asks for about other plans. If the covered person cannot furnish all the information the claims administrator needs, the claims administrator has the right to get this information from any source. If this information is not provided by the covered person or the requested source, your claim for benefits may be denied.

Payments Made

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Plan. The UFA will not have to pay that amount again.

The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of payments the Plan makes is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the individuals the Plan paid or for whom the Plan paid; or any other individual or organization that may be responsible for the benefits or services provided for you. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Medicare and Other Government Plans

Benefits provided through a UFA plan aren’t intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances individuals who are eligible for or are enrolled in Medicare may also be enrolled under a UFA plan.

Medicare

When an individual who is covered under the SBF or RFSBF becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the UFA is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

An Important Note about Medicare Enrollment Requirements

When the UFA health plan pays benefits first, without regard to Medicare, and you want Medicare to pay medical benefits after this Plan, you must enroll for Medicare Parts A and B. For information about prescription drugs, see ***“ An Important Note about the UFA Prescription Drug Benefits for Active Members and Their Dependents and Medicare Part D”*** section below.

If you don't enroll for Medicare when first eligible, you must enroll during the special enrollment period that applies to you when you stop being eligible under this Plan in order to avoid paying a premium penalty for late enrollment. This special enrollment period is not available for domestic partners. Domestic partners who become eligible for Medicare based on age should enroll for Medicare when first eligible, even if you're still actively employed.

When this Plan Pays Primary to Medicare

This Plan pays primary to Medicare for individuals enrolled in Medicare if eligibility for Medicare is due to the individual being:

- Age 65 and the member has "current employment status" with the UFA, as defined by federal law and determined by the UFA.
- Disabled and the member has "current employment status" with the UFA, as defined by federal law and determined by the UFA.

This Plan will also be primary if eligibility for Medicare is due to end-stage renal disease (ESRD) under the conditions of and for the periods specified by federal law, generally no longer than 30 months.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan, as outlined below, for individuals enrolled in Medicare if eligibility for Medicare is due to:

- A domestic partner becoming eligible for Medicare due to attainment of age 65;
- Disability and the member doesn't have "current employment status" with the employer, as defined by federal law and determined by the employer; or
- End-stage renal disease (ESRD), but only after the conditions and/or periods specified in federal law cause Medicare to become primary.

When Medicare would pay benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, regardless of whether the individual enrolled in Medicare. If Medicare would be your primary payer, you should enroll for both Parts A and B when you're first eligible; otherwise, the expenses may not be covered by this Plan or by Medicare.

How this Plan Pays When Medicare Is Primary

If Medicare pays benefits first (when the employee does not qualify for the RFSBF and is not a current employee), this Plan pays benefits as described below. This method of payment only applies to individuals eligible for Medicare. It doesn't apply to any covered individual unless that individual becomes eligible under Medicare and Medicare is the primary payer.

The amount of charges for covered expenses under this Plan is determined first; however, the amount of covered expenses is based on the amount of charges allowed under Medicare rules instead of the reasonable and customary charges as defined by the Plan.

- Then, the amount payable under Medicare for the same expenses is subtracted from the amount the Plan would have paid if the UFA Plan were your only coverage. This Plan pays the difference between the two amounts.

- The amount payable under Medicare, which is subtracted from this Plan's benefits, is determined as the amount that would have been payable under Medicare when Medicare is primary even if the individual:
    - Is not enrolled for Medicare — Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
    - Is enrolled in a Medicare+Choice (Medicare Advantage) plan and receives non-covered out-of-network services because the individual didn't follow rules of that plan — Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
    - Receives services from a provider who has opted out of Medicare — Medicare benefits are determined as if the services were covered under Medicare Parts A and B, and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
    - Receives services in a Veterans Administration facility or other facility of the federal government — Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
    - Is enrolled under a plan with a Medicare Medical Savings Account — Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

An Important Note about the UFA Prescription Drug Benefits for Active Members and Their Dependents and Medicare Part D

Medicare participants are eligible to receive prescription drug benefits through Medicare, provided they enroll in — and pay the extra premium for — Medicare Part D. However, it's important to understand that the prescription drug benefits provided to active members and their dependents through the Prescription Drug Plan are deemed "creditable" and thus a Medicare-eligible individual who is also covered under one of these plans can choose not to enroll in Medicare Part D and continue to receive prescription drug benefits at no cost through this plan. Furthermore, such individual can generally enroll in Medicare Part D at a later date without penalty since he or she was covered under a plan that provided "creditable coverage," as long as there is not a break in coverage of more than 63 days.

The UFA distributes notices of creditable coverage in accordance with Medicare regulations.

Medicaid

Medicaid (also called Medical Assistance) is a joint federal and state program that helps pay medical costs for certain people and families who have limited income and resources and meet other requirements. When you enroll in a Medicaid Health Plan, Medicaid is generally the payer of last resort. This means that if you're enrolled in both the UFA coverage and Medicaid, the UFA/SBF/RFSBF coverage generally will pay for covered services first, and your Medicaid Health Plan generally pays only after the UFA coverage pays. Also, you should know that if the UFA coverage pays more than Medicaid normally pays, it is possible that your Medicaid Health Plan may not pay anything at all.

If you or a dependent is enrolled in Medicaid, you should check with your state Medicaid agency for more information about how Medicaid will pay for covered services after the Plan pays.

Government Plans (Other than Medicare and Medicaid)

If you or a dependent are also covered under a government plan, this Plan doesn't cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to the individual under the government plan.

This provision doesn't apply to any government plan, which by law requires this Plan to pay primary.

A government plan is any plan, program, or coverage — other than Medicare or Medicaid — established under the laws or regulations of any government, or in which any government participates other than as an employer.

In all cases, the final COB determination will be made by the Plan Administrator.

Additional Provisions

Refund of Overpayments

If benefits are paid under this Plan for expenses incurred on account of a covered individual, that covered individual or any other individual or organization that was paid must make a refund to the Plan if all or some of the:

- Expenses were not paid by the covered individual or did not legally have to be paid by the covered individual.
- Payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another individual or organization, the covered individual agrees to cooperate with the UFA in obtaining the refund when requested.

If the covered individual, or any other individual or organization that was paid erroneously, doesn't promptly refund the full amount, the Plan may reduce the amount of any future benefits payable to that individual that are payable to that individual under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the claims administrator for the UFA. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Subrogation and Right of Recovery

Definitions

As used throughout this provision, the term **responsible party** means any party actually, possibly, or potentially responsible for making any payment to a covered individual due to a covered individual's injury, illness, or condition. The term responsible party includes the liability insurer of such party or any insurance coverage, or any party of fault determined by a factfinder. This term applies whether or not the covered individual is partially at fault.

For purposes of this provision, the term **insurance coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, homeowner's insurance, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a covered individual includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or dependent of any Plan participant or person entitled to receive any benefits from the Plan.

Subrogation

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a covered individual has against any responsible party with respect to any payment made by the responsible party to a covered individual due to a covered individual's injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan.

Reimbursement

In addition, if a covered individual receives any payment from any responsible party or insurance coverage because of an injury, illness, or condition, the UFA has the right to recover from, and be reimbursed by, the covered individual for all amounts this Plan has paid and will pay because of that injury, illness, or condition, up to and including the full amount the covered individual receives from any responsible party. This right to reimbursement applies regardless of the manner in which the recovery is structured or worded, and even if the covered individual has not been paid or fully reimbursed for all of his or her damages or expenses. The amount repaid to the Plan shall not be reduced to pay any attorneys' fees or costs incurred in connection with securing recovery related to the injury, illness, or condition.

Constructive Trust

By accepting benefits — whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider — from the Plan, the covered individual agrees that if he/she receives any payment from any responsible party because of an injury, illness, or condition, he/she will immediately notify the Plan and serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust may result in (a) a suspension of future benefits under the Plan; (b) offset against amounts that would otherwise be paid to or on behalf of the covered individual; and/or (c) termination of the covered individual's coverage under the Plan.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the UFA for the treatment of the injury, illness, or condition for which the responsible party is liable.

The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any injury, illness, or condition for which the UFA paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the UFA including, but not limited to, the covered individual; the covered individual's attorney, representative or agent; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan or the UFA. A covered individual may not assign their rights to any other party without the express written consent of the UFA or the Plan.

First-Priority Claim

By accepting benefits — whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider — from the Plan, the covered individual acknowledges that this Plan's recovery rights are a first priority claim against all responsible parties and are to be paid to the Plan before any other claim for the covered individual's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis

from any responsible party's payments, even if such payment to the Plan will result in a recovery to the covered individual which is insufficient to make the covered individual whole or to compensate the covered individual in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the covered individual to pursue the covered individual's damage claim. Further, this Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence of any other equitable defenses that may affect this Plan's right to subrogation or reimbursement.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any responsible party and regardless of whether the settlement or judgment received by the covered individual identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

The Plan has the right to recover any monies due out of future benefit payments for the covered individual and may suspend all future benefits related to the covered individual until the Plan is repaid in full.

Cooperation

The covered individual shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the covered individual to notify the Plan within 30 days from the date when any notice is given to any party, including an insurance company or attorney, of the covered individual's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the covered individual.

The covered individual and his/her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. The Plan has the right to terminate the covered individual's participation in the Plan or to institute court proceedings against the covered individual in the event that the covered individual fails to provide information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

The covered individual shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but isn't limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan. Additionally, the covered individual may not assign his or her rights to settlement or recovery against a responsible party to any other party, including his or her attorneys, without the UFA or the Plan's express written consent.

The covered individual acknowledges that the UFA has the right to conduct an investigation regarding the injury, illness, or condition to identify any responsible party. The UFA reserves the right to notify the responsible party and his/her agents of its lien. Agents include, but aren't limited to, insurance companies and attorneys.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the covered individual or made on behalf of the covered individual to any provider) from the Plan, the covered individual agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the covered individual hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Any reference to state law in any other provision of this policy will not apply to this provision if the underlying benefit plans are governed by ERISA. By acceptance of benefits under the Plan, the participant agrees that a breach of these rules would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the underlying benefit plans are entitled to invoke such equitable remedies as may be necessary to enforce the terms of those plans, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Type of Coverage

Coverage under the Plan is non-occupational. Only non-occupational accidental injuries and non-occupational diseases are covered. Coverage for occupational injuries and diseases are covered under the Workers' Compensation program. Benefits under this Plan do not substitute or affect any requirements for coverage under Workers' Compensation.

Any coverage that applies to charges for services and supplies is provided only if they are furnished to an individual while covered.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.

Clerical Error

If a clerical error or other mistake occurs, that error doesn't create a right to benefits. These errors include, but aren't limited to, providing misinformation on eligibility or benefit coverage or entitlement.

Oral statements made by the Plan Sponsor, the Plan Administrator, the claims administrator, or any other individual may not amend the terms of this Plan. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

It is your responsibility to confirm the accuracy of statements made by the UFA or its designees, including the claims administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times, the claims administrator may need additional information from you. You agree to furnish all information and proof that may reasonably be required regarding any matters

pertaining to the Plan; if you don't provide this information when requested, it may delay payment or result in a denial of benefits.

By accepting benefits under the Plan, you authorize and direct any individual or institution that has provided services to you to furnish the claims administrator with all information or copies of records relating to the services provided to you. The claims administrator has the right to request this information at any reasonable time. This applies to all covered individuals, including dependents enrolled by the member. The claims administrator agrees that such information and records will be considered confidential.

The claims administrator has the right to release any and all records concerning health care services that are necessary to implement and administer the terms of the Plan for appropriate medical review or quality assessment, or as required by law or regulation. During and after the term of the Plan, the claims administrator and related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

If you would like complete listings of your medical records or billing statements, we recommend you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the claims administrator, you may be charged reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the claims administrator will designate other persons or entities to request records or information from or related to you, and to release those records, as necessary. Such designees have the same rights to this information as the Plan Administrator.

Qualifying Change in Family Status Guide

A qualifying change in family status is a life- or work-related change that allows you to change your benefits outside annual enrollment to accommodate the change.

Use the Summary of Allowable Changes table as a guide when you experience a qualifying change in family status. You'll find useful information about the types of changes you can make to your benefits based upon your changing circumstances.

Benefit changes can be made within the recommended timeframe, as shown here, by providing the necessary documentation (for example, birth and marriage certificates).

Qualifying Change in Family Status	Deadline for Changing Your Benefit Election
You have a baby, adopt a child, or a child is placed with you for adoption, so you add your new dependent to your health benefits. Or you enroll in the Prescription Drug, Dental, Vision or Hearing plan — and include your new dependent in your enrollment.	60 days
You or your eligible dependents gain or lose Medicaid or Children's Health Insurance Program (CHIP) eligibility.	60 days
You or your eligible dependents become eligible for COBRA coverage.	60 days
All other qualifying changes in family status — divorce, marriage, death, employment change that affects your benefits-eligibility status.	30 days

Notification of Change in Family Status

The Security Benefit Fund must be informed of ANY changes in your status. For example:

- When you get married, we need a copy of the marriage certificate and your spouse's full Social Security number.
- When you become a new parent, we need a copy of the birth certificate and the child's full Social Security number.
- If you get divorced, we need a copy of the first and last page of the divorce decree. If your ex-spouse is awarded a portion of your Compensation Accrual Fund (or CAF), it will be noted in either your divorce decree or in a document known as a Qualified Domestic Relations Order (or QDRO). If so, you MUST notify the UFA/CAF. Send a FULL copy of

the finalized QDRO or divorce decree (where the award is stipulated) to the UFA/CAF. The fax number is **212-683-0693**.

- When a spouse dies, we need a copy of the death certificate.
- When you move, please update your address with the SBF.

If you wish to add or remove a domestic partner, please contact SBF for instructions.

Email: **sbfstaff@ufanyc.org** or call **212-683-4723** or look on the UFA website for information (**ufanyc.org**).

For ANY change in status, you should update your beneficiaries with the UFA. The easiest way to do this is to submit a beneficiary enrollment card electronically by going to **ufanyc.org/retirees/forms/#**. You can also email **sbfstaff@ufanyc.org** or call the Security Benefit Fund at **212-683-4723** to request a beneficiary enrollment card — however you are HIGHLY ENCOURAGED to submit it electronically at **ufanyc.org/retirees/forms/#**. Once you receive it, fill it in, sign and date it, and return it to the SBF as soon as possible.

To change your address with the NYC Fire Pension Fund, or to make changes for direct deposit, please call NYC Fire Pension Fund at **929-436-0099 / 929-436-4838** or email **info@nycfirepension.org**.

Summary of Allowable Changes

Qualifying Change in Family Status	Benefit	Available Changes
Newly Eligible for the UFA Coverage		
You gain a dependent through marriage, birth, adoption or placement for adoption of a dependent child.	Prescription Drug	Add your dependent to coverage
	Dental and Vision	Add your dependent to coverage
	Life Insurance	Increase your life insurance coverage
You form a domestic partnership.	Prescription Drug	Add your dependent to coverage
	Dental and Vision	Add your dependent to coverage
	Life Insurance	Increase your life insurance coverage

Qualifying Change in Family Status	Benefit	Available Changes
Your Domestic Partner's previously ineligible child becomes eligible for benefits.	Prescription Drug	Add your dependent to coverage
	Dental and Vision	Add your dependent to coverage
	Life Insurance	Increase your life insurance coverage
A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires either: • You to provide health coverage for your child or dependent foster child; or • Your spouse, former spouse or other individual to provide coverage for your child or foster child if that other person does in fact provide that coverage.	Prescription Drug	Remove your spouse from coverage
	Dental and Vision	Remove your spouse from coverage
	Life Insurance	Increase or decrease your coverage amount
Loss of Eligibility for UFC Coverage		
Your dependent ceases to qualify as a dependent under this coverage. (For example, your dependent child reaches the age limit.)	Prescription Drug	Remove your dependent from coverage
	Dental and Vision	Remove your dependent from coverage
	Life Insurance	None
A change in your or your dependent's employment status, such as beginning or ending employment,	Prescription Drug	Enroll yourself and/or add or remove your dependent from coverage

Qualifying Change in Family Status	Benefit	Available Changes
strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage.	Dental and Vision	Enroll yourself and/or add or remove your dependent from coverage
	Life Insurance	None
Gains Other Coverage		
You or your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines).	Prescription Drug	Drop coverage for yourself and/or your dependent
	Dental and Vision	Drop coverage for yourself and/or your dependent
	Life Insurance	None
Loses Other Coverage		
Loss of eligibility for other group coverage, termination of program sponsor contributions for the other group coverage, COBRA Continuation of the other group coverage was exhausted.	Prescription Drug	Enroll yourself and/or add your dependent(s) to coverage
	Dental and Vision	Enroll yourself and/or add your dependent(s) to coverage
	Life Insurance	None
You or your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.	Prescription Drug	Enroll yourself and/or add your dependent(s) to coverage
	Dental and Vision	Enroll yourself and/or add your dependent(s) to coverage
	Life Insurance	None

Qualifying Change in Family Status	Benefit	Available Changes
You or your dependent loses entitlement to Medicare or Medicaid eligibility.	Prescription Drug	Enroll yourself and/or add your dependent(s) to coverage
	Dental and Vision	Enroll yourself and/or add your dependent(s) to coverage
	Life Insurance	None
Leaves of Absence		
Taking leave under the Family and Medical Leave Act.	Prescription Drug	Coverage continues as long as premiums are paid; can enroll or make changes if an annual enrollment occurs during the leave
	Dental and Vision	
	Life Insurance	
Move		
A change in your or your dependent's residence, if it causes you or your dependent to gain or lose coverage.	Prescription Drug	Enroll or drop coverage, as applicable
	Dental and Vision	Enroll or drop coverage, as applicable
	Life Insurance	None
Significant Plan Change(s)		
A significant curtailment in your current option, a significant improvement in an option for which you are not enrolled, a significant increase or decrease in cost for one or more of the options under the Plan, or a new benefit option under the Plan.	Prescription Drug	Enroll or drop coverage
	Dental and Vision	Enroll or drop coverage
	Life Insurance	None

Rights and Administrative Information

This section provides you with important information about the member benefits available to you through the UFA. In this section, you will find information regarding:

- The administration of the UFA benefit plans including prescription drug, dental, vision, and hearing coverage and life insurance.
- The rights guaranteed to you under federal law.
- Additional administrative information.

Administrative Information

The following information applies to the Plan:

Plan Name	Uniformed Firefighters Association ("UFA") of Greater New York Health and Welfare Benefits Program.
Plan Type, Funding, and Administration	Welfare benefit plan. The benefits provided under the Plan are described elsewhere in this SPD. Certificates of Coverage are provided in Appendix B.
Plan Funding and Administration	Plan benefits are funded through the Security Benefit Fund ("SBF") for active members and their covered dependents, and the Retired Firefighters Security Benefit Fund ("RFSBF") for Medicare-eligible retired members and their covered dependents. The SBF and RFSBF are funded through contributions made by the Contributing Employer(s) and members of the Uniformed Firemen's Association, Local 94, I.A.F.F. AFL-CIO. The ***"Directory of Benefits"*** section of the SPD lists the insurance companies and third-party administrators/claims administrators for the benefits offered under the Plan. The ***"Directory of Benefits"*** also describes whether a benefit is fully-insured or self-insured, whether employees must enroll in the coverage or they are automatically covered, and whether employees must contribute toward the cost of the benefit.
Plan Year	January 1 through December 31.
Plan Sponsor and Contributing Employer(s)	The Security Benefit Fund ("SBF") for active members and their covered dependents, and the Retired Firefighter Security Benefit Fund ("RFSBF")

	for Medicare-eligible retired members and their covered dependents are the Plan Sponsors. The Plan is maintained pursuant to a collective bargaining agreement between the Uniformed Firemen's Association, Local 94, I.A.F.F. AFL-CIO, and the following Contributing Employer(s): City of New York.
Employer Identification Number	• Security Benefit Fund ("SBF"): 13-2505742 • Retired Firefighters Security Benefit Fund ("RFSBF"): 51-0180654
Plan Administrator	Board of Trustees of the SBF and the RFSBF **212-683-4832**.
Agent for Service of Legal Process	Board of Trustees of the SBF and the RFSBF **212-683-4832**.

Plan Documents and Other Communications

In all cases, the provisions of the Plan document, the insurance contracts, and trust agreement (if any) control the administration and operation of the Plan and any underlying benefits.

If a conflict arises between verbal descriptions, information in this SPD, insurance certificates of coverage, or insurance contracts, the following documents will govern, in this order:

- Applicable insurance contract;
- Applicable certificate of coverage; and
- This combined Plan document/Summary Plan Description.

From time to time, additional communications may be made about benefits under the Plan, for example, benefit summaries other than this SPD, enrollment materials, and verbal representations made by individuals at the UFA. These communications do not govern benefits under the Plan and are provided solely for informational or administrative purposes. Your benefits are controlled solely by this combined Plan document/Summary Plan Description, insurance contract, and certificate of coverage.

Administrative Services and Benefits Claims

The current Plan Administrator for the Plan is the Board of Trustees of the Security Benefit Fund ("SBF") and the Retired Firefighters Security Benefit Fund ("RFSBF"). The Plan Administrator may, in his sole discretion, arrange for other individuals or entities to provide administrative services regarding particular benefits and to determine benefit claims under the Plan. The identity of the service providers and the nature of the services they provide may be changed from time to time at our sole discretion — the Plan Administrator is not required to provide prior notice of or receive approval for any such change.

It is your responsibility to cooperate with these individuals or entities in the performance of their responsibilities.

Discretionary Authority

The Plan Administrator and the claims administrators have sole and exclusive discretion to administer the Plan, including but not limited to the authority to:

- Interpret benefits under the applicable benefit plan.
- Interpret the terms, conditions, limitations, and exclusions of the applicable benefit plan, including this SPD and any riders and amendments.
- Make factual determinations related to the applicable benefit plan, plan benefits, and eligibility requirements.
- Determine all claims and appeals under the Plan.

The Plan Administrator and the claims administrators may delegate this authority to the individual or entity selected by the Plan Administrator at its discretion. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect.

In certain circumstances, for purposes of overall cost savings or efficiency under the health care plans, we may, in our sole discretion, offer benefits for services that would otherwise not be covered health services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

No Guarantee of Employment

By adopting and maintaining the Plan, the Employer has not entered into an employment contract with any member. Nothing in this SPD or other official Plan documentation gives any member the right to be employed by the UFA or interferes with the UFA's right to discharge any member at any time and for any reason. Similarly, this Plan does not give the employer the right to require any member to remain employed by the employer or interfere with the member's right to terminate employment with the UFA at any time and for any reason.

Plan Amendment or Termination

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the Plan or any underlying benefit plans and policies in whole or in part, at any time for any reason without notice.

If any of the benefit plans and policies are terminated, you have no further rights under the affected plan other than payment of claims for eligible expenses that you incurred before the plan terminated.

If the Plan Sponsor terminates the Plan or any underlying benefit plan, you may be able to convert certain group coverage(s) to an individual policy(ies); however, restrictions and limitations may apply.

Any provision of the Plan which, on its effective date, conflicts with the requirements of federal statutes or regulations, or applicable state law provisions (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations.

No Guarantee of Tax Consequences

Neither the Plan, Plan Administrator, Plan Sponsor, or Employer makes any commitment or guarantee that any amounts paid to you or for your benefit will be excludable from your gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any participant in the Plan. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income and employment tax purposes, and to notify the Plan Administrator if you have reason to believe that any such payment is not so excludable.

Directory of Benefits

The Plan is made up of the following underlying benefit plans. Individual plan information is listed in the directory below.

As you review the directory, consider the following:

Self-insured means that the UFA pays the claims and related administration costs incurred by its members and their eligible dependents through contributions from the general assets of the Employer or by funding it through a trust established for the purpose of paying benefits. In this case, the Plan Administrator or its designee, like a claims administrator, administers each self-insured plan benefit and reviews and decides claims for those benefits.

Generally, insured means that an insurance carrier is responsible for claims incurred by the UFA members and their eligible dependents which are funded by insurance premiums paid by the UFA and/or members. The insurance company is the claims administrator and reviews and decides claims for benefits under the fully insured Plan benefits.

Health and Welfare Plans	Claims Administrator or Insurance Carrier	Financing Arrangement	Elective or Default Benefit
Dental	MetLife **metlife.com/UFAdental** MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 **866-832-5756** (Dental PPO) **800-880-1800** (Dental HMO)	Insured	Election required
Prescription Drug	CVS/Caremark (active & non-Medicare-eligible retirees) **caremark.com** **866-832-0563** SilverScript (Medicare-eligible retirees) **silverscript.com** **866-412-5373**	Self-insured	Election required
Vision	General Vision Services #7552 (active members) #7553 (retired members) 520 8th Avenue, 9th Floor New York, NY 10018 **800-847-4661**	Insured	Election required
Hearing	General Hearing Services #7552 (active members) #7553 (retired members) 520 8th Avenue, 9th Floor New York, NY 10018 **800-480-0558**	Insured	Election required
Life Insurance	First Symetra National Life Insurance Company of New York 420 Lexington Ave, Suite 300 New York, NY 10170-0399 **800-457-9015**	Insured	Default benefit No employee contributions required for basic life insurance; required for supplemental life insurance

Filing a Claim for Benefits

This section provides you with important information about how to file a claim for benefits for self-funded benefits (Prescription Drug benefits for both active and retired members) under the Plan. In this section, you will find information regarding when to file a claim and specific procedures regarding the following claims types:

- Eligibility and enrollment;

- Health benefit claims;
- Survivor benefit claims; or
- Continuation of coverage benefit claims.

For information about filing claims for benefits under the insured plans (e.g., Dental HMO and Life Insurance), please see the certificates of coverage found in **"*Appendix B*"** in this document.

When to File a Claim

If you believe that you are eligible to receive benefits under any of these plans, you should file a claim for benefits. Under certain health care plans, you may not need to file a claim to receive benefits. For example, most network medical, dental, and vision care providers will submit claims directly to the plan. For details about when you need to file a claim, refer to the applicable certificate of coverage found in **"*Appendix B*"**.

All claims submitted to the claims administrator or insurer must be on forms provided by the claims administrator or insurer unless forms are not currently available, in which case you may simply supply the appropriate party with a written statement outlining the details of your claim.

Complete the claim form according to the directions and return it to the appropriate claims administrator or insurer within the specified timeframe. If you do not submit a claim within the specified timeframe, your claim may be denied. Claims must be submitted to the claims administrator or insurer at the address specified in ***"Directory of Benefits"*** in this section.

Once your claim has been reviewed, you will receive the appropriate benefit or a notification of adverse benefit determination from the claims administrator.

Eligibility and Enrollment Claims

For questions and information regarding eligibility or enrollment, please consult the applicable benefit sections of this SPD.

If you received a denial from the UFA on any eligibility or enrollment issue and believe that the denial is not justified, please submit a written appeal to:

Board of Trustees
Security Benefit Fund and Retired Firefighters Security Benefit Fund of the Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010

Eligibility and enrollment issues include, but are not limited to:

- Denial of benefit elections due to a late enrollment;
- Denial of an election change in connection with a qualifying change in family status because you missed the deadline; or
- Ineligibility for health incentives due to a missed deadline.

You should send your written appeal, along with the reasons you believe that the denial was inappropriate and any other documentation that supports your position, to:

Board of Trustees
Security Benefit Fund and Retired Firefighters Security Benefit Fund of the Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010

Your appeal and all supporting documentation must be received by the Board of Trustees within 60 days of the date you or your dependent are determined to be ineligible or denied enrollment. The UFA will respond to your appeal as soon as possible, but not later than 60 days after its receipt.

If your initial appeal is denied, a second level appeal is available. You must submit your second level appeal in writing within 60 days of receipt of notice that your first level appeal was denied. More information about the second level appeal will be provided in the decision on the initial appeal.

Benefit Claims

In General. The Plan Administrator has the responsibility and sole discretionary authority for interpreting the terms of the Plan, except as provided below. All decisions and interpretations of the Plan Administrator, or its designee, made pursuant to the Plan will be final, conclusive, and binding on all persons, subject only to the Plan's claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

Insured Benefits. The Company provides certain benefits through the purchase of insurance policies for which it makes contributions. Each insurance company is responsible for determining eligibility for, and the amount of, any benefit payable under its policy and for prescribing claims procedures to be followed. The insurers are listed in the ***"Directory of Benefits"*** section above and in ***"Appendix A"***. All claims for benefits and appeals are filed directly with the applicable insurance company. The procedures for submitting claims and appealing denied claims for insured benefits are described in the applicable benefit materials published by the insurer. See the applicable certificate of coverage in ***"Appendix B"*** for more details.

Each insurer is a "fiduciary" under the Plan. Each insurer has sole and complete discretion to interpret and administer all claims and appeals for the applicable insured benefit under the Plan and such decisions will be conclusive and binding.

Self-Insured Benefits. The Company provides certain benefits on a self-insured basis, meaning that claims are paid from the Company's general assets. The Company has hired third-party administrators (also known as claims administrators) to administer those claims. The claims administrator is responsible for determining eligibility for and the amount of any benefit payable. The claims administrators are listed in ***"Appendix A"***. The specific procedures for submitting claims and appealing denied claims for self-insured benefits are set forth in ***"Appendix A."***

Claims and *Appeals*. The claims and appeals procedures for all benefits provided under this Plan are described in **"*Appendix A"*** or are found in the applicable certificate of coverage found in ***"Appendix B."***

Statute of Limitations and Exhaustion of Administrative Remedies. You must use and exhaust the Plan's administrative claims and appeals procedures before you can file suit in court. See ***"Appendix A"*** for more details on the procedures regarding a statute of limitations, where suit must be filed, and exhaustion of administrative remedies.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act ("HIPAA") requires group health plans to notify plan participants and beneficiaries about their policies and practices to protect the confidentiality of their health information. The following notice satisfies the HIPAA requirement with respect to all health information created, received, or maintained by UFA health benefits program (prescription drug, dental, vision, and hearing benefits).

While providing you with this notice is a requirement under HIPAA, we would like to take this opportunity to assure you that our practice has been — and will continue to be — to treat any of your personal health information that may be obtained as sensitive and confidential. In addition, Human Resources professionals and any UFA representative who may have access to your Protected Health Information or PHI (that is, any health information that identifies you, as more fully described below) are bound by HIPAA standards to protect that information.

To help you understand the following notice, we have summarized a few key points:

Specifically, the group health plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Provide you with this notice of the Plan's legal duties and privacy practices with respect to health information about you;
- Notify you in the event of a breach that may have compromised the privacy or security of your protected health information; and
- Follow the terms of the notice that are in effect.

In the following notice, "health plan" refers collectively to the prescription drug, vision, and hearing coverages, which are provided under the Plan.

If you are enrolled in any fully-insured dental and life insurance plans, you will receive a privacy notice from the insurance carrier for the health plan in which you are enrolled.

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

This Notice of Privacy Practices applies to prescription drug coverage, which is a member of an organized health care arrangement referred to throughout this Notice as a "Plan."

The purpose of this Notice is to describe how the Plan may use and disclose your protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice also describes the obligations of the Plan with respect to your protected health information and describes your rights to control and access your protected health information. Each Plan has agreed to the provisions set forth in this Notice.

1. Responsibilities of the plan

The Plan is required under HIPAA to maintain the privacy of your protected health information. Protected health information includes all individually identifiable health information transmitted or maintained by the Plan that relates to your past, present, or future health, treatment, or payment for health care services. The Plan must abide by the terms of this Notice, must provide

you with a copy of this Notice upon request, and must provide notice to affected individuals following a breach of unsecured protected health information.

2. How the plan may use and disclose your protected health information

The following categories describe the different situations in which the Plan is permitted or required to use or disclose your protected health information:

For Management of Treatment or Payment Purposes

The Plan has the right to use and disclose your protected health information to satisfy its responsibilities with respect to providing you with coverage and benefits under the Plan. Such disclosures will include those necessary to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibilities under the Plan, or to coordinate Plan coverage. For example, the Plan may disclose your protected health information to determine if a treatment that you received was covered under the Plan.

- **Health care operations.** The Plan has the right to use and disclose your protected health information to perform functions necessary for the operation of the Plan. Such disclosures will include the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity. For example, the Plan may disclose your protected health information to respond to your customer service request, in connection with its fraud compliance programs, or to provide you with information regarding a new disease management program. The Plan may not use any protected health information that is “genetic information” (as defined by the Genetic Information Nondiscrimination Act of 2008) for underwriting purposes.
- **Plan administration functions.** The Plan (or its business associates, as applicable) may disclose your protected health information to the Plan Sponsor to permit it to perform administrative functions on behalf of the Plan and to service your benefits.
- **Business associates.** The Plan Sponsor of the Plan may contract with certain service providers (“Business Associates”) to perform various functions on behalf of the Plan. To provide these services, Business Associates may receive, create, maintain, use, or disclose protected health information. The Plan Sponsor (on behalf of the Plan) and each Business Associate will enter into, or have already entered into, an agreement requiring the Business Associate to safeguard your protected health information as required by law and in accordance with the terms of this Notice.
- **Organized health care arrangement.** The Plan may share your protected health information with each other for payment purposes and to carry out health care operations.

- **Required by law.** The Plan may use or disclose your protected health information to the extent required by Federal, state, or local law.
- **Lawsuits and disputes.** The Plan may disclose your protected health information in response to a court or administrative order. Your protected health information may also be disclosed in response to a subpoena, discovery request, or other lawful process if efforts have been made to tell you about the request or to obtain an order protecting your protected health information.
- **Certain government agencies and officials.** The Plan may disclose your protected health information to (i) government agencies involved in oversight of the health care system, (ii) government authorities authorized to receive reports of abuse, neglect, or domestic violence, (iii) law enforcement officials for law enforcement purposes, (iv) military command authorities, if you are or were a member of the armed forces, (v) correctional institutions, if you are an inmate or in under the custody of a law enforcement official, and (vi) Federal officials for intelligence, counterintelligence, and other national security activities.
- **Public health and research activities; medical examiners.** The Plan may also disclose your protected health information (i) for public health activities or to prevent a serious threat to health and safety, (ii) to organizations that handle organ donations, if you are an organ donor, (iii) to coroners, medical examiners, and funeral directors as necessary, and (iv) to researchers, if certain conditions regarding the privacy of your protected health information have been met.
- **Workers' compensation.** The Plan may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** The Plan may be required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA Privacy Rules.
- **Other uses and disclosures with written authorization.** Disclosures and uses of your protected health information that are not described above may be made by a Plan with your written authorization. If a Plan is authorized to use or disclose your protected health information, you may revoke that authorization, in writing, at any time, except to the extent that the Plan has taken action relying on the authorization. The Plan will not be able to take back any disclosures of your protected health information that have already been made with your authorization. In most cases, the use or disclosure of psychotherapy notes, the use or disclosure of protected health information for marketing purposes, or the sale of protected health information will require your written authorization.

3. Your rights with respect to your protected health information

The following summarizes your rights with respect to your protected health information:

- **Right to request a restriction on uses and disclosures of protected health information.** You have the right to request a restriction or limitation on the protected health information used or disclosed about you by the Plan for treatment, payment, or health care operations. You also have the right to request a limit on the disclosure of your protected health information to someone who is involved in your care or the payment for your care, such as a family member, friend, or other person you have identified as responsible for your care.

  In general, the Plan is not required to agree to a restriction that you request (unless for the purposes of treating the individual in a medical emergency), although in certain circumstances, the Plan may be obligated to honor your request for a restriction on disclosures to another health plan relating to a health care item or service for which you paid in full.

  The Plan will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full.

- **Right to request confidential communications.** You have the right to request that the Plan communicate with you about your protected health information in a certain way or at a certain location. For example, you can request that the Plan only contact you at work or by mail.

  The Plan will accommodate all reasonable requests.

- **Right to inspect and copy your protected health information.** You have the right to inspect and copy your protected health information which may be used to make decisions about your Plan benefits. Under certain circumstances, the Plan may deny you access to a portion of your records. For example, you do not have a right to inspect and copy psychotherapy notes or information that the Plan has collected in connection with, or in reasonable anticipation of, any legal claim or proceeding. If you request copies, the Plan may charge you copying and mailing costs.

- **Right to amend your protected health information.** You have the right to request an amendment of your protected health information that is maintained by a Plan if you believe that the information is inaccurate or incomplete. The Plan may deny your request if your protected health information is accurate and complete or if the law does not permit the Plan to amend the requested information. The Plans cannot amend information created by your doctor or any person other than the Plan.

- **Right to receive an accounting of disclosures of your protected health information.** You have the right to request an accounting of disclosures the Plan has made of your protected health information during the six years prior to the date of your request. However, you will not receive an accounting of (i) disclosures made to you, and (ii) disclosures made to carry out treatment, payment, or health care operations (except

to the extent required by law, if the Plan maintains your Protected Health Information as an electronic health record). Certain other disclosures are also excepted from the HIPAA accounting requirements. If you request more than one accounting in any 12-month period, the Plan will charge you a reasonable fee for each accounting after the first accounting statement.

- **Right to receive a paper copy of this notice.** You have the right to receive a paper copy of this Notice upon request. To obtain a paper copy of this Notice, contact the UFA.

Changes to this Privacy Notice

The health plan reserves the right to change this notice at any time and from time to time, and to make the revised or changed notice effective for health information that the health plan already has about you, as well as any information that the health plan may receive in the future.

Complaints

If you believe that your health information privacy rights as described under this Notice have been violated, you may file a written complaint with the health plan by contacting the UFA at the address under ***"Contact Information"*** below. 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 **877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.

The complaint should generally be filed within 180 days of when the act or omission complained of occurred. **Note:** You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the health plan will be made only with your written authorization. If you authorize the health plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the health plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the health plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

Please contact the UFA at **212-683-4723** for more information about your rights under HIPAA or if you have any questions about this notice.

Copies of this notice are also available from the UFA.

The descriptions in this SPD are intended to meet the UFA's SPD requirements for the benefits available to eligible members, except as otherwise noted.

Appendix

APPENDIX A – Claims and Appeals Procedures

In general, you, your designated beneficiary, your authorized representative, or the service provider (i.e., the doctor's office) must file a written claim on the appropriate form. You can obtain the necessary provider information by calling **212-683-4723** or by visiting **ufanyc.org** directly by contacting the claims administrator or insurance company. See the ***"Customer Services and Claims Information"*** chart below for contact information.

Customer Services and Claims Information

Benefit	Claims Administrator/ Insurance Company	Contact Information	Policy/Group Number	Claim Filing Limit
Prescription Drug	CVS Caremark	**caremark.com** **866-832-0563**	RxBin: Rx4765 (applies to both active and retired members)	
Dental	MetLife	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 **866-832-5756** (Dental PPO) **800-880-1800** (Dental HMO)	PPO DHMO	NY/NJ: 180 days FL: 12 months CA/TX: 6 months
Vision	General Vision Services	To find a provider: **ufanyc.org/optical-providers** **855-653-0586**	Active: 7552 Retirees: 7553	

Claims Administration

For fully-insured plans, you must file claims for benefits with the insurance companies. The applicable insurer will review claims under the terms of the applicable plan, in accordance with the insurance contract. For self-insured plans, claims must be filed with the claims administrators. As part of the claims administration process, the insurance companies or claims administrators will:

- Pay claims for benefits due.
- Provide written explanations of the reasons for denied claims.
- Handle requests for reviews of denied claims.

For fully insured plans, the insurance company makes the final decision on denied claims.

Typically, the benefit summaries, certificates, or insurance policies for the individual benefit programs will describe the claims review and appeal process.

In the event they do not, the following provisions apply.

Review of Your Claims

Your request for Plan benefits will be considered a Claim for Plan benefits, and it will be subject to a full and fair review. Any claim for benefits under a specific benefit program, such as the dental plan, must be submitted and reviewed solely under the claims procedures established under or in connection with that specific benefit program. However, if a benefit program that is subject to ERISA does not provide a claims procedure that satisfies the requirements of ERISA, the claims procedure provided below will apply.

To file a claim for benefits, you must properly complete and file the appropriate claim form. Any appropriate documentation should accompany the claim form. Sometimes, a service provider may submit a claim directly on your behalf. If that happens, you will receive an Explanation of Benefits ("EOB"). The EOB is a summary of the coverage you received, which describes the benefits that were paid on your behalf, and provides a list of any benefits that were not paid. The EOB is not a bill, but a statement from the Plan to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeal rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

By law, your claim must be evaluated and processed within a certain period that varies depending on the type of claim.

The Appeals Procedure

As a Plan participant, you have the right to appeal decisions to deny or limit your Plan benefits. Appeals should be filed with the applicable insurance company or claims administrator for review in accordance with the procedures set forth below.

Notice of Denial

If your claim is wholly or partially denied, the insurer or claims administrator will provide a written or electronic notice of this denial. This notice must be provided to you within a reasonable period (as described in the ***"Review of Your Claims"*** section above) after your claim is received. The written notice must contain the following information:

- The specific reason or reasons for the denial.
- Specific reference to the Plan provisions on which the denial is based.
- A description of any additional information or material necessary to correct your claim.

- An explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits for appealing the Plan's determination, including an explanation of your right to obtain information about the Plan's procedures and to bring a civil action under Section 502(a) of ERISA after a denial of benefits on review.

How to Appeal a Denied Claim — Level 1 Appeal

You have the right to appeal a claim that is denied. If you have questions about claims under these plans, please contact the Plan Administrator. The following section describes the claims appeal process.

If your claim has been denied, and you believe your claim was denied in error, you may appeal this decision to the Plan. You must follow the claims review procedure outlined below:

- Upon the denial of your claim for benefits, you may file your claim for review and submit any issues, comments, documents, records, or other information, in writing, with the applicable claims administrator or insurer, as listed in the ***"Customer Services and Claims Information"*** chart above.
- You must file an appeal no later than the time stated in the previous charts relating to the specific benefit/claim, after you received written notification of the denial of your claim for benefits.
- Upon request, you may have access to and copies of all *relevant* documents free of charge.

For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether the document, record, or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

  If you request the diagnosis code and its corresponding meaning or the treatment code and its corresponding meaning, it will be provided to you as soon as practicable. However, the Plan will not consider a request for such diagnosis and treatment information, in itself, to be an appeal or request for external review.

  The Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by the ACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provide that benefits for an ongoing course of treatment

cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

- Your claim for review will be given a full and fair review. All comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- The claims administrator's or insurer's decision on your claim for review will be communicated to you in writing and will include specific references to the pertinent Plan provisions on which the decision was based.
- If benefits are provided or administered by an insurance company, insurance service, health maintenance organization, or other similar organization that is subject to regulation under state insurance laws, that company, service, or organization will be the entity to which claims are addressed. If you have any questions regarding the proper person or entity to address claims, please reference the ***"Customer Services and Claims Information"*** chart above.

If your claim is denied based in whole or in part on a medical judgment — including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate — the fiduciary reviewing the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted by the fiduciary reviewing the claim will be an individual who is neither an individual who was consulted in connection with the denial of the appeal nor the subordinate of such individual. Upon your request to the claims administrator, the claims administrator will identify medical or vocational experts whose advice was obtained by the Plan in connection with the denial, without regard to whether the advice was relied on in making the benefit determination.

If Your Appeal of a Claim Is Denied — Level 2 External Review

If the outcome of the mandatory first level appeal of a claim is adverse to you and it was based on medical judgment or is a rescission of coverage, you may be eligible for an independent external review pursuant to federal law.

You must submit your request for external review to the claims administrator (or the insurance company, insurance service, health maintenance organization, or other similar organization that is subject to regulation under state insurance laws) within four months of the notice of your Level 1 internal adverse determination.

A request for an external review must be in writing unless the claims administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the claims administrator's internal appeal process. You or your authorized representative may request it verbally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile, or other similar method. To proceed with an expedited external review, you

or your authorized representative must contact the claims administrator at the number shown on your identification card and provide at least the following information:

- The identity of the claimant.
- The date(s) of the service.
- The specific condition or symptom.
- The provider's name.
- The service or supply for which approval of benefits was sought.
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless the claims administrator determines that it is not reasonable to require a written statement.

The claims administrator may work with an independent advisor(s) to assist in making any benefit determination.

Reversal of Claims Administrator's Decision

When notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination is received, the claims administrator will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. If the final external review decision upholds the determination of the claims administrator, you may file a Voluntary Level 3 Appeal with the Appeals Committee within the time specified in the above chart. The claims administrator will provide a benefit determination no later than 60 days from the date of filing such appeal (an additional 60 days when special circumstances apply).

If Your Appeal Is Denied – Level 3 Appeal

There may be an additional level of appeal available to you — a Level 3 Appeal for non-medical benefits. This appeal is heard by the Appeals Committee for all self-insured benefits, and by the applicable insurer for insured benefits, if the insurance policy provides for this additional level. If your Level 3 Appeal is denied, the denial notice will contain the following information:

- The specific reasons for the denial.
- A reference to the specific Plan provisions on which the denial was based.
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination.
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures.
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).
- A statement describing your right to bring a civil lawsuit under federal law.

- A statement that “you or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”

If more information is needed to make a decision on your appeal, the Plan Administrator or designee will send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the request, the Plan Administrator or designee will conduct its review based upon the available information, which review will be completed within a reasonable period but not later than 40 business days from receipt of the appeal request. After the appeal decision is made, you will be notified within five business days, in writing, by the Plan Administrator of the Plan’s decision concerning your appeal.

The Appeals Committee’s decision on all self-insured plans will be final and binding on all parties concerned, and the insurer’s decision on the insured plans will be final and binding. If your appeal is denied, any legal action challenging the denial would need to be filed within one year following the date of the denial (or, for claims for insured benefits, within such shorter or longer period prescribed by the applicable insurance certificate, but in no event no later than three years after written proof of loss was required to be made, according to the applicable insurance certificate for that benefit).

Statute of Limitations, Venue, and Exhaustion of Administrative Remedies

You must use and exhaust the Plan’s administrative claims and appeals procedures described above before you can file suit in court.

If you have exhausted these procedures and are dissatisfied with the decision on appeal of a denied claim, you may file suit in court to review the claims administrator’s decision on appeal, but only if the action begins no later than the earlier of the applicable statute of limitations, or the second anniversary of the claims administrator’s decision on appeal. **Any such suit must be filed in the applicable United States District Court.**

Within ten days of the Plan’s receipt of your written request, you are entitled to an explanation of the Plan’s basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected your claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim begin to run upon your receipt of the notice.

APPENDIX B – Certificates of Coverage

Life Insurance – Symetra Benefit Summary

Dental – MetLife Benefit Summary – Actives

Dental – MetLife Benefit Summary – Retirees

Life Insurance – Symetra Benefit Summary

SYMETRA
RETIREMENT | BENEFITS | LIFE
FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

Home Office:
420 Lexington Avenue, Suite 300
New York, NY 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny

June 18, 2025

SENT VIA EMAIL

To: The Stabilization Reserve Fund of the Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010
Attn: Maria Zingone

Re: Administrative Services Update – One Time Open Enrollment (Effective Immediately)

Policy No(s). 24 000118 00

Dear The Stabilization Reserve Fund of the Uniformed Firefighters Association:

First Symetra National Life Insurance Company of New York, a New York corporation ("Symetra"), through the issuance of this letter agreement ("Letter Agreement"), has agreed to update and/or clarify certain administrative services and terms with The Stabilization Reserve Fund of the Uniformed Firefighters Association ("Policyholder") concerning group life insurance, Policy No(s). 24 000118 00, effective October 1, 2017 (the "Policy(ies)") as further set forth in this Letter Agreement.

This Letter Agreement takes effect immediately and terminates upon the termination of the Policy, unless earlier terminated by mutual agreement of Symetra and Policyholder.

Policyholder maintains sole responsibility to inform its employees, and their dependents, of Symetra's updated administrative services and terms contained in this Letter Agreement, including how the updated administrative services and terms may impact eligibility and coverage under the Policy. For the avoidance of doubt, Symetra will not advise Policyholder's employees, and their dependents, of the issuance of this Letter Agreement, including Symetra's updated administrative services and terms for the Policy as explained below.

General Provisions impacting the Policy:

1. This Letter Agreement does not vary, alter or extend any provisions of the Policy, other than as explained in the "Specific Provisions" below.

2. If any provision of this Letter Agreement is found to be invalid, illegal or unenforceable in any jurisdiction, for any reason, then, to the full extent permitted by law:

a. all other provisions will remain in full force and effect in such jurisdiction and will be liberally construed in order to carry out the intent of Symetra and Policyholder as nearly as may be possible;

b. such invalidity, illegality or unenforceability will not affect the validity, legality or enforceability of any other provision; and

Symetra® is a registered service mark of Symetra Life Insurance Company. Symetra Life Insurance Company, not a licensed insurer in New York, is the parent company of First Symetra National Life Insurance Company of New York.

c. any court or arbitrator having jurisdiction will have the power to reform such provision to the extent necessary for such provision to be enforceable under applicable law.

3. This Letter Agreement does not, and is not intended to, confer upon any person, other than Symetra and Policyholder, any rights, remedies, obligations or liabilities, other than as explained in the "Specific Provisions" below.

Specific Provisions impacting coverage under the Policy:

Open Enrollment Provisions:

There is an open enrollment period from June 14, 2025 through July 11, 2025. This open enrollment applies to Supplemental Life Insurance coverage(s) only.

During this period, the evidence of insurability requirement in the Policy is waived for benefit increases for late entrants listed below. Allowable benefit increases are:

Life insurance coverage(s):

Benefit increases may not exceed the policy's guaranteed issue amount.

For currently enrolled:
Employees: 1 increment of $50,000

This open enrollment does not apply to any amount of coverage for which an employee previously applied but was not approved, or for those who were previously required to submit Evidence of Insurability but failed to do so. This open enrollment also does not apply to employees who have not satisfied the service waiting period.

Coverage enrolled for during this open enrollment period is effective August 1, 2025. However, any benefit amounts subject to Evidence of Insurability are not effective until approved in writing by Symetra.

Note, requests for subsequent open enrollment periods must be approved by Symetra.

Sincerely,

Keith Daigle
Vice President, Workforce Benefits Underwriting
First Symetra National Life Insurance Company of New York

*Retain a copy of this Amendment with your Policy.

First Symetra National Life Insurance Company of New York

420 Lexington Avenue, Suite 300
New York, New York 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny

Incorporation Provision

Policy Rider

Rider Number: 4
Policyholder: The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number: 24 000118 00

The Certificate(s) of Insurance, Rider(s), Policy change(s) and certificate change(s) are attached to, incorporated in and made a part of, The Policy. The Rider(s) do not vary, waive, alter or extend any of the terms, conditions or provisions of The Policy, except as stated herein.

Rider	Effective Date of Incorporation	Applicable to
4	May 16, 2025	Class 1

Certificate of Insurance	Effective Date of Change
LGC-03305-CERT/NY 02/14	August 1, 2025

Certificate Changes

The following are amended:
Schedule of Insurance – Life – Life Insurance Benefit
Schedule of Insurance – Life – Reduction in Amount of Life Insurance
Schedule of Insurance – Accidental Death and Dismemberment – Accidental Death and Dismemberment Insurance Benefit (AD&D)
Benefits – Life – Conversion Policy Provisions

The following are added:
Definitions – Life – Normal Retirement Age
Benefits – Life – Portability Benefits
Benefits – Life – Qualifying Events
Benefits – Life – Electing Portability
Benefits – Life – Limitations
Benefits – Life – Effect of Portability on other Provisions

Certificate Page(s) Changed:

LGC-03305-CERT/NY 02/14; Schedule of Insurance – Life
LGC-03305-CERT/NY 02/14; Schedule of Insurance – Accidental Death and Dismemberment
LGC-03305-CERT/NY 02/14; Definitions – Life
LGC-03305-CERT/NY 02/14; Benefits – Life

The provisions found in the certificate(s) will control the benefit plan, period of coverage, exclusions, claims and other general policy provisions pertaining to state insurance law requirements.

Incorporation Provision

Policy Rider

Rider Number: 4
Policyholder: The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number: 24 000118 00

The provisions found in the certificate will control the benefit plan, period of coverage, exclusions, claims and other general policy provisions pertaining to state insurance law requirements.

In all other respects, the certificate remains the same.

The Stabilization Reserve Fund of the Uniformed Firefighters Association	First Symetra National Life Insurance Company of New York:
	Margaret Meister
By: _____	By: Margaret Meister President
Title: _____	
Date: _____	Date: June 18, 2025

Instructions: (1) Sign and return to First Symetra.
(2) Retain a copy with your policy.

First Symetra National Life Insurance Company of New York

420 Lexington Avenue, Suite 300
New York, New York 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny

Certificate Rider

Rider Number: 4
Policyholder: The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number: 24 000118 00

The Rider(s) forms a part of the Certificate of Insurance give in connection with The Policy. The Rider(s) do not vary, waive, alter or extend any of the terms, conditions or provisions of the Certificate of Insurance, except as stated herein.

Certificate of Insurance	Effective Date of Change	Applicable to
LGC-03305-CERT/NY 02/14	August 1, 2025	Class 1

Certificate Changes

The following are amended:
Schedule of Insurance – Life – Life Insurance Benefit
Schedule of Insurance – Life – Reduction in Amount of Life Insurance
Schedule of Insurance – Accidental Death and Dismemberment – Accidental Death and Dismemberment Insurance Benefit (AD&D)
Benefits – Life – Conversion Policy Provisions

The following are added:
Definitions – Life – Normal Retirement Age
Benefits – Life – Portability Benefits
Benefits – Life – Qualifying Events
Benefits – Life – Electing Portability
Benefits – Life – Limitations
Benefits – Life – Effect of Portability on other Provisions

Certificate Page(s) Changed:

LGC-03305-CERT/NY 02/14; Schedule of Insurance – Life
LGC-03305-CERT/NY 02/14; Schedule of Insurance – Accidental Death and Dismemberment
LGC-03305-CERT/NY 02/14; Definitions – Life
LGC-03305-CERT/NY 02/14; Benefits – Life

This rider forms a part of the Certificate to which it is attached and all certificates given in connection with The Policy.

This rider becomes effective on the later to occur of:

a) The Policy or certificate Effective Date to which this rider is attached; or
b) the first day of the month on or next following the date We accept Your application and required premium.

Certificate Rider

Rider Number:	4
Policyholder:	The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number:	24 000118 00

In all other respects, The Policy and certificate remain the same.

Signed for First Symetra National Life Insurance Company of New York

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

- Please retain a copy of this Rider with Your Certificate.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

First Symetra National Life Insurance Company of New York
260 Madison Avenue 8th Floor
New York, NY 10016

Mailing Address:
Benefits Division
PO Box 34690
Seattle, WA 98124-1690
Phone 1-800-796-3872
TTY/TDD 1-800-833-6388

Endorsement

This Endorsement is added to and becomes a part of the Certificate to which it is attached. In the case of conflict between the provisions of the Certificate and this Endorsement, the provisions of this Endorsement will control.

The **Accelerated Death Benefit** section of the BENEFITS section of the Certificate is replaced with the following:

BENEFITS
Accelerated Death Benefit
Certificate holder and Spouse

This benefit applies only if indicated in the Schedule of Insurance.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS WHICH WILL BE PAID UPON DEATH. THE ACCELERATED DEATH BENEFIT MAY BE PAID ONLY ONE TIME UNDER A CERTIFICATE.

When can benefits be accelerated?
An Accelerated Death Benefit will be paid only once to You. This benefit is paid as a lump sum if:

1) Your Accelerated Death Benefit request amount is equal to no less than the lower of 25 percent of the amount of insurance under the Certificate or $50,000 and the minimum amount requested may be no greater than 50% of Your amount of Life Insurance;
2) You are Terminally Ill as defined below;
3) You request a portion of Your amount of Life Insurance to be paid as an Accelerated Death Benefit; and
4) satisfactory proof of Terminal Illness is received by us.

The benefit may not exceed 80% of Your amount of Life Insurance.

No discount or lien is associated with the receipt of Accelerated Benefit amounts.

What does Terminal Illness or Terminally Ill mean?
Terminally Ill or Terminal Illness shall mean a life expectancy of 12 months or less.

EXAMPLE: The following is only an example. Please refer to the Schedule of Benefits for Your benefit amounts.

If Your amount of Life Insurance is $10,000 and You are Terminally Ill, You may request any portion of Your life insurance between $3,000 and $8,000 to be paid to You now instead of to the beneficiary at Your death.

However, if You decide to ask for only $3,000 now, You may **not** request the remaining $5,000 in the future.

Your remaining insurance shall be subject to any reductions provided by any part of this Certificate.

PROOF OF TERMINAL ILLNESS – Can First Symetra have a claimant examined for proof of Terminal Illness?
First Symetra has the right to require proof of Terminal Illness.

Any diagnosis submitted must be provided by an attending physician licensed to practice in the United States. If:

1) You fail to submit proof satisfactory to First Symetra that You have a Terminal Illness; or
2) refuse to be examined as may be required by First Symetra;

then no Accelerated Death Benefit will be payable.

EFFECT OF CONVERSION – Does the election of conversion affect this provision?
Yes. If You choose to convert insurance under this Certificate, then the provisions under this benefit will no longer apply. The amount You may convert shall be subject to the Conversion Privilege of this Certificate less any Accelerated Death Benefits You may have received.

LIMITATIONS – What limitations apply to this benefit?
This provision will be subject to all applicable terms and conditions of this Certificate. You may not request an additional Accelerated Death Benefit if You have already received one.

The Accelerated Death Benefit provision does not apply to a Dependent Child or to You if You have attained Your defined retirement age under the 1983 amendments to the Social Security Act.

ASSIGNMENT – What if You made an assignment under this Certificate?
If You have assigned the interest of Your amount of Life Insurance, in order for us to pay benefits under this provision, First Symetra must receive a release from the person to whom the assignment was made.

First Symetra National Life Insurance Company of New York

Jacqueline M. Veneziani

Jacqueline M. Veneziani
Secretary

SYMETRA
RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

First Symetra National Life Insurance Company of New York

Group Life Insurance

CERTIFICATE

CLASS 1

Symetra® is a registered service mark of Symetra Life Insurance Company. Symetra Life Insurance Company not a licensed insurer in New York, is the parent company of First Symetra National Life Insurance Company of New York.

First Symetra National Life Insurance Company Of New York

420 Lexington Avenue, Suite 300
New York, New York 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny
(A stock insurance company, herein called The Company, We, Our or Us)

Annually Renewable Nonparticipating Group Term Life Insurance Certificate

Policyholder:	The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number:	24 000118 00
Policy Effective Date:	October 1, 2017
Policy Anniversary Date:	September first of each year beginning in 2018

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

READ YOUR CERTIFICATE CAREFULLY.
CERTAIN WAR RISKS ARE NOT ASSUMED.
IN CASE OF ANY DOUBT WRITE THE COMPANY FOR FURTHER EXPLANATION.

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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Definitions – Accidental Death and Dismemberment
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Period of Coverage
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Benefits – Accidental Death and Dismemberment
General Provisions

Rider #4, Effective August 1, 2025

Schedule of Insurance – Life

The benefits described herein are those in effect as of: August 1, 2025

Cost of Coverage:
Contributory Coverage:
Supplemental Life Insurance
Supplemental Dependent Life Insurance

Eligible Class(es) for Coverage: All Active Members working a minimum number of hours each week as determined by the New York State Professional Fire Fighters Association.

Class 1 All Eligible Active Members in good standing of the Uniformed Firefighters Association who are employed as Firefighter, Fire Marshal, Wiper or Pilots and Marine Engineers

Eligibility Waiting Period for Coverage:
If You are an Active Member with a Participating Entity on the Policy Effective Date: None.

If You become an Active Member with a Participating Entity after the Policy Effective Date: None.

Life Insurance Benefit

Member

Supplemental	Benefit Amount	Benefit Maximum Amount	Guaranteed Issue Amount
Class 1	$150,000, $200,000, $250,000, $300,000, $350,000, $400,000, $450,000 or $500,000 as selected by You on the enrollment card	$500,000	$500,000

Dependent

Supplemental	Benefit Amount	Benefit Maximum Amount	Guaranteed Issue Amount
Class 1			
Spouse	$100,000	$100,000	$100,000
Child			
14 days to 26 years	$5,000	$5,000	$5,000

Reduction in Amount of Life Insurance

We will reduce the amount of Life Insurance for You and Your Dependent by any amount:
1) of individual Life Insurance issued in accordance with the Conversion Right;
2) that was continued under the Portability provision; or
3) of Life Insurance in force, paid or payable under the Prior Policy.

Schedule of Insurance – Life

Reduction in Coverage Due to Age

Applies to Supplemental Life Insurance and Supplemental Accidental Death and Dismemberment Insurance:
Your coverage terminates when You attain age 65.

Applies to Supplemental Spouse Life Insurance:
No reduction.

Schedule of Insurance – Accidental Death and Dismemberment

Cost of Coverage:
Contributory Coverage:
Supplemental Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment Insurance Benefit (AD&D)

Supplemental Accidental Death and Dismemberment Insurance can be elected as a standalone option.

Member

	Principal Sum	Principal Maximum Sum
Supplemental Class 1	$50,000, $100,000, $150,000 or $200,000 as selected by You on the enrollment card	$200,000

Additional Accidental Death and Dismemberment Insurance Benefits

Seat Belt Benefit

Seat Belt Benefit Amount:	10% of Supplemental AD&D Principal Sum
Seat Belt Maximum Amount:	$20,000
Seat Belt Minimum Amount:	$1,000

Air Bag Benefit

Air Bag Benefit Amount:	10% of Supplemental AD&D Principal Sum
Air Bag Maximum Amount:	$20,000

Repatriation Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000

Child Education Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Day Care Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Spouse Education Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Definitions – Life

Active Member
means a member who works for the Participating Entity on a regular basis in the usual course of the Participating Entity's business.

Contributory Coverage
means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child
means:

1) Your unmarried children, stepchildren, legally adopted children; or
2) any other children related to You by blood or marriage or domestic partnership who:
   a) live with You in a regular parent-child relationship or
   b) You claimed as a dependent on Your last filed federal income tax return;

provided such children are primarily dependent upon You for financial support and maintenance and are:

1) at least 14 days old but under age 26; or
2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

Dependent
means Your Spouse, Your same or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law and Your Dependent Child. A Dependent must be a citizen or legal resident of the United States. Any person who is in full-time military service cannot be a Dependent.

Guaranteed Issue Amount
means the amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Normal Retirement Age
means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Participating Entity
means an entity who is a participant in accordance with the provisions of The Policy.

Definitions – Life

Physician
means a legally qualified Physician or surgeon other than a Physician or surgeon who is Related to You by blood or marriage.

Prior Policy
means, if applicable, the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date.

Related
means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Spouse
means Your Spouse who is not legally separated or divorced from You. Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

The Policy
means The Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us or Our
means the insurance company named on the face page of The Policy.

You or Your
means the person to whom this certificate is issued.

Definitions – Accidental Death and Dismemberment

Airworthiness Certificate
means:
1) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Civil or Public Aircraft
means a Civil or Public Aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

Common Carrier
means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

FAA
means:
1) the Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

Injury
means bodily Injury resulting:
1) directly from an accident; and
2) independently of all other causes;
which occurs while You are covered under The Policy.

Loss resulting from:
1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

Military Transport Aircraft
means a transport aircraft operated by:
1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of a governmental authority recognized by the United States.

Definitions – Accidental Death and Dismemberment

Motor Vehicle
means a self-propelled, four or more wheeled:

1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

On
means, when used with reference to any conveyance (land, water or air), in or On, boarding or alighting from the conveyance.

Scheduled Aircraft
means a Civil or Public Aircraft operated by a scheduled airline which:

1) is licensed by the FAA for the transportation of passengers for hire; and
2) publishes its flight schedules and fares for regular passenger service.

Eligibility and Enrollment

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:

1) the Policy Effective Date;
2) the date on which You complete the Eligibility Waiting Period for Coverage; or
3) the date You become a member of an Eligible Class.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:

1) the date You become insured for member coverage; or
2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as a member under The Policy. No person can be insured as a Dependent of more than one member under The Policy.

Enrollment: *How do I enroll for coverage for myself and my Dependents?*
To enroll for Contributory Coverage, You must:

1) complete and sign a group insurance enrollment form, satisfactory to Us; and
2) deliver it to the Policyholder.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may only enroll:

1) during an Annual Enrollment Period if designated by the Policyholder; or
2) within 31 days of the date You have a Change in Family Status.

Any enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an amount of Life Insurance greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

1) Your amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; or
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Eligibility and Enrollment

Dependent Evidence of Insurability Requirements: *When will my Dependent first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

1) enroll for Your Dependent coverage more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an amount of Dependent Life Insurance greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if the amount of Life Insurance for Your Dependent Child is $15,000 or less.

If Your Dependent Evidence of Insurability is not satisfactory to Us:

1) the amount of Dependent Life Insurance will equal the amount for which Your Dependent was eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; or
2) Your Dependent will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statement; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You or Your Dependent are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:

1) You get married or You execute a domestic partner affidavit;
2) You and Your Spouse divorce or terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your Spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your Spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

Period of Coverage

Effective Date: *When does my coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible, if You enroll on or before that date;
2) the first of the month following the last day of any Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage, for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

However, all Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not an Active Member due to a physical or mental condition such coverage will not start until the date You are an Active Member.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date You were not an Active Member and would otherwise meet the Eligibility requirements of The Policy. However, Your amount of Insurance will be the lesser of the amount of Life Insurance and Accidental Death and Dismemberment Principal Sum:

1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made in accordance with any enrollment provision requirements.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are an Active Member.

However, if the coverage provided through this provision ends because You are an Active Member, You may be covered under The Policy.

Period of Coverage

Dependent Effective Date: *When does Dependent coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date;
2) the first of the month following the last day of any Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage, for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependent Evidence of Insurability.

In no event will Dependent coverage become effective before You become insured.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, is to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

he or she is:

1) confined in a hospital; or
2) Confined Elsewhere;

such coverage will not start until he or she:

1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to Disabled children who qualify under the definition of Dependent Child.

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependent?*
If, on the day before the Policy Effective Date, You were covered with respect to Your Dependent under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependent. However, the Dependent amount of Insurance will be the lesser of the amount of Life Insurance:

1) they had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependent?*
After Your initial enrollment, You may increase or decrease coverage for You or Your Dependent or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

Period of Coverage

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the first of the month following the date of the change.

Any increase in coverage will take effect on the latest of:
1) the first of the month following the date of the change;
2) the date requirements of the Deferred Effective Date provision are met; or
3) the date Evidence of Insurability is approved, if required.

Increase in Amount of Life Insurance: *If I request an increase in the amount of Life Insurance for myself or my Dependent, must we provide Evidence of Insurability?*
If You or Your Dependent are:
1) already enrolled for an amount of Life Insurance under The Policy, then You and Your Dependent must provide Evidence of Insurability for any increase; or
2) not already enrolled for Life Insurance under The Policy, You and Your Dependent must provide Evidence of Insurability for any amount of coverage, including an initial amount of Life Insurance.

In any event, if the amount of Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependent, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the amount of Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependent Evidence of Insurability is not satisfactory to Us, the amount of Insurance he or she had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or the class is cancelled;
3) the date the required premium is due but not paid;
4) the date You or Your Participating Entity terminates Your membership;
5) the date Your Participating Entity ceases to be a Participating Entity;
6) the date You are no longer an Active Member; or
7) the date You attain age 65.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Participating Entity terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent.

Period of Coverage

Continuation for Dependent Child with Disabilities: *Will coverage for Dependent Child with Disabilities be continued?*
If Your Dependent Child reaches the age at which they would otherwise cease to be a Dependent as defined, and they are:

1) age 26 or older;
2) Disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child coverage will not terminate solely due to age. However:

1) You must submit proof satisfactory to Us of such Dependent Child's disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child must have become Disabled before attaining age 26.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the amount of Life Insurance for such Dependent Child will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

Benefits – Life

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*
If You or Your Dependent die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of the certificate.

Accelerated Benefit: *What is the benefit?*
In the event that You or Your Dependent are diagnosed as Terminally Ill, and You request in writing that a portion of the Terminally Ill person's amount of Life Insurance be paid as an Accelerated Benefit while the Terminally Ill person is:

1) covered under The Policy for an amount of Life Insurance of at least $10,000; and
2) under the Policy limiting age;

We will pay the Accelerated Benefit Amount as shown below, provided We receive proof of such Terminal Illness.

The amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. Premiums will not be adjusted.

You may request a minimum Accelerated Benefit Amount of $25,000, and a maximum of $100,000. However, in no event will the Accelerated Benefit Amount exceed 50% of the Terminally Ill person's amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $10,000 and are Terminally Ill, You can request any portion of the amount of Life Insurance Benefits from $3,000 to $5,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $2,000 in the future.

Any benefits received under this benefit may affect eligibility for public assistance and may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependent do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependent refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

Benefits – Life

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill or my Dependent is no longer Terminally Ill?*
If You or Your Dependent are diagnosed by a Physician as no longer Terminally Ill and:

1) are in an Eligible Class, coverage will remain in force, provided premium is paid; or
2) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, You and Your Dependent may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

1) the Accidental Death and Dismemberment Insurance Benefits; or
2) any amount of Life Insurance for which You or Your Dependent were not eligible and covered; under The Policy.

You or Your Dependent will be eligible to convert coverage if coverage under The Policy ends because:

1) The Policy is terminated; or
2) coverage for an Eligible Class is terminated; or
3) Your Participating Entity is no longer a Participating Entity.

The amount which may be converted under these circumstances is the Life Insurance Benefit under The Policy less any amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or my Dependent coverage?*
The Policyholder will provide You with written notice of Your and Your Dependent conversion rights within 15 days before or after the date Your and Your Dependent coverage ends and You will have 31 days from the date coverage ended, or from any extended notice period, to convert Your coverage. This written notice will be given by the Policyholder to You or mailed to Your last known address.

To convert Your coverage or coverage for Your Dependent, You must apply within 31 days after Life Insurance terminates. However, if You are provided with notice of Your and Your Dependent conversion rights more than 15 days, but less than 90 days after the date Your and Your Dependent coverage ends, You will have 45 days after You are provided with the notice to convert Your coverage.

Your and Your Dependent conversion rights will expire 90 days after the date Your and Your Dependent coverage ends if the Policyholder does not provide You with notice of Your and Your Dependent conversion rights within 90 days after the date Your and Your Dependent coverage ends.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must pay the required premium for coverage within the time period specified in this provision.

Any individual policy issued to You or Your Dependent under the Conversion Right:

1) will be effective as of the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Benefits – Life

Conversion Policy Provisions: *What are the Conversion Policy Provisions?*
The Conversion Policy will base premiums on the insured's class of risk under The Policy in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide the same terms and conditions of coverage as The Policy or any benefit other than the Life Insurance Benefit.

If Your or Your Dependent coverage under the Policy ceases because of termination of Your employment or membership in an eligible class ends You may choose to have a Conversion Policy issued by the Insurer. The Conversion Policy may be any policy customarily issued by the Insurer except term insurance, except that the Conversion Policy may be preceded by preliminary term insurance for a period of one year with the premium payable, at Your option, in any mode customarily offered by the Insurer.

If Your or Your Dependent coverage under the Policy ceases due to Your total and permanent disability, You may choose to have a Conversion Policy issued by the Insurer. The Conversion Policy may be any policy customarily issued by the Insurer, including term insurance. The Conversion Policy may be preceded by preliminary term insurance for a period of one year with the premium payable, at Your option, in any mode customarily offered by the Insurer, and in the amount of Your Life Insurance Benefit in effect immediately before Your coverage was terminated, less the amount of any life insurance which is replaced with the same or another insurer within 45 days of the date Your coverage under this Policy ceases.

Any amount of Life Insurance which was, or is being, continued under a certificate of insurance issued in accordance with the Portability provision is not also available to be converted until such coverage ends. Amounts may be continued as described above or converted, but the amounts cannot be continued and converted at the same time.

Death within the Conversion Period: *What if I or my Dependent die before coverage is converted?*
We will pay the deceased person's amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates;
2) You or Your Dependent die within 31 days of the date coverage terminates or during any extended notice period; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, or a successful application for Conversion has been made, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Portability Benefits: *What is Portability?*
Portability is a provision which allows You to continue coverage under a Group Portability policy when coverage would otherwise end due to certain Qualifying Events. Portability applies to Supplemental Life Insurance only.

Qualifying Events: *What are Qualifying Events?*
Qualifying Events for You are:

1) Your employment terminates, for any reason prior to Normal Retirement Age; or
2) Your membership in an Eligible Class under The Policy ends.

Electing Portability: *How do I elect Portability?*
You may elect Portability for Your coverage after Your Supplemental coverage ends because You had a Qualifying Event. The Policy must still be in force and the Employer must continue to be a Participating Entity in order for Portability to be available.

To elect Portability for You, You must:

1) complete and have Your Employer sign a Portability application; and
2) submit the application to Us, with the required premium.

This must be received within 31 days after Life Insurance terminates. However, if You are provided with notice of Your Portability rights more than 15 days, but less than 90 days after the date Your coverage ends, You will have 45 days after You are provided with the notice to elect Portability. If notice is not given within 90 days, then the insured has 90 days to apply for portability.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

1) issued without Evidence of Insurability;
2) issued on one of the forms then being issued by Us for Portability purposes; and
3) effective on the day following the date Your coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations: *What limitations apply to this benefit?*
You may elect to continue 50%, 75% or 100% of the amount of Life Insurance which is ending. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the amount of Life Insurance that may be continued will not exceed $500,000 for You.

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You be able to continue an amount of Life Insurance which is less than $5,000.

Portability is not available for any amount of Life Insurance for which You were not eligible and covered.

In addition, Portability is not available if You are entering active military service.

Effect of Portability on other Provisions: *How does Portability affect other provisions?*
Portability is not available for any amount of Life Insurance which was, or is being, continued in accordance with the Conversion Right under The Policy. However, if:

1) You elect to continue only a portion of terminated coverage under this Portability provision; or
2) the amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

Benefits – Accidental Death and Dismemberment

Accidental Death and Dismemberment Insurance Benefit: *When is the Accidental Death and Dismemberment Insurance Benefit payable?*
If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:

Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Loss means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

Exposure and Disappearance: *What if Loss is due to exposure or disappearance?*
Exposure to the elements will be presumed to be Injury if:
1) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant at the time of the accident; and
2) The Policy would have covered an Injury resulting from the accident.

We will presume that You suffered Loss of life if:
1) Your body has not been found within one year after the disappearance of a conveyance in which You were an occupant at the time of its disappearance;
2) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
3) The Policy would have covered Injury resulting from the accident.

Benefits – Accidental Death and Dismemberment

Seat Belt and Air Bag Benefit: *When is the Seat Belt and Air Bag Benefit payable?*
If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:

1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:

1) positioned in a seat equipped with a factory-installed Air Bag; and
2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:

1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The Seat Belt and Air Bag Benefit will not be payable if You are operating the Motor Vehicle at the time of Injury while:

1) Intoxicated; or
2) taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

Intoxicated means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Benefits – Accidental Death and Dismemberment

Repatriation Benefit: *When is the Repatriation Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:
1) the actual expenses incurred for:
   a) preparation of the body for burial or cremation; and
   b) transportation of the body to the place of burial or cremation;
2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Child Education Benefit: *When is the Child Education Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Child Education Benefit to Your Child.

This Benefit will be paid:
1) after We receive proof that Your Child qualifies as a Student, as defined in this Benefit; and
2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:
1) the amount resulting from multiplying Your amount of Principal Sum by the Child Education Percentage; or
2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Children:
1) on the date; and
2) for whom;
We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:
1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
2) the end of the 12th consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:
1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Student.

Benefits – Accidental Death and Dismemberment

Student means Your Child who on the date of Your death:

1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

Child means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 21 who:

1) regularly attends an accredited institution of learning; and
2) is primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Day Care Benefit: *When is the Day Care Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Day Care Benefit for each of Your Children if such Child is under age seven at the time of Your death.

This Benefit will be paid:

1) after We receive proof of enrollment in a Day Care Program as described in this Benefit; and
2) according to the General Provisions of The Policy.

We will make one Day Care Benefit payment each year, for a maximum of four Day Care Benefit payments, for each Child. The Benefit will be paid to the person who has primary responsibility for the Child's Day Care expenses.

Proof of enrollment satisfactory to Us for each Child in a Day Care Program includes, but will not be limited to, the following:

1) a copy of the Child's approved enrollment application in a Day Care Program;
2) cancelled check(s) evidencing payment to a Day Care facility or Day Care provider; or
3) a letter from the Day Care facility or Day Care provider stating that the Child:
   a) is attending a Day Care Program; or
   b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the death.

Proof of enrollment must be sent to Us prior to the last day of the 12th month following the date of death.

If You die, the Day Care Benefit provides an annual amount equal to the lesser of:

1) the amount resulting from multiplying Your amount of Principal Sum by the Day Care Benefit; or
2) the Maximum Amount for this Benefit.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision for payment of benefits for Loss of life if:

1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Child eligible for the Day Care Benefit.

Day Care or Day Care Program means a program of child care which:

1) is operated in a private home, school or other facility;
2) provides, and makes a charge for, the care of children;
3) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or
4) if licensing is not required, provides child care on a daily basis for 12 months a year.

Child means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age seven and primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Spouse Education Benefit: *When is the Spouse Education Benefit payable?*
If You sustain an Injury that results in a Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Spouse Education Benefit to Your surviving Spouse.

This Benefit will be paid:

1) after We receive proof satisfactory to Us that the Spouse has enrolled in an Occupational Training program; and
2) according to the General Provisions of The Policy.

The Spouse Education Benefit is the least of:

1) the Expense Incurred for Occupational Training;
2) the amount resulting from multiplying Your amount of Principal Sum by the Spouse Education Benefit Percentage; or
3) the Maximum Amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

1) for the purpose of obtaining an independent source of income; and
2) within one year of Your death.

Occupational Training means any:

1) education;
2) professional; or
3) trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

Expense Incurred means:

1) the actual tuition charged, exclusive of room and board; and
2) the actual cost of the materials needed;

for the Occupational Training. The expense must be incurred within two years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Benefits – Accidental Death and Dismemberment

Exclusions: *What is not covered under The Policy?* (Applies to Accidental Death and Dismemberment Insurance only)
The Policy does not cover any Loss caused or contributed by:

1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) war or act of war, whether declared or not;
4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5) Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6) Injury sustained while On any aircraft:
   a) as a pilot, crewmember or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Participating Entity or organization whose eligible persons are covered under The Policy; or
   d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
7) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
8) Injury sustained while committing or attempting to commit a felony;
9) Injury sustained while Intoxicated; or
10) Injury sustained while driving while Intoxicated.

Intoxicated means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

General Provisions

Notice of Claim: *When should I notify The Company of a claim?*
You, or the person who has the right to claim benefits, must give Us, or Our representative, written notice of a claim within 30 days after:

1) the date of death; or
2) the date of Loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Failure to give notice as soon as reasonably possible will not invalidate or reduce any claim. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

Proof of Loss: *What is Proof of Loss?*
With respect to the Life Insurance Benefits, Proof of Loss shall consist of a completed claim form and a certified copy of the death certificate.

For all other coverages, Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your enrollment form;
4) Your beneficiary designation (if applicable);
5) if applicable, documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information; or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us or Our representative; with respect to the Accidental Death and Dismemberment Benefits, within 90 days; after the loss.

If Proof of Loss other than for Life Insurance Benefits is not given by the time it is due, it will not invalidate or reduce the claim if:

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than one year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

General Provisions

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a Loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits and benefits for Loss of life under the Accidental Death and Dismemberment Insurance Benefits will be paid in accordance with the life insurance beneficiary designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) the executors or administrators of Your estate;
2) all to Your surviving Spouse;
3) if Your Spouse does not survive You, in equal shares to Your surviving Children; or
4) if no Child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.
We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving Spouse or the executor or administrator of Your estate.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Policyholder.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

General Provisions

Claim Appeal: *What recourse will my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Incontestability: *When can The Policy be contested?*
Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment Insurance Benefits.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You and a copy will be provided to You or Your beneficiary.

No statement made relating to Your Dependent being insurable will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the Dependent's lifetime. In order to be used, the statement must be in writing and signed by You or Your representative.

Assignment: *Are there any rights of assignment?*
Except for the dismemberment benefits under the Accidental Death and Dismemberment Insurance Benefit, You have the right to assign all of Your rights and interest under The Policy including, but not limited to, the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any assignment made by You under The Policy effective on the date the assignment is signed, subject to action taken by Us prior to receipt of notice of assignment, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

Legal Actions: *When can legal action be taken?*
Legal action cannot be taken against Us sooner than 60 days after the date written Proof of Loss is furnished

General Provisions

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Misstatements: *What happens if facts are misstated?*
If material facts about Your or Your Dependent age or sex were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Entire Policy:
The rights of the Policyholder, Your rights, or the rights of Your beneficiary under this Policy shall not be affected by any provision other than one contained in The Policy, including Your certificate of insurance, or any riders or endorsements hereon or in any amendments hereto signed by the Policyholder and The Company, or in the copy of the Policyholder's application attached to this Policy or in the individual statements, if any, submitted by You in connection therewith. All statements made by the Policyholder or persons insured under this Policy in the application for the issuance, renewal or reinstatement of coverage will be deemed representations and not warranties.

First Symetra National Life Insurance Company of New York
420 Lexington Avenue, Suite 300
New York, New York 10170-0399

Phone: 1-800-457-9015
TTY/TTD (800) 833-6388
www.symetra.com/ny

PREMIUM RATE NOTICE

Policy Number: 24 000118 00

Policyholder: **The Stabilization Reserve Fund of the Uniformed Firefighters Association**

Effective Date of Premium Rates: August 1, 2025

Coverage			Monthly Rate
Supplemental Life Insurance	Class 1:		$0.108 per $1,000
	Class 2 and 4:		$0.502 per $1,000
Supplemental Accidental Death and Dismemberment Insurance			$0.040 per $1,000
Supplemental Spouse Life Insurance	Class 4:		$11.997 per family unit
Supplemental Dependent Life Insurance	Class 1:		$9.711 per family unit
	Class 2:		
		Option 1	$1.836 per family unit
		Option 2	$1.890 per family unit
		Option 3	$2.673 per family unit

Rates will be guaranteed until September 1, 2027 unless there is a change in benefits, eligibility, or an Associated Company is added.

First Symetra National Life Insurance Company of New York

By: Margaret Meister, President

Registrar: Connie Kwong-Lam

Date: June 18, 2025

Instructions: (1) Use these rates beginning on the effective date shown above.
(2) Retain this Premium Rate Notice with your policy.

420 Lexington Avenue, Suite 300
New York, NY 10170-0399

Phone 1-800-457-9015 www.symetra.com/ny

Important information regarding your Certificate of Insurance:

This Certificate evidencing your insurance coverage is made available to you by your group insurance policyholder.

First Symetra National Life Insurance Company of New York (Symetra) is only responsible for the accuracy of the Certificate which Symetra provides to the policyholder. The policyholder is **solely** responsible for the accuracy of the information contained herein.

From time to time your Certificate may be modified by Symetra, and an updated electronic Certificate will be made available to you by the policyholder. You are advised to periodically review your Certificate to ensure that you have the most current version.

You have the right to request a paper copy of your current Certificate at any time. If you wish to receive a paper copy of your Certificate you may obtain one by contacting the policyholder.

First Symetra National Life Insurance Company of New York

420 Lexington Avenue, Suite 300
New York, New York 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny

Certificate Rider

Rider Number: 4
Policyholder: The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number: 24 000118 00

The Rider(s) forms a part of the Certificate of Insurance give in connection with The Policy. The Rider(s) do not vary, waive, alter or extend any of the terms, conditions or provisions of the Certificate of Insurance, except as stated herein.

Certificate of Insurance	Effective Date of Change	Applicable to
LGC-03305-CERT/NY 02/14	August 1, 2025	Class 1

Certificate Changes

The following are amended:
Schedule of Insurance – Life – Life Insurance Benefit
Schedule of Insurance – Life – Reduction in Amount of Life Insurance
Schedule of Insurance – Accidental Death and Dismemberment – Accidental Death and Dismemberment Insurance Benefit (AD&D)
Benefits – Life – Conversion Policy Provisions

The following are added:
Definitions – Life – Normal Retirement Age
Benefits – Life – Portability Benefits
Benefits – Life – Qualifying Events
Benefits – Life – Electing Portability
Benefits – Life – Limitations
Benefits – Life – Effect of Portability on other Provisions

Certificate Page(s) Changed:

LGC-03305-CERT/NY 02/14; Schedule of Insurance – Life
LGC-03305-CERT/NY 02/14; Schedule of Insurance – Accidental Death and Dismemberment
LGC-03305-CERT/NY 02/14; Definitions – Life
LGC-03305-CERT/NY 02/14; Benefits – Life

This rider forms a part of the Certificate to which it is attached and all certificates given in connection with The Policy.

This rider becomes effective on the later to occur of:

a) The Policy or certificate Effective Date to which this rider is attached; or
b) the first day of the month on or next following the date We accept Your application and required premium.

Certificate Rider

Rider Number: 4
Policyholder: The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number: 24 000118 00

In all other respects, The Policy and certificate remain the same.

Signed for First Symetra National Life Insurance Company of New York

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

- Please retain a copy of this Rider with Your Certificate.

SYMETRA®
RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

First Symetra National Life Insurance Company of New York
260 Madison Avenue 8th Floor
New York, NY 10016

Mailing Address:
Benefits Division
PO Box 34690
Seattle, WA 98124-1690
Phone 1-800-796-3872
TTY/TDD 1-800-833-6388

Endorsement

This Endorsement is added to and becomes a part of the Certificate to which it is attached. In the case of conflict between the provisions of the Certificate and this Endorsement, the provisions of this Endorsement will control.

The **Accelerated Death Benefit** section of the BENEFITS section of the Certificate is replaced with the following:

BENEFITS
Accelerated Death Benefit
Certificate holder and Spouse

This benefit applies only if indicated in the Schedule of Insurance.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS WHICH WILL BE PAID UPON DEATH. THE ACCELERATED DEATH BENEFIT MAY BE PAID ONLY ONE TIME UNDER A CERTIFICATE.

When can benefits be accelerated?
An Accelerated Death Benefit will be paid only once to You. This benefit is paid as a lump sum if:

1) Your Accelerated Death Benefit request amount is equal to no less than the lower of 25 percent of the amount of insurance under the Certificate or $50,000 and the minimum amount requested may be no greater than 50% of Your amount of Life Insurance;
2) You are Terminally Ill as defined below;
3) You request a portion of Your amount of Life Insurance to be paid as an Accelerated Death Benefit; and
4) satisfactory proof of Terminal Illness is received by us.

The benefit may not exceed 80% of Your amount of Life Insurance.

No discount or lien is associated with the receipt of Accelerated Benefit amounts.

What does Terminal Illness or Terminally Ill mean?
Terminally Ill or Terminal Illness shall mean a life expectancy of 12 months or less.

EXAMPLE: The following is only an example. Please refer to the Schedule of Benefits for Your benefit amounts.

If Your amount of Life Insurance is $10,000 and You are Terminally Ill, You may request any portion of Your life insurance between $3,000 and $8,000 to be paid to You now instead of to the beneficiary at Your death.

However, if You decide to ask for only $3,000 now, You may **not** request the remaining $5,000 in the future.

Your remaining insurance shall be subject to any reductions provided by any part of this Certificate.

PROOF OF TERMINAL ILLNESS – Can First Symetra have a claimant examined for proof of Terminal Illness?
First Symetra has the right to require proof of Terminal Illness.

Any diagnosis submitted must be provided by an attending physician licensed to practice in the United States. If:

1) You fail to submit proof satisfactory to First Symetra that You have a Terminal Illness; or
2) refuse to be examined as may be required by First Symetra;

then no Accelerated Death Benefit will be payable.

EFFECT OF CONVERSION – Does the election of conversion affect this provision?
Yes. If You choose to convert insurance under this Certificate, then the provisions under this benefit will no longer apply. The amount You may convert shall be subject to the Conversion Privilege of this Certificate less any Accelerated Death Benefits You may have received.

LIMITATIONS – What limitations apply to this benefit?
This provision will be subject to all applicable terms and conditions of this Certificate. You may not request an additional Accelerated Death Benefit if You have already received one.

The Accelerated Death Benefit provision does not apply to a Dependent Child or to You if You have attained Your defined retirement age under the 1983 amendments to the Social Security Act.

ASSIGNMENT – What if You made an assignment under this Certificate?
If You have assigned the interest of Your amount of Life Insurance, in order for us to pay benefits under this provision, First Symetra must receive a release from the person to whom the assignment was made.

First Symetra National Life Insurance Company of New York

Jacqueline M. Veneziani

Jacqueline M. Veneziani
Secretary

SYMETRA
RETIREMENT | BENEFITS | LIFE

FIRST SYMETRA NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

First Symetra National Life Insurance Company of New York

Group Life Insurance

CERTIFICATE

CLASS 1

Symetra® is a registered service mark of Symetra Life Insurance Company. Symetra Life Insurance Company not a licensed insurer in New York, is the parent company of First Symetra National Life Insurance Company of New York.

First Symetra National Life Insurance Company Of New York

420 Lexington Avenue, Suite 300
New York, New York 10170-0399
Phone 1-800-457-9015 www.symetra.com/ny
(A stock insurance company, herein called The Company, We, Our or Us)

Annually Renewable Nonparticipating Group Term Life Insurance Certificate

Policyholder:	The Stabilization Reserve Fund of the Uniformed Firefighters Association
Policy Number:	24 000118 00
Policy Effective Date:	October 1, 2017
Policy Anniversary Date:	September first of each year beginning in 2018

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. The Policy may be inspected at the office of the Policyholder.

Signed for The Company

Jacqueline M. Veneziani, Secretary

Margaret Meister, President

READ YOUR CERTIFICATE CAREFULLY.
CERTAIN WAR RISKS ARE NOT ASSUMED.
IN CASE OF ANY DOUBT WRITE THE COMPANY FOR FURTHER EXPLANATION.

You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

Table of Contents

Certificate Face Page
Schedule of Insurance – Life
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Definitions – Accidental Death and Dismemberment
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Period of Coverage
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Benefits – Accidental Death and Dismemberment
General Provisions

Rider #4, Effective August 1, 2025

Schedule of Insurance – Life

The benefits described herein are those in effect as of: August 1, 2025

Cost of Coverage:
Contributory Coverage:
Supplemental Life Insurance
Supplemental Dependent Life Insurance

Eligible Class(es) for Coverage: All Active Members working a minimum number of hours each week as determined by the New York State Professional Fire Fighters Association.

Class 1 All Eligible Active Members in good standing of the Uniformed Firefighters Association who are employed as Firefighter, Fire Marshal, Wiper or Pilots and Marine Engineers

Eligibility Waiting Period for Coverage:
If You are an Active Member with a Participating Entity on the Policy Effective Date: None.

If You become an Active Member with a Participating Entity after the Policy Effective Date: None.

Life Insurance Benefit

Member

	Benefit Amount	Benefit Maximum Amount	Guaranteed Issue Amount
Supplemental Class 1	$150,000, $200,000, $250,000, $300,000, $350,000, $400,000, $450,000 or $500,000 as selected by You on the enrollment card	$500,000	$500,000

Dependent

	Benefit Amount	Benefit Maximum Amount	Guaranteed Issue Amount
Supplemental Class 1			
Spouse	$100,000	$100,000	$100,000
Child 14 days to 26 years	$5,000	$5,000	$5,000

Reduction in Amount of Life Insurance

We will reduce the amount of Life Insurance for You and Your Dependent by any amount:
1) of individual Life Insurance issued in accordance with the Conversion Right;
2) that was continued under the Portability provision; or
3) of Life Insurance in force, paid or payable under the Prior Policy.

Schedule of Insurance – Life

Reduction in Coverage Due to Age

Applies to Supplemental Life Insurance and Supplemental Accidental Death and Dismemberment Insurance:
Your coverage terminates when You attain age 65.

Applies to Supplemental Spouse Life Insurance:
No reduction.

Schedule of Insurance – Accidental Death and Dismemberment

Cost of Coverage:
Contributory Coverage:
Supplemental Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment Insurance Benefit (AD&D)

Supplemental Accidental Death and Dismemberment Insurance can be elected as a standalone option.

Member

	Principal Sum	Principal Maximum Sum
Supplemental Class 1	$50,000, $100,000, $150,000 or $200,000 as selected by You on the enrollment card	$200,000

Additional Accidental Death and Dismemberment Insurance Benefits

Seat Belt Benefit

Seat Belt Benefit Amount:	10% of Supplemental AD&D Principal Sum
Seat Belt Maximum Amount:	$20,000
Seat Belt Minimum Amount:	$1,000

Air Bag Benefit

Air Bag Benefit Amount:	10% of Supplemental AD&D Principal Sum
Air Bag Maximum Amount:	$20,000

Repatriation Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000

Child Education Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Day Care Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Spouse Education Benefit

Benefit Amount:	5% of Supplemental AD&D Principal Sum
Maximum Amount:	$5,000
Minimum Amount:	$2,500

Definitions – Life

Active Member
means a member who works for the Participating Entity on a regular basis in the usual course of the Participating Entity's business.

Contributory Coverage
means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child
means:

1) Your unmarried children, stepchildren, legally adopted children; or
2) any other children related to You by blood or marriage or domestic partnership who:
   a) live with You in a regular parent-child relationship or
   b) You claimed as a dependent on Your last filed federal income tax return;

provided such children are primarily dependent upon You for financial support and maintenance and are:

1) at least 14 days old but under age 26; or
2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

Dependent
means Your Spouse, Your same or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law and Your Dependent Child. A Dependent must be a citizen or legal resident of the United States. Any person who is in full-time military service cannot be a Dependent.

Guaranteed Issue Amount
means the amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Normal Retirement Age
means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Participating Entity
means an entity who is a participant in accordance with the provisions of The Policy.

Definitions – Life

Physician
means a legally qualified Physician or surgeon other than a Physician or surgeon who is Related to You by blood or marriage.

Prior Policy
means, if applicable, the group life insurance policy carried by the Policyholder on the day before the Policy Effective Date.

Related
means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Spouse
means Your Spouse who is not legally separated or divorced from You. Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

The Policy
means The Policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us or Our
means the insurance company named on the face page of The Policy.

You or Your
means the person to whom this certificate is issued.

Definitions – Accidental Death and Dismemberment

Airworthiness Certificate
means:
1) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Civil or Public Aircraft
means a Civil or Public Aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

Common Carrier
means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

FAA
means:
1) the Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

Injury
means bodily Injury resulting:
1) directly from an accident; and
2) independently of all other causes;
which occurs while You are covered under The Policy.

Loss resulting from:
1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

Military Transport Aircraft
means a transport aircraft operated by:
1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of a governmental authority recognized by the United States.

Definitions – Accidental Death and Dismemberment

Motor Vehicle
means a self-propelled, four or more wheeled:

1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

On
means, when used with reference to any conveyance (land, water or air), in or On, boarding or alighting from the conveyance.

Scheduled Aircraft
means a Civil or Public Aircraft operated by a scheduled airline which:

1) is licensed by the FAA for the transportation of passengers for hire; and
2) publishes its flight schedules and fares for regular passenger service.

Eligibility and Enrollment

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:

1) the Policy Effective Date;
2) the date on which You complete the Eligibility Waiting Period for Coverage; or
3) the date You become a member of an Eligible Class.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:

1) the date You become insured for member coverage; or
2) the date You acquire Your first Dependent.

You may not elect coverage for Your Dependent if such Dependent is covered as a member under The Policy. No person can be insured as a Dependent of more than one member under The Policy.

Enrollment: *How do I enroll for coverage for myself and my Dependents?*
To enroll for Contributory Coverage, You must:

1) complete and sign a group insurance enrollment form, satisfactory to Us; and
2) deliver it to the Policyholder.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may only enroll:

1) during an Annual Enrollment Period if designated by the Policyholder; or
2) within 31 days of the date You have a Change in Family Status.

Any enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an amount of Life Insurance greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:

1) Your amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; or
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Eligibility and Enrollment

Dependent Evidence of Insurability Requirements: *When will my Dependent first be required to provide Evidence of Insurability?*
We require Evidence of Insurability, satisfactory to Us, for initial coverage, if You:

1) enroll for Your Dependent coverage more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an amount of Dependent Life Insurance greater than the Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if the amount of Life Insurance for Your Dependent Child is $15,000 or less.

If Your Dependent Evidence of Insurability is not satisfactory to Us:

1) the amount of Dependent Life Insurance will equal the amount for which Your Dependent was eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; or
2) Your Dependent will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statement; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You or Your Dependent are insurable for initial coverage or an increase in coverage under The Policy.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:

1) You get married or You execute a domestic partner affidavit;
2) You and Your Spouse divorce or terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your Spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your Spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

Period of Coverage

Effective Date: *When does my coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible, if You enroll on or before that date;
2) the first of the month following the last day of any Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage, for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

However, all Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not an Active Member due to a physical or mental condition such coverage will not start until the date You are an Active Member.

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date You were not an Active Member and would otherwise meet the Eligibility requirements of The Policy. However, Your amount of Insurance will be the lesser of the amount of Life Insurance and Accidental Death and Dismemberment Principal Sum:

1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made in accordance with any enrollment provision requirements.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are an Active Member.

However, if the coverage provided through this provision ends because You are an Active Member, You may be covered under The Policy.

Period of Coverage

Dependent Effective Date: *When does Dependent coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date;
2) the first of the month following the last day of any Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage, for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependent Evidence of Insurability.

In no event will Dependent coverage become effective before You become insured.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, is to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

he or she is:

1) confined in a hospital; or
2) Confined Elsewhere;

such coverage will not start until he or she:

1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to Disabled children who qualify under the definition of Dependent Child.

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependent?*
If, on the day before the Policy Effective Date, You were covered with respect to Your Dependent under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependent. However, the Dependent amount of Insurance will be the lesser of the amount of Life Insurance:

1) they had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependent?*
After Your initial enrollment, You may increase or decrease coverage for You or Your Dependent or add a new Dependent to Your existing Dependent coverage:

1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

Period of Coverage

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the first of the month following the date of the change.

Any increase in coverage will take effect on the latest of:
1) the first of the month following the date of the change;
2) the date requirements of the Deferred Effective Date provision are met; or
3) the date Evidence of Insurability is approved, if required.

Increase in Amount of Life Insurance: *If I request an increase in the amount of Life Insurance for myself or my Dependent, must we provide Evidence of Insurability?*
If You or Your Dependent are:
1) already enrolled for an amount of Life Insurance under The Policy, then You and Your Dependent must provide Evidence of Insurability for any increase; or
2) not already enrolled for Life Insurance under The Policy, You and Your Dependent must provide Evidence of Insurability for any amount of coverage, including an initial amount of Life Insurance.

In any event, if the amount of Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependent, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the amount of Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependent Evidence of Insurability is not satisfactory to Us, the amount of Insurance he or she had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or the class is cancelled;
3) the date the required premium is due but not paid;
4) the date You or Your Participating Entity terminates Your membership;
5) the date Your Participating Entity ceases to be a Participating Entity;
6) the date You are no longer an Active Member; or
7) the date You attain age 65.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Participating Entity terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent.

Period of Coverage

Continuation for Dependent Child with Disabilities: *Will coverage for Dependent Child with Disabilities be continued?*
If Your Dependent Child reaches the age at which they would otherwise cease to be a Dependent as defined, and they are:

1) age 26 or older;
2) Disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child coverage will not terminate solely due to age. However:

1) You must submit proof satisfactory to Us of such Dependent Child's disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child must have become Disabled before attaining age 26.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the amount of Life Insurance for such Dependent Child will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

Benefits – Life

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*
If You or Your Dependent die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of the certificate.

Accelerated Benefit: *What is the benefit?*
In the event that You or Your Dependent are diagnosed as Terminally Ill, and You request in writing that a portion of the Terminally Ill person's amount of Life Insurance be paid as an Accelerated Benefit while the Terminally Ill person is:

1) covered under The Policy for an amount of Life Insurance of at least $10,000; and
2) under the Policy limiting age;

We will pay the Accelerated Benefit Amount as shown below, provided We receive proof of such Terminal Illness.

The amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. Premiums will not be adjusted.

You may request a minimum Accelerated Benefit Amount of $25,000, and a maximum of $100,000. However, in no event will the Accelerated Benefit Amount exceed 50% of the Terminally Ill person's amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $10,000 and are Terminally Ill, You can request any portion of the amount of Life Insurance Benefits from $3,000 to $5,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $2,000 in the future.

Any benefits received under this benefit may affect eligibility for public assistance and may be taxable. You should consult a personal tax advisor for further information.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependent do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependent refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

Benefits – Life

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill or my Dependent is no longer Terminally Ill?*
If You or Your Dependent are diagnosed by a Physician as no longer Terminally Ill and:

1) are in an Eligible Class, coverage will remain in force, provided premium is paid; or
2) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, You and Your Dependent may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

1) the Accidental Death and Dismemberment Insurance Benefits; or
2) any amount of Life Insurance for which You or Your Dependent were not eligible and covered; under The Policy.

You or Your Dependent will be eligible to convert coverage if coverage under The Policy ends because:

1) The Policy is terminated; or
2) coverage for an Eligible Class is terminated; or
3) Your Participating Entity is no longer a Participating Entity.

The amount which may be converted under these circumstances is the Life Insurance Benefit under The Policy less any amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or my Dependent coverage?*
The Policyholder will provide You with written notice of Your and Your Dependent conversion rights within 15 days before or after the date Your and Your Dependent coverage ends and You will have 31 days from the date coverage ended, or from any extended notice period, to convert Your coverage. This written notice will be given by the Policyholder to You or mailed to Your last known address.

To convert Your coverage or coverage for Your Dependent, You must apply within 31 days after Life Insurance terminates. However, if You are provided with notice of Your and Your Dependent conversion rights more than 15 days, but less than 90 days after the date Your and Your Dependent coverage ends, You will have 45 days after You are provided with the notice to convert Your coverage.

Your and Your Dependent conversion rights will expire 90 days after the date Your and Your Dependent coverage ends if the Policyholder does not provide You with notice of Your and Your Dependent conversion rights within 90 days after the date Your and Your Dependent coverage ends.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must pay the required premium for coverage within the time period specified in this provision.

Any individual policy issued to You or Your Dependent under the Conversion Right:

1) will be effective as of the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Benefits – Life

Conversion Policy Provisions: *What are the Conversion Policy Provisions?*
The Conversion Policy will base premiums on the insured's class of risk under The Policy in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide the same terms and conditions of coverage as The Policy or any benefit other than the Life Insurance Benefit.

If Your or Your Dependent coverage under the Policy ceases because of termination of Your employment or membership in an eligible class ends You may choose to have a Conversion Policy issued by the Insurer. The Conversion Policy may be any policy customarily issued by the Insurer except term insurance, except that the Conversion Policy may be preceded by preliminary term insurance for a period of one year with the premium payable, at Your option, in any mode customarily offered by the Insurer.

If Your or Your Dependent coverage under the Policy ceases due to Your total and permanent disability, You may choose to have a Conversion Policy issued by the Insurer. The Conversion Policy may be any policy customarily issued by the Insurer, including term insurance. The Conversion Policy may be preceded by preliminary term insurance for a period of one year with the premium payable, at Your option, in any mode customarily offered by the Insurer, and in the amount of Your Life Insurance Benefit in effect immediately before Your coverage was terminated, less the amount of any life insurance which is replaced with the same or another insurer within 45 days of the date Your coverage under this Policy ceases.

Any amount of Life Insurance which was, or is being, continued under a certificate of insurance issued in accordance with the Portability provision is not also available to be converted until such coverage ends. Amounts may be continued as described above or converted, but the amounts cannot be continued and converted at the same time.

Death within the Conversion Period: *What if I or my Dependent die before coverage is converted?*
We will pay the deceased person's amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates;
2) You or Your Dependent die within 31 days of the date coverage terminates or during any extended notice period; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, or a successful application for Conversion has been made, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Portability Benefits: *What is Portability?*
Portability is a provision which allows You to continue coverage under a Group Portability policy when coverage would otherwise end due to certain Qualifying Events. Portability applies to Supplemental Life Insurance only.

Qualifying Events: *What are Qualifying Events?*
Qualifying Events for You are:

1) Your employment terminates, for any reason prior to Normal Retirement Age; or
2) Your membership in an Eligible Class under The Policy ends.

Electing Portability: *How do I elect Portability?*
You may elect Portability for Your coverage after Your Supplemental coverage ends because You had a Qualifying Event. The Policy must still be in force and the Employer must continue to be a Participating Entity in order for Portability to be available.

To elect Portability for You, You must:

1) complete and have Your Employer sign a Portability application; and
2) submit the application to Us, with the required premium.

This must be received within 31 days after Life Insurance terminates. However, if You are provided with notice of Your Portability rights more than 15 days, but less than 90 days after the date Your coverage ends, You will have 45 days after You are provided with the notice to elect Portability. If notice is not given within 90 days, then the insured has 90 days to apply for portability.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

1) issued without Evidence of Insurability;
2) issued on one of the forms then being issued by Us for Portability purposes; and
3) effective on the day following the date Your coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations: *What limitations apply to this benefit?*
You may elect to continue 50%, 75% or 100% of the amount of Life Insurance which is ending. This amount will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. However, the amount of Life Insurance that may be continued will not exceed $500,000 for You.

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You be able to continue an amount of Life Insurance which is less than $5,000.

Portability is not available for any amount of Life Insurance for which You were not eligible and covered.

In addition, Portability is not available if You are entering active military service.

Effect of Portability on other Provisions: *How does Portability affect other provisions?*
Portability is not available for any amount of Life Insurance which was, or is being, continued in accordance with the Conversion Right under The Policy. However, if:

1) You elect to continue only a portion of terminated coverage under this Portability provision; or
2) the amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

Benefits – Accidental Death and Dismemberment

Accidental Death and Dismemberment Insurance Benefit: *When is the Accidental Death and Dismemberment Insurance Benefit payable?*
If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss, after We receive Proof of Loss in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum, to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:

Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Loss means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

Exposure and Disappearance: *What if Loss is due to exposure or disappearance?*
Exposure to the elements will be presumed to be Injury if:
1) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You were an occupant at the time of the accident; and
2) The Policy would have covered an Injury resulting from the accident.

We will presume that You suffered Loss of life if:
1) Your body has not been found within one year after the disappearance of a conveyance in which You were an occupant at the time of its disappearance;
2) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
3) The Policy would have covered Injury resulting from the accident.

Benefits – Accidental Death and Dismemberment

Seat Belt and Air Bag Benefit: *When is the Seat Belt and Air Bag Benefit payable?*
If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:

1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:

1) positioned in a seat equipped with a factory-installed Air Bag; and
2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:

1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The Seat Belt and Air Bag Benefit will not be payable if You are operating the Motor Vehicle at the time of Injury while:

1) Intoxicated; or
2) taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

Intoxicated means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Benefits – Accidental Death and Dismemberment

Repatriation Benefit: *When is the Repatriation Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:
1) the actual expenses incurred for:
   a) preparation of the body for burial or cremation; and
   b) transportation of the body to the place of burial or cremation;
2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Child Education Benefit: *When is the Child Education Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Child Education Benefit to Your Child.

This Benefit will be paid:
1) after We receive proof that Your Child qualifies as a Student, as defined in this Benefit; and
2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:
1) the amount resulting from multiplying Your amount of Principal Sum by the Child Education Percentage; or
2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Children:
1) on the date; and
2) for whom;
We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:
1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
2) the end of the 12th consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:
1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Student.

Benefits – Accidental Death and Dismemberment

Student means Your Child who on the date of Your death:

1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your death; or
2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your death and was a student in the 12th grade on the date of Your death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

Child means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 21 who:

1) regularly attends an accredited institution of learning; and
2) is primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Day Care Benefit: *When is the Day Care Benefit payable?*
If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Day Care Benefit for each of Your Children if such Child is under age seven at the time of Your death.

This Benefit will be paid:

1) after We receive proof of enrollment in a Day Care Program as described in this Benefit; and
2) according to the General Provisions of The Policy.

We will make one Day Care Benefit payment each year, for a maximum of four Day Care Benefit payments, for each Child. The Benefit will be paid to the person who has primary responsibility for the Child's Day Care expenses.

Proof of enrollment satisfactory to Us for each Child in a Day Care Program includes, but will not be limited to, the following:

1) a copy of the Child's approved enrollment application in a Day Care Program;
2) cancelled check(s) evidencing payment to a Day Care facility or Day Care provider; or
3) a letter from the Day Care facility or Day Care provider stating that the Child:
   a) is attending a Day Care Program; or
   b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the death.

Proof of enrollment must be sent to Us prior to the last day of the 12th month following the date of death.

If You die, the Day Care Benefit provides an annual amount equal to the lesser of:

1) the amount resulting from multiplying Your amount of Principal Sum by the Day Care Benefit; or
2) the Maximum Amount for this Benefit.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision for payment of benefits for Loss of life if:

1) a Principal Sum is payable because of Your death; and
2) no person qualifies as a Child eligible for the Day Care Benefit.

Day Care or **Day Care Program** means a program of child care which:

1) is operated in a private home, school or other facility;
2) provides, and makes a charge for, the care of children;
3) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or
4) if licensing is not required, provides child care on a daily basis for 12 months a year.

Child means Your unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age seven and primarily dependent on You for financial support and maintenance.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Spouse Education Benefit: *When is the Spouse Education Benefit payable?*
If You sustain an Injury that results in a Loss of life payable under the Accidental Death and Dismemberment Insurance Benefit, We will pay an additional Spouse Education Benefit to Your surviving Spouse.

This Benefit will be paid:

1) after We receive proof satisfactory to Us that the Spouse has enrolled in an Occupational Training program; and
2) according to the General Provisions of The Policy.

The Spouse Education Benefit is the least of:

1) the Expense Incurred for Occupational Training;
2) the amount resulting from multiplying Your amount of Principal Sum by the Spouse Education Benefit Percentage; or
3) the Maximum Amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

1) for the purpose of obtaining an independent source of income; and
2) within one year of Your death.

Occupational Training means any:

1) education;
2) professional; or
3) trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

Expense Incurred means:

1) the actual tuition charged, exclusive of room and board; and
2) the actual cost of the materials needed;

for the Occupational Training. The expense must be incurred within two years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Benefits – Accidental Death and Dismemberment

Exclusions: *What is not covered under The Policy?* (Applies to Accidental Death and Dismemberment Insurance only)
The Policy does not cover any Loss caused or contributed by:

1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) war or act of war, whether declared or not;
4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5) Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6) Injury sustained while On any aircraft:
   a) as a pilot, crewmember or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Participating Entity or organization whose eligible persons are covered under The Policy; or
   d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
7) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
8) Injury sustained while committing or attempting to commit a felony;
9) Injury sustained while Intoxicated; or
10) Injury sustained while driving while Intoxicated.

Intoxicated means:

1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

General Provisions

Notice of Claim: *When should I notify The Company of a claim?*
You, or the person who has the right to claim benefits, must give Us, or Our representative, written notice of a claim within 30 days after:

1) the date of death; or
2) the date of Loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Failure to give notice as soon as reasonably possible will not invalidate or reduce any claim. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
Within 15 days of receiving a Notice of Claim, We will send forms to the claimant to provide Proof of Loss. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.

Proof of Loss: *What is Proof of Loss?*
With respect to the Life Insurance Benefits, Proof of Loss shall consist of a completed claim form and a certified copy of the death certificate.

For all other coverages, Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your enrollment form;
4) Your beneficiary designation (if applicable);
5) if applicable, documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability;
6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information; or
9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss should be sent to Us or Our representative; with respect to the Accidental Death and Dismemberment Benefits, within 90 days; after the loss.

If Proof of Loss other than for Life Insurance Benefits is not given by the time it is due, it will not invalidate or reduce the claim if:

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than one year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

General Provisions

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a Loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits due in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits and benefits for Loss of life under the Accidental Death and Dismemberment Insurance Benefits will be paid in accordance with the life insurance beneficiary designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) the executors or administrators of Your estate;
2) all to Your surviving Spouse;
3) if Your Spouse does not survive You, in equal shares to Your surviving Children; or
4) if no Child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.
We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving Spouse or the executor or administrator of Your estate.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Policyholder.

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the provisions upon which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

General Provisions

Claim Appeal: *What recourse will my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Incontestability: *When can The Policy be contested?*
Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment Insurance Benefits.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You and a copy will be provided to You or Your beneficiary.

No statement made relating to Your Dependent being insurable will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the Dependent's lifetime. In order to be used, the statement must be in writing and signed by You or Your representative.

Assignment: *Are there any rights of assignment?*
Except for the dismemberment benefits under the Accidental Death and Dismemberment Insurance Benefit, You have the right to assign all of Your rights and interest under The Policy including, but not limited to, the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any assignment made by You under The Policy effective on the date the assignment is signed, subject to action taken by Us prior to receipt of notice of assignment, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

Legal Actions: *When can legal action be taken?*
Legal action cannot be taken against Us sooner than 60 days after the date written Proof of Loss is furnished

General Provisions

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Misstatements: *What happens if facts are misstated?*
If material facts about Your or Your Dependent age or sex were not stated accurately:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Entire Policy:
The rights of the Policyholder, Your rights, or the rights of Your beneficiary under this Policy shall not be affected by any provision other than one contained in The Policy, including Your certificate of insurance, or any riders or endorsements hereon or in any amendments hereto signed by the Policyholder and The Company, or in the copy of the Policyholder's application attached to this Policy or in the individual statements, if any, submitted by You in connection therewith. All statements made by the Policyholder or persons insured under this Policy in the application for the issuance, renewal or reinstatement of coverage will be deemed representations and not warranties.

Dental – MetLife Benefit Summary – Actives

November 20, 2023
Marty Tighe
Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010

Re: Sample Dental Benefits Program Description ("Sample SPD")

Dear Marty Tighe:

It is the understanding of Metropolitan Life Insurance Company ("MetLife") that your Dental Program is not subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The enclosed information is being provided to you at your request as part of MetLife's dedication to customer service.

In accordance with your approval of the intended plan design, enclosed herein please find a sample Program Description. Please note that it is part of MetLife's standard services only to provide a sample Program Description for a customer to review with its own legal counsel to ensure consistency with the operation of the Program and consistency with any other documents under your Program. While MetLife has agreed to provide you with the sample Program Description, you as the Program Sponsor are legally responsible to comply with any requirements under applicable laws and for ensuring that this sample Program Description is accurate and updated when necessary.

Finally, pursuant to the terms of the Administrative Services Agreement entered into between you and MetLife, please provide MetLife with a final version of your Program Description.

Sincerely,

Denise Lang
Client Service Consultant
Employee Benefits Sales
Metropolitan Life Insurance Company
501 US Highway 22, Bridgewater, NJ 08807
Tel (908) 253-1467

Enclosure

DRAFT SPECIMEN

YOUR PROGRAM DESCRIPTION

Uniformed Firefighters Association

Active Members

Value PDP Plan

Dental Benefits for You and Your Dependents

Effective January 1, 2024

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Program Description is merely a draft specimen, which You should review with Your own tax or legal advisors to ensure compliance with applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with applicable laws. Changes may be necessary to assure compliance with law and to assure consistency with Your specific program provisions and program administration.

YOUR PROGRAM DESCRIPTION

INTRODUCTION

This Program Description describes the benefits available to you under the benefits plan of Uniformed Firefighters Association. Please read this booklet carefully to become familiar with your benefits. This Program is effective as of January 1, 2024.

This is a self-funded Dental Benefits plan provided by the Program Sponsor. Metropolitan Life Insurance Company ("MetLife") does not insure the benefits described in this booklet.

Claims are administered on behalf of This Program by MetLife as the Claim Administrator pursuant to the terms of an administrative service agreement.

Please note that the terms "You" and "Your" throughout this booklet refer to the Member, except where otherwise indicated. Many of the terms that are important in understanding your benefits are explained in the DEFINITIONS section.

Uniformed Firefighters Association

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BENEFITS AT A GLANCE

This section provides You and Your Dependents with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You and Your Dependents refer to the provisions contained in this Program Description for details about Your benefits.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Benefits On You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	100%	100%
Type C Services	100%	100%
Orthodontic Covered Services	100%	100%
Maximum Benefit:		
Yearly Individual Maximum	$2,500 for the following Covered Services: Type B; Type C	$2,500 for the following Covered Services: Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$3,000	$2,500

DEFINITIONS

As used in this Program Description, the terms listed below will have the meanings set forth below. When defined terms are used in this Program Description, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

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

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

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

For the purposes of determining who may become covered for benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Program as a Member.

Claim Administrator means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The Claim Administrator does not insure the benefits described in this Program Description.

Covered Percentage means the percentage of the Maximum Allowed Charge that This Program will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

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

- prescribed or performed by a Dentist while such person is covered for Dental Benefits;
- Dentally Necessary to treat the condition; and
- described in the section entitled BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Program Description.

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

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

Domestic Partner means each of two people, one of whom is a Member of the Program Sponsor, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

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

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

Full-Time means Active Work of at least 20 hours per week on the Program Sponsor's regular work schedule for the eligible class of Members to which You belong.

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

Maximum Allowed Charge means:

1. With respect to In-Network Dentists, the lesser of:
    - the amount charged by the In-Network Dentist; or
    - the maximum amount which the In-Network Dentist has agreed with MetLife to accept as payment in full for the dental service.

2. With respect to Out-of-Network Dentists, the lesser of:
    - the amount charged by the Out-of-Network Dentist; or
    - the Out-of-Network scheduled amount for the state where the dental service is performed.

Member means a member in good standing of Uniformed Firefighters Association.

Noncontributory Coverage means coverage for which the Program Sponsor does not require You to pay any part of the cost of coverage.

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

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or

- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the group benefits. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

Program Sponsor means Uniformed Firefighters Association.

Proof means Written evidence satisfactory to the Claim Administrator that a person has satisfied the conditions and requirements for any benefit described in this Program Description. When a claim is made for any benefit described in this Program Description, Proof must establish:

- the nature and extent of the loss or condition;
- This Program's obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator, and consistent with applicable law.

Spouse means Your lawful spouse. Wherever the term "Spouse" appears in the Program Description it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Program as a Member.

This Program means the self-funded Dental Benefits plan of the Program Sponsor.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator and consistent with applicable law.

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

You and **Your** mean and Member who is eligible for the benefits described in this Program Description.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU

ELIGIBLE CLASS(ES)

Full-Time Members of the Security Benefit Fund of the Uniformed Firemen's Association, Local 94, I.A.F.F. AFL-CIO

DATE YOU ARE ELIGIBLE FOR COVERAGE

You may only become eligible for the coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

If You are in an eligible class on January 1, 2024, You will be eligible for the coverage described in this Program Description on that date.

ENROLLMENT PROCESS

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

The Dental Benefits have a regular enrollment period established by the Program Sponsor. Subject to the rules of This Program, You may enroll for Dental Benefits only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Program Sponsor for more information regarding the flexible benefits plan.

DATE YOUR COVERAGE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for coverage, such coverage will take effect on the date You become eligible.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for coverage until the next annual enrollment period for Dental Benefits, as determined by the Program Sponsor, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Program Sponsor, You may enroll for coverage for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period.

Enrollment Due to a Qualifying Event

You may enroll for coverage, for which You are eligible, or change the amount of Your coverage between annual enrollment periods only if You have a Qualifying Event.

This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the date the Claims Administrator states in Writing.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU (continued)

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Program Sponsor's plan or a new benefit option under the Program Sponsor's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage;
- You previously did not enroll for Dental Benefits for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of Program Sponsor contributions for the other group coverage; or
    3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your Spouse, former Spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

DATE YOUR COVERAGE ENDS

Your coverage will end on the earliest of:

1. the date This Program ends;
2. the date coverage ends for Your class;
3. the last day of the calendar month in which You cease to be in an eligible class;
4. the end of the period for which the last contribution has been paid for You;
5. the date Your employment ends; Your employment will end if You cease to be in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE; or
6. the date You retire in accordance with the Program Sponsor’s retirement plan.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT COVERAGE

Full-Time Members of the Security Benefit Fund of the Uniformed Firemen's Association, Local 94, I.A.F.F. AFL-CIO

DATE YOU ARE ELIGIBLE FOR DEPENDENT COVERAGE

You may only become eligible for the Dependent coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

If You are in an eligible class on January 1, 2024, You will be eligible for Dependent coverage on the later of:

1. January 1, 2024; and
2. the date You obtain a Dependent.

If You enter an eligible class after January 1, 2024, You will be eligible for Dependent coverage on the later of:

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

No person may be covered as a Dependent of more than one Member.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL COVERAGE

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

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

The Dental Benefits have a regular enrollment period established by the Program Sponsor. Subject to the rules of This Program, You may enroll for Dependent coverage only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Program Sponsor for more information regarding the flexible benefits plan.

DATE COVERAGE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent coverage, such coverage will take effect on the date You become eligible.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent coverage until the next annual enrollment period for Dental Benefits, as determined by the Program Sponsor, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Program Sponsor, You may enroll for Dependent coverage for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

Enrollment Due to a Qualifying Event

You may enroll for Dependent coverage for which You are eligible, or change the amount of Your Dependent coverage, between annual enrollment periods only if You have a Qualifying Event.

This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the date the Claims Administrator states in Writing.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Program Sponsor's plan or a new benefit option under the Program Sponsor's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage;
- You previously did not enroll for Dental Coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of Program Sponsor contributions for the other group coverage;
    3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your Spouse, former Spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Once You have enrolled one Child for Dependent Coverage, each succeeding Child will automatically be covered for such coverage on the date the Child qualifies as a Dependent.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Benefits for You ends;
3. the date You cease to be in an eligible class;
4. the date This Program ends;
5. the date coverage for Your Dependents ends under This Program;
6. the date coverage for Your Dependents ends for Your class;
7. the end of the period for which the last contribution has been paid for the Dependent;
8. the last day of the calendar month the Dependent reaches the limiting age;
9. the end of the period for which the last contribution has been paid for the Dependent; or
10. the last day of the calendar month the person ceases to be a Dependent.

CONTINUATION OF COVERAGE

FOR MENTALLY OR PHYSICALLY DISABLED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Program Sponsor for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL BENEFITS

If Dental Benefits for You or a Dependent ends, You or Your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of this Program Description entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE or contact the Program Sponsor for information regarding continuation of coverage under COBRA.

AT THE PROGRAM SPONSOR'S OPTION

The Program Sponsor has elected to continue coverage by paying contributions for Members who cease Active Work in an eligible class for any of the reasons specified below. If Your coverage is continued, coverage for Your Dependents may also be continued.

Coverage will continue for the following periods:

1. if You cease Active Work due to layoff, for a period in accordance with the Program Sponsor's general practice for a Member in Your job class;
2. if You cease Active Work due to any other Program Sponsor approved leave of absence, for a period in accordance with the Program Sponsor's general practice for a Member in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Program Sponsor's general practice for a Member in Your job class;
4. if You cease Active Work due to strike, for a period in accordance with the Program Sponsor's general practice for a Member in Your job class.

The Program Sponsor's general practice for Members in a job class determines which Members with the above types of absences are to be considered as still covered and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your coverage will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be covered under This Program;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your coverage will end in accordance with the DATE YOUR COVERAGE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOU.

CONTINUATION OF COVERAGE (continued)

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

DENTAL BENEFITS

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claim Administrator. When the Claim Administrator receives such Proof, the Claim Administrator will review the claim and if the Claim Administrator approves it, This Program will pay the Dental Benefits in effect on the date that service was completed.

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

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

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting MetLife's website at www.metlife.com/dental.

BENEFIT AMOUNTS

This Program will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Program Description.

In-Network

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

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

Out-of-Network

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

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

- any other part of the Maximum Allowed Charge for which This Program does not pay benefits; and
- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth Maximum Benefit Amounts This Program will pay for Covered Services received In-Network and Out-of-Network. This Program will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

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

Alternate Benefit

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

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

For example:

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

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

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Program Description, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, This Program will only pay benefits for the root canal therapy.

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed 20% of the amount charged by the Dentist when the course of treatment begins.

The benefit payable for the periodic follow-up visits will also be based on the amount charged by the Dentist when the course of treatment begins. It will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claim Administrator that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to these Dental Benefits

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

If the periodic follow-up visits commenced prior to these Dental Benefits being in effect:

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

Pretreatment Estimate of Benefits

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

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

Benefits This Program Will Pay After Coverage Ends

This Program will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a prosthetic device if:

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

This Program will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a Cast Restoration if:

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

This Program will pay benefits for a 31 day period after Your coverage ends for completion of root canal therapy if:

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

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams twice in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), twice in a Year.
4. Problem-focused exams twice in a Year.
5. Full mouth or panoramic x-rays once every 60 months.
6. Bitewing x-rays:
   - 2 sets every Year for a Child; and
   - 1 set every Year for everyone else.
7. Intraoral-periapical x-rays.
8. X-rays, except as mentioned elsewhere.
9. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
10. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
11. Diagnostic casts.
12. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
13. Topical fluoride treatment for a Child under age 19 once in 12 months.

Type B Covered Services

1. Emergency palliative treatment to relieve tooth pain.
2. Initial placement of amalgam fillings.
3. Replacement of an existing amalgam filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
4. Initial placement of resin-based composite fillings.
5. Replacement of an existing resin-based composite filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
6. Protective (sedative) fillings.
7. Oral surgery, except as mentioned elsewhere in this Program Description.
8. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
9. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
10. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
11. Full mouth debridements, but not more than once per lifetime.
12. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
13. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.

14. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
15. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any year.
16. Pulp capping (excluding final restoration).
17. Therapeutic pulpotomy (excluding final restoration).
18. Pulp therapy.
19. Apexification/recalcification.
20. Pulpal regeneration, but not more than once per lifetime.
21. Local chemotherapeutic agents.
22. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claim Administrator determines such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
23. Injections of therapeutic drugs.
24. Space maintainers for a Child under age 14 once per lifetime per tooth area.
25. Sealants or sealant repairs for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
26. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
27. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
28. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C Covered Services

1. Biopsies of hard or soft oral tissue.
2. Initial installation of full or partial Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits under this Program.
3. Addition of teeth to a partial removable Denture to replace teeth removed while these Dental Benefits were in effect for the person receiving such services.
4. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 60 months prior to replacement.
5. Replacement of a non-serviceable removable Denture if such Denture was installed more than 60 months prior to replacement.
6. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES (continued)

7. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
8. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
9. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
10. Initial installation of Cast Restorations (except implant supported Cast Restorations).
11. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 60 months have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
12. Prefabricated crown, but no more than one replacement for the same tooth within 60 consecutive months.
13. Core buildup, but no more than once per tooth in a period of 60 months.
14. Posts and cores, but no more than once per tooth in a period of 60 months.
15. Labial veneers, but no more than once per tooth in a period of 60 months.
16. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
17. Other consultations, but not more than once in a 12 month period.
18. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
19. Repair of implants, but no more than once in a 12 month period.
20. Implant supported Cast Restorations, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
21. Implant supported fixed Dentures, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
22. Implant supported removable Dentures, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
23. Tissue conditioning, but not more than once in a 36 month period.
24. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
25. Cleaning and inspection of a removable appliance twice in 12 months.

Orthodontic Covered Services

Orthodontia, for a Child under age 19.

DENTAL BENEFITS: EXCLUSIONS

This Program will not pay Dental Benefits for charges incurred for:

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

DENTAL BENEFITS: EXCLUSIONS (continued)

27. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
28. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
29. duplicate prosthetic devices or appliances;
30. replacement of a lost or stolen appliance, Cast Restoration or Denture;
31. replacement of an orthodontic device;
32. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
33. intra and extraoral photographic images.

DENTAL BENEFITS: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Program.

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

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

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

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

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

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

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

The term does not include any of the following:

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

The provisions of This Program, which limit benefits based on benefits or services provided under plans which the Program Sponsor (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

Each contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Program means the Dental Benefits described in this Program Description, except for any provisions in this Program Description that limit coverage based on benefits for services provided under plans which the Program Sponsor (or an affiliate) contributes to or sponsors.

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

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

Active or Inactive Member: A Plan that covers a person as a Member who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired Member (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

EFFECT ON BENEFITS OF THIS PROGRAM

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

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

- the person This Program has paid or for whom This Program has paid;
- insurance companies; or
- other organizations.

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

GENERAL PROVISIONS

Assignment

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

Dental Benefits: Who This Program Will Pay

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

Conformity with Law

If the terms and provisions of this Program Description do not conform to any applicable law, this Program Description shall be interpreted to so conform.

Overpayments

Recovery of Dental Benefit Overpayments

This Program has the right to recover any amount that the Claim Administrator determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Claim Administrator determines that:

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

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

How This Program Recovers Overpayments

This Program may recover the overpayment from You by:

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

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

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

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE

COBRA is a federal law that requires most group health plans to give their Members and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Program for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your dental coverage under This Program for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Program for up to 36 months. Also, your covered children may be able to continue coverage under This Program for up to 36 months after they no longer qualify as covered dependents under the terms of This Program. Group health plans for Program Sponsors with fewer than 20 Members, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

a. the end of the 18, 29 or 36 month continuation period, as the case may be;

b. the date of expiration of the last period for which the required payment was made;

c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent’s preexisting condition;

d. the date your Program Sponsor ceases to provide any group health plan for its Members.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Program. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Program Sponsor within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Member does not make that election. However, covered Members may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Program must pay the full cost of that coverage (including both the share you now pay and the share your Program Sponsor now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

Qualifying Event Due To Bankruptcy Of Program Sponsor

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Program Sponsor, and that bankruptcy results in the loss of coverage of any retired Member covered under This Program, the retired Member will become a qualified beneficiary with respect to the bankruptcy. The retired Member’s covered spouse and covered dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under This Program.

If You Elect COBRA

If you choose COBRA coverage and pay the required contributions, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Program Sponsor to similarly situated active Members, spouses or dependent children. This means that if the coverage for similarly situated Members, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

Duration Of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Member's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

Disability. If any person entitled to COBRA coverage (the covered Member, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Member, covered spouse or covered dependent child must notify the Program Sponsor's COBRA Administrator within 60 days of the **latest** of: (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Member's coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or

- The last day of the 29th month of total coverage.

A person entitled to COBRA coverage must notify the COBRA Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. This Program reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage terminates.

Subsequent Qualifying Events. If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Member and the spouse divorce, the covered Member dies, the covered Member becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Program, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Program Sponsor's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

Contributions For COBRA Coverage

A person entitled to COBRA coverage is entirely responsible for paying the contributions for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

Initial Contribution Payment

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under This Program will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Program Description is merely a draft specimen, which You should review with Your own tax or legal advisors to ensure compliance with applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with applicable laws. Changes may be necessary to assure compliance with law and to assure consistency with Your specific program provisions and program administration.

Dental – MetLife Benefit Summary – Retirees

November 20, 2023
Marty Tighe
Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010

Re: Sample Dental Benefits Program Description ("Sample SPD")

Dear Marty Tighe:

It is the understanding of Metropolitan Life Insurance Company ("MetLife") that your Dental Program is not subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The enclosed information is being provided to you at your request as part of MetLife's dedication to customer service.

In accordance with your approval of the intended plan design, enclosed herein please find a sample Program Description. Please note that it is part of MetLife's standard services only to provide a sample Program Description for a customer to review with its own legal counsel to ensure consistency with the operation of the Program and consistency with any other documents under your Program. While MetLife has agreed to provide you with the sample Program Description, you as the Program Sponsor are legally responsible to comply with any requirements under applicable laws and for ensuring that this sample Program Description is accurate and updated when necessary.

Finally, pursuant to the terms of the Administrative Services Agreement entered into between you and MetLife, please provide MetLife with a final version of your Program Description.

Sincerely,

Denise Lang
Client Service Consultant
Employee Benefits Sales
Metropolitan Life Insurance Company
501 US Highway 22, Bridgewater, NJ 08807
Tel (908) 253-1467

Enclosure

DRAFT SPECIMEN

YOUR PROGRAM DESCRIPTION

Uniformed Firefighters Association

Retired Members

Value PDP Plan
Dental Benefits for You and Your Dependents

Effective January 1, 2024

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Program Description is merely a draft specimen, which You should review with Your own tax or legal advisors to ensure compliance with applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with applicable laws. Changes may be necessary to assure compliance with law and to assure consistency with Your specific program provisions and program administration.

YOUR PROGRAM DESCRIPTION

INTRODUCTION

This Program Description describes the benefits available to you under the benefits plan of Uniformed Firefighters Association. Please read this booklet carefully to become familiar with your benefits. This Program is effective as of January 1, 2024.

This is a self-funded Dental Benefits plan provided by the Program Sponsor. Metropolitan Life Insurance Company ("MetLife") does not insure the benefits described in this booklet.

Claims are administered on behalf of This Program by MetLife as the Claim Administrator pursuant to the terms of an administrative service agreement.

Please note that the terms "You" and "Your" throughout this booklet refer to the Member, except where otherwise indicated. Many of the terms that are important in understanding your benefits are explained in the DEFINITIONS section.

Uniformed Firefighters Association

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BENEFITS AT A GLANCE

This section provides You and Your Dependents with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You and Your Dependents refer to the provisions contained in this Program Description for details about Your benefits.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Benefits On You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	100%	100%
Type C Services	100%	100%
Orthodontic Covered Services	100%	100%
Maximum Benefit:		
Yearly Individual Maximum	$2,500 for the following Covered Services: Type B; Type C	$2,500 for the following Covered Services: Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$3,000	$2,500

DEFINITIONS

As used in this Program Description, the terms listed below will have the meanings set forth below. When defined terms are used in this Program Description, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

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

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

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

For the purposes of determining who may become covered for benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Program as a Member.

Claim Administrator means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The Claim Administrator does not insure the benefits described in this Program Description.

Covered Percentage means the percentage of the Maximum Allowed Charge that This Program will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

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

- prescribed or performed by a Dentist while such person is covered for Dental Benefits;
- Dentally Necessary to treat the condition; and
- described in the section entitled BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Program Description.

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

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

Domestic Partner means each of two people, one of whom is a Member of the Program Sponsor, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

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

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

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

Maximum Allowed Charge means:

1. With respect to In-Network Dentists, the lesser of:
    - the amount charged by the In-Network Dentist; or
    - the maximum amount which the In-Network Dentist has agreed with MetLife to accept as payment in full for the dental service.

2. With respect to Out-of-Network Dentists, the lesser of:
    - the amount charged by the Out-of-Network Dentist; or
    - the Out-of-Network scheduled amount for the state where the dental service is performed.

Member means a member in good standing of Uniformed Firefighters Association.

Noncontributory Coverage means coverage for which the Program Sponsor does not require You to pay any part of the cost of coverage.

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

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or

- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the group benefits. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

Program Sponsor means Uniformed Firefighters Association.

Proof means Written evidence satisfactory to the Claim Administrator that a person has satisfied the conditions and requirements for any benefit described in this Program Description. When a claim is made for any benefit described in this Program Description, Proof must establish:

- the nature and extent of the loss or condition;
- This Program's obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator, and consistent with applicable law.

Spouse means Your lawful spouse. Wherever the term "Spouse" appears in the Program Description it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Program as a Member.

This Program means the self-funded Dental Benefits plan of the Program Sponsor.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to the Claim Administrator and consistent with applicable law.

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

You and **Your** mean a Member who is eligible for the benefits described in this Program Description.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU

ELIGIBLE CLASS(ES)

Members of the Retired Firefighters Security Benefit Fund of the Uniformed Firefighters Association Local 94, I.A.F.F., AFL-CIO

You are eligible for coverage if You were covered for coverage on the day immediately preceding the date of Your retirement and have retired in accord with the Program Sponsor's retirement plan. Please be aware that end of employment will mean the end of the person's status as a retiree, as stated in the Program Sponsor's retirement plan.

DATE YOU ARE ELIGIBLE FOR COVERAGE

You may only become eligible for the coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

If You are in an eligible class on January 1, 2024, You will be eligible for the coverage described in this Program Description on that date.

If You enter an eligible class after January 1, 2024, You will be eligible for coverage on the date You enter that class.

ENROLLMENT PROCESS

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

The Dental Benefits have a regular enrollment period established by the Program Sponsor. Subject to the rules of This Program, You may enroll for Dental Benefits only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Program Sponsor for more information regarding the benefit plan.

DATE YOUR COVERAGE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for coverage, such coverage will take effect on the date You become eligible.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for coverage until the next annual enrollment period for Dental Benefits, as determined by the Program Sponsor, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Program Sponsor, You may enroll for coverage for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period.

Enrollment Due to a Qualifying Event

You may enroll for coverage, for which You are eligible, or change the amount of Your coverage between annual enrollment periods only if You have a Qualifying Event.

This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the date the Claims Administrator states in Writing.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU (continued)

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Program Sponsor's plan or a new benefit option under the Program Sponsor's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage;
- You previously did not enroll for Dental Benefits for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of Program Sponsor contributions for the other group coverage; or
    3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your Spouse, former Spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

DATE YOUR COVERAGE ENDS

Your coverage will end on the earliest of:

1. the date This Program ends;
2. the date coverage ends for Your class;
3. the last day of the calendar month in which You cease to be in an eligible class; or
4. the end of the period for which the last contribution has been paid for You.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT COVERAGE

Members of the Retired Firefighters Security Benefit Fund of the Uniformed Firefighters Association Local 94, I.A.F.F., AFL-CIO

DATE YOU ARE ELIGIBLE FOR DEPENDENT COVERAGE

You may only become eligible for the Dependent coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

If You are in an eligible class on January 1, 2024, You will be eligible for Dependent coverage on the later of:

1. January 1, 2024; and
2. the date You obtain a Dependent.

If You enter an eligible class after January 1, 2024, You will be eligible for Dependent coverage on the later of:

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

No person may be covered as a Dependent of more than one Member.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL COVERAGE

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

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

The Dental Benefits have a regular enrollment period established by the Program Sponsor. Subject to the rules of This Program, You may enroll for Dependent coverage only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Program Sponsor for more information regarding the benefit plan.

DATE COVERAGE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent coverage, such coverage will take effect on the date You become eligible.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent coverage until the next annual enrollment period for Dental Benefits, as determined by the Program Sponsor, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Program Sponsor, You may enroll for Dependent coverage for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

Enrollment Due to a Qualifying Event

You may enroll for Dependent coverage for which You are eligible, or change the amount of Your Dependent coverage, between annual enrollment periods only if You have a Qualifying Event.

This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event, will take effect on the date the Claims Administrator states in Writing.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a change in Your or Your dependent's residence, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Program Sponsor's plan or a new benefit option under the Program Sponsor's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this coverage or under other group coverage;
- You previously did not enroll for Dental Coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of Program Sponsor contributions for the other group coverage;
    3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your Spouse, former Spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Once You have enrolled one Child for Dependent Coverage, each succeeding Child will automatically be covered for such coverage on the date the Child qualifies as a Dependent.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Benefits for You ends;
3. the date You cease to be in an eligible class;
4. the date This Program ends;
5. the date coverage for Your Dependents ends under This Program;
6. the date coverage for Your Dependents ends for Your class;
7. the end of the period for which the last contribution has been paid for the Dependent;
8. the last day of the calendar month the Dependent reaches the limiting age;
9. the end of the period for which the last contribution has been paid for the Dependent; or
10. the last day of the calendar month the person ceases to be a Dependent.

FOR MENTALLY OR PHYSICALLY DISABLED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Program Sponsor for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL BENEFITS

If Dental Benefits for You or a Dependent ends, You or Your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of this Program Description entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE or contact the Program Sponsor for information regarding continuation of coverage under COBRA.

DENTAL BENEFITS

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claim Administrator. When the Claim Administrator receives such Proof, the Claim Administrator will review the claim and if the Claim Administrator approves it, This Program will pay the Dental Benefits in effect on the date that service was completed.

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

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

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting MetLife's website at www.metlife.com/dental.

BENEFIT AMOUNTS

This Program will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Program Description.

In-Network

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

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

Out-of-Network

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

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

- any other part of the Maximum Allowed Charge for which This Program does not pay benefits; and
- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth Maximum Benefit Amounts This Program will pay for Covered Services received In-Network and Out-of-Network. This Program will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

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

Alternate Benefit

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

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

For example:

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

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

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this Program Description, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, This Program will only pay benefits for the root canal therapy.

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed 20% of the amount charged by the Dentist when the course of treatment begins.

The benefit payable for the periodic follow-up visits will also be based on the amount charged by the Dentist when the course of treatment begins. It will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claim Administrator that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to these Dental Benefits

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

If the periodic follow-up visits commenced prior to these Dental Benefits being in effect:

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

Pretreatment Estimate of Benefits

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

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

Benefits This Program Will Pay After Coverage Ends

This Program will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a prosthetic device if:

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

This Program will pay benefits for a 31 day period after Your coverage ends for the completion of installation of a Cast Restoration if:

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

This Program will pay benefits for a 31 day period after Your coverage ends for completion of root canal therapy if:

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

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams twice in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), twice in a Year.
4. Problem-focused exams twice in a Year.
5. Full mouth or panoramic x-rays once every 60 months.
6. Bitewing x-rays:
   - 2 sets every Year for a Child; and
   - 1 set every Year for everyone else.
7. Intraoral-periapical x-rays.
8. X-rays, except as mentioned elsewhere.
9. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
10. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
11. Diagnostic casts.
12. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
13. Topical fluoride treatment for a Child under age 19 once in 12 months.

Type B Covered Services

1. Emergency palliative treatment to relieve tooth pain.
2. Initial placement of amalgam fillings.
3. Replacement of an existing amalgam filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
4. Initial placement of resin-based composite fillings.
5. Replacement of an existing resin-based composite filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
6. Protective (sedative) fillings.
7. Oral surgery, except as mentioned elsewhere in this Program Description.
8. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
9. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
10. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
11. Full mouth debridements, but not more than once per lifetime.
12. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
13. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.

14. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
15. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any year.
16. Pulp capping (excluding final restoration).
17. Therapeutic pulpotomy (excluding final restoration).
18. Pulp therapy.
19. Apexification/recalcification.
20. Pulpal regeneration, but not more than once per lifetime.
21. Local chemotherapeutic agents.
22. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claim Administrator determines such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
23. Injections of therapeutic drugs.
24. Space maintainers for a Child under age 14 once per lifetime per tooth area.
25. Sealants or sealant repairs for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
26. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
27. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
28. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C Covered Services

1. Biopsies of hard or soft oral tissue.
2. Initial installation of full or partial Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits under this Program.
3. Addition of teeth to a partial removable Denture to replace teeth removed while these Dental Benefits were in effect for the person receiving such services.
4. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 60 months prior to replacement.
5. Replacement of a non-serviceable removable Denture if such Denture was installed more than 60 months prior to replacement.
6. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
7. Relinings and rebasings of existing removable Dentures:
   - if at least 6 months have passed since the installation of the existing removable Denture; and
   - not more than once in any 36 month period.

DENTAL BENEFITS: DESCRIPTION OF COVERED SERVICES (continued)

8. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
9. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
10. Initial installation of Cast Restorations (except implant supported Cast Restorations).
11. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 60 months have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
12. Prefabricated crown, but no more than one replacement for the same tooth within 60 consecutive months.
13. Core buildup, but no more than once per tooth in a period of 60 months.
14. Posts and cores, but no more than once per tooth in a period of 60 months.
15. Labial veneers, but no more than once per tooth in a period of 60 months.
16. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
17. Other consultations, but not more than once in a 12 month period.
18. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
19. Repair of implants, but no more than once in a 12 month period.
20. Implant supported Cast Restorations, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
21. Implant supported fixed Dentures, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
22. Implant supported removable Dentures, but no more than once for the same tooth position in a 60 month period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was covered for Dental Benefits.
23. Tissue conditioning, but not more than once in a 36 month period.
24. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
25. Cleaning and inspection of a removable appliance twice in 12 months.

Orthodontic Covered Services

Orthodontia, for a Child under age 19.

DENTAL BENEFITS: EXCLUSIONS

This Program will not pay Dental Benefits for charges incurred for:

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

DENTAL BENEFITS: EXCLUSIONS (continued)

27. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
28. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
29. duplicate prosthetic devices or appliances;
30. replacement of a lost or stolen appliance, Cast Restoration or Denture;
31. replacement of an orthodontic device;
32. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
33. intra and extraoral photographic images.

DENTAL BENEFITS: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Program.

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

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

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

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

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

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

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

The term does not include any of the following:

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

The provisions of This Program, which limit benefits based on benefits or services provided under plans which the Program Sponsor (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

Each contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Program means the Dental Benefits described in this Program Description, except for any provisions in this Program Description that limit coverage based on benefits for services provided under plans which the Program Sponsor (or an affiliate) contributes to or sponsors.

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

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Active or Inactive Member: A Plan that covers a person as a Member who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired Member (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

EFFECT ON BENEFITS OF THIS PROGRAM

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

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

- the person This Program has paid or for whom This Program has paid;
- insurance companies; or
- other organizations.

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

GENERAL PROVISIONS

Assignment

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

Dental Benefits: Who This Program Will Pay

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

Conformity with Law

If the terms and provisions of this Program Description do not conform to any applicable law, this Program Description shall be interpreted to so conform.

Overpayments

Recovery of Dental Benefit Overpayments

This Program has the right to recover any amount that the Claim Administrator determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Claim Administrator determines that:

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

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

How This Program Recovers Overpayments

This Program may recover the overpayment from You by:

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

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

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

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE

COBRA is a federal law that requires most group health plans to give their Members and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Program for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your dental coverage under This Program for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Program for up to 36 months. Also, your covered children may be able to continue coverage under This Program for up to 36 months after they no longer qualify as covered dependents under the terms of This Program. Group health plans for Program Sponsors with fewer than 20 Members, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

a. the end of the 18, 29 or 36 month continuation period, as the case may be;

b. the date of expiration of the last period for which the required payment was made;

c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent’s preexisting condition;

d. the date your Program Sponsor ceases to provide any group health plan for its Members.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Program. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Program Sponsor within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Member does not make that election. However, covered Members may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Program must pay the full cost of that coverage (including both the share you now pay and the share your Program Sponsor now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

Qualifying Event Due To Bankruptcy Of Program Sponsor

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Program Sponsor, and that bankruptcy results in the loss of coverage of any retired Member covered under This Program, the retired Member will become a qualified beneficiary with respect to the bankruptcy. The retired Member’s covered spouse and covered dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under This Program.

If You Elect COBRA

If you choose COBRA coverage and pay the required contributions, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Program Sponsor to similarly situated active Members, spouses or dependent children. This means that if the coverage for similarly situated Members, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

Duration Of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Member's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

Disability. If any person entitled to COBRA coverage (the covered Member, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Member, covered spouse or covered dependent child must notify the Program Sponsor's COBRA Administrator within 60 days of the **latest** of: (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Member's coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or

- The last day of the 29th month of total coverage.

A person entitled to COBRA coverage must notify the COBRA Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. This Program reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage terminates.

Subsequent Qualifying Events. If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Member and the spouse divorce, the covered Member dies, the covered Member becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Program, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Program Sponsor's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

Contributions For COBRA Coverage

A person entitled to COBRA coverage is entirely responsible for paying the contributions for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

Initial Contribution Payment

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under This Program will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Program Description is merely a draft specimen, which You should review with Your own tax or legal advisors to ensure compliance with applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with applicable laws. Changes may be necessary to assure compliance with law and to assure consistency with Your specific program provisions and program administration.