Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Employer and may be changed or ended without Your consent or notice to You.

Employer:	Stephens County Board of Education
Group Policy Number:	TM 05951619-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s):	
For General Information	1-800-438-6388

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE: You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For New Mexico Residents: If You are not satisfied with Your certificate for any reason, You may return it to Us within 30 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund any premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

NOTICE FOR RESIDENTS OF TEXAS

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

If You reside in Texas, note the following Procedures for Dental Claims will be followed:

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-438-6388.

Claim Submission

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

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

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will notify You acknowledging receipt of Your claim, commence with any investigation, and request any additional information within 15 days of receipt of Your claim.

MetLife will notify You in writing of the acceptance or rejection of Your claim within 15 business days of receipt of all information needed to process Your claim.

If MetLife cannot accept or reject Your claim within 15 business days after receipt of all information, MetLife will notify You within 15 business days stating the reason why we require an extension. If an extension is requested, We will notify You of our decision to approve or deny Your claim within 45 days. Upon notification of approval, Your claim will be paid within 5 business days.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

NOTICE FOR RESIDENTS OF TEXAS

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

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

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

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

Reasonable Access to an In-Network Dentist

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

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

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

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

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-438-6388.

Claim Submission

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

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

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

For claims that require Utilization Review determinations, such notification will be provided in accordance with the provisions under "Prospective and Retrospective Utilization Review Determinations" below.

For claims that do not require Utilization Review determination, such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further

information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

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

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your Written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in Writing and must include at least the following information:

- Name of employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination

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

After MetLife receives Your Written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in Writing of its final decision within 30 days after MetLife's receipt of Your Written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide Written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final Written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final Written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

NOTICE FOR RESIDENTS OF ALASKA

Upon Written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

Prospective and Retrospective Utilization Review Determinations

Utilization Review-MetLife Consultant Review Manual

The MetLife Dental Consultant Claim Review Manual was established and the criteria therein are updated with input of licensed practicing dentists. The Dental Consultant Claim Review Manual and the guidelines, practices and procedures contained therein are reviewed on an annual basis.

Licensure and Compensation Requirements

No MetLife dental consultant will be paid bonuses or incentive compensation for making Adverse Determinations. No financial incentives may be based on the number of approvals or denials made by a consultant. All prospective initial Adverse Determinations shall be made and documented by a licensed practitioner.

Initial Determinations-Prospective Review (Pretreatment Estimate)

All initial Prospective Reviews (Pretreatment Estimates) of non-emergency course of treatments for a patient will be made within five (5) working days after the receipt of all information necessary to make the determination. The consultant shall call the treating provider immediately to notify them of the decision. If the consultant does not have sufficient information to make the determination, within five (5) working days the treating provider must be notified.

Prospective Adverse Review-Notification Requirements

We shall make all initial Prospective Reviews (Pretreatment Estimates) of non-emergency course of treatments for a patient within five (5) working days after receipt of the information necessary to make the determination.

Notification of a prospective Adverse Determination made by a consultant shall be mailed or otherwise communicated to You, Your Authorized Representative and treating provider of record within five (5) working days of receipt of all information necessary to complete a review of non-urgent and/or non-emergent services, or at any time prior to the expected date of service if the proposed date is farther away than five (5) working days. This notification may be preceded by an oral communication given to You, Your Authorized Representative or provider.

The notification of a prospective Adverse Determination shall contain:

- The principal reason for the prospective Adverse Determination, including specific criteria and standards used to make the determination.
- The factual basis for the adverse decision in clear, understandable language.
- The procedures to initiate an appeal of the prospective Adverse Determination.
- The Written details of Our internal Grievance process and procedures.
- The telephone number and address of the MetLife unit to contact regarding the appeal, and
- The Director's address, telephone number, and facsimile number
- The notification will be provided in a culturally and linguistically appropriate manner**.**

Retrospective Adverse Review-Guideline Requirements

All recommendations based on a determination that a previously completed dental service ordered by a practitioner was not Dentally Necessary, or that an alternative treatment existed, will be made according to the guidelines contained in the MetLife Dental Consultant Review Manual and must be signed by an appropriately qualified and licensed practitioner. These guidelines shall be used to aid the application of the consultant's professional judgment, experience and knowledge in reaching an appropriate recommendation.

NOTICE FOR RESIDENTS OF ALASKA

If a course of treatment has been preauthorized or approved for a patient, We will not revise or modify the specific criteria or standards used for the Utilization Review to make an adverse decision regarding the services delivered to that patient.

Retrospective Adverse Review-Notification Requirements

Notice of a retrospective Adverse Determination shall be mailed or otherwise communicated to You, Your Authorized Representative and Your provider within thirty (30) calendar days of receipt of a request for payment with all necessary documentation.

Notice of a retrospective Adverse Determination will:

- Provide Written documentation that the retrospective Adverse Determination was based on a lack of Dental Necessity or the existence of an alternative treatment,
- Contain the factual basis for the adverse decision in clear, understandable language.
- Include the reference the specific criteria and standards upon which the decision was based
- The telephone number and business address of the MetLife unit to contact regarding the appeal, and allow a reasonable period of time in which to appeal
- Contain a statement that You, Your Authorized Representative or health care provider has the right to file a complaint with the Director within 180 days of receipt of Our Grievance decision.
- State the Director's address, telephone number, and facsimile number
- Contain Written details of Our internal Grievance process.
- The notification will be provided in a culturally and linguistically appropriate manner.

Adverse Determinations-Urgent Care Claims (Expedited Dental Review)

All requests for prospective Urgent Care Claims which result in an Adverse Determination will be conducted in within 24 hours of receipt of all necessary information to complete the review:

- A MetLife dental consultant will call You, Your Authorized Representative or treating provider of the Adverse Determination and;
- mail to You, Your Authorized Representative and treating provider the Adverse Determinations in Writing with an explanation of the reasons for the decision and documents on which the decision was based within 24 hours. This notification must include:
- The principal reason for the prospective Adverse Determination, including specific criteria and standards used to make the determination.

The factual basis for the adverse decision in clear, understandable language.

- The procedures to initiate an appeal of the prospective Adverse Determination.
- The telephone number and address of the unit to contact regarding the appeal, and
- A statement that You**,** Your Authorized Representative or health provider has the right to file a complaint with the Director within 180 days of receipt of Our Grievance decision.
- The notification will be provided in a culturally and linguistically appropriate manner.

Grievance Review of Adverse Determinations

A Grievance may be requested for both Prospective Adverse Determinations and Retrospective Adverse Determinations. You, Your Authorized Representative or the provider may request a formal appeal of a Prospective Adverse Determination within 180 days of the date the requested service was denied.

For non-emergency cases, if We do not have sufficient information to complete our process, within five (5) working days, We shall:

- Notify You, Your Authorized Representative or health care provider that We cannot proceed with our review until additional information is received.

- We will assist You, Your Authorized Representative, or health care provider in gathering the information without delay.

Expedited Dental Review

Expedited dental review only applies to Prospective Adverse Determinations. The treating provider must certify in Writing and provide supporting documentation that the time required to process the requested dental service through informal reconsideration and formal appeal is likely to cause significant negative change in the dental condition of the covered person. All requests for expedited dental review will be forwarded to the MetLife Dental Consultant Review area. A dental consultant shall ensure that the dental services have not yet been performed and review any supporting documentation. The consultant will then contact the treating provider regarding the request, and return an expedited decision within 24 hours.

Dental consultants shall call Your treating provider should the supporting documentation be incomplete. The consultant should inform Your treating provider as to what is necessary to give the claim a full and complete review. Once the information is complete, the consultant shall orally inform Your treating provider of the decision within 24 hours.

Grievance Procedure

A Written description of the Grievance procedure, by which You, Your Authorized Representative or provider of record may seek review of Adverse Determinations, shall be made available:

- On the reverse side of the Explanation of Benefits (EOB) document.
- Upon request from You, Your Authorized Representative or Your health provider.

New Reviewer Requirement

No consultant who has participated in prior reviews of a decision being appealed may make a recommendation that a first level appeal be denied.

Notification of Decision of Grievance

Notice of the decision regarding a Grievance shall be mailed to You, Your Authorized Representative and provider within 30 working days after the date the Grievance was filed.

In addition, the notice shall contain the following:

- The principal reason for the Adverse Determination, including specific criteria and standards used to make the determination.
- The factual basis for the adverse decision in clear, understandable language.
- The procedures to initiate an appeal of the Adverse Determination.
- The telephone number and address of the person to contact regarding the appeal, and
- A statement that You, Your Authorized Representative or health provider on Your behalf has the right to file a complaint with the Director within 180 days of receipt of Our Grievance decision.
- The Director's address, telephone number, and facsimile number
- The notification will be provided in a culturally and linguistically appropriate manner.

Notification of Right to External Review

Availability of External Review

If We deny Your request for the payment of dental course of treatment, You, Your Authorized Representative or provider have the option to request an External Review of any recommendation of an appeal within 180 days after the date of receipt of a Grievance decision.

You may have the right to have Our decision reviewed by health care professionals who have no association with Us if Our decision involved making a judgment as to the Dental Necessity, appropriateness, health care

setting, level of care, or effectiveness of the dental service or treatment You requested by submitting a request for External Review to:

The Director of the Alaska Division of Insurance
Alaska Division of Insurance
550 West 7th Avenue
Anchorage, AK 99501-3567,
or by electronic mail to insurance@alaska.gov,
or by facsimile transmission by calling (907) 269-7910.

External Appeal-Effect

If the Independent Review Organization decides We should pay the claim, We will pay the claim.

Overpayments

Recovery of Overpayments

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

An overpayment occurs if it is determined that:

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

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

How We Recover Overpayments

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

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

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

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

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

> **"Domestic Partner** means each of two people, one of whom is an employee of the Employer, a resident of California and who have registered as domestic partners or members of a civil union with the California or another government recognized by California as having similar requirements.
>
> For purposes of determining who may become a Covered Person, the term does not include any person who:
>
> - is in the military of any country or subdivision of a country;
> - is insured under the Group Policy as an employee."

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

Wherever the term Spouse appears, except in the definition of Spouse, it shall be replaced by Spouse or Domestic Partner.

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

NOTICE FOR RESIDENTS OF CONNECTICUT

If You are a resident of Connecticut, and live in a county where there are no In-Network Dentists and travel distance to an In-Network Dentist is more than 45 minutes travel time and 30 miles away (or for Fairfield County, 30 minutes travel time and 15 miles away), We will pay benefits for Covered Services provided by an Out-of-Network Dentist as if the service was provided by an In-Network Dentist. Additionally, if You are unable to schedule an appointment with an In-Network general Dentist within 10 business days or an In-Network specialty Dentist within 15 business days, We will pay benefits for Covered Services provided by an Out-of-Network Dentist as if the service was provided by an In-Network Dentist. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Dentist. Please call Us at 1-800-942-0854 for assistance.

If You or a Dependent receive emergency or urgent dental care from an Out-of-Network Dentist, We will pay benefits for those Covered Services provided by an Out-of-Network Dentist as if the services were provided by an In-Network Dentist.

For those requiring assistance due to a hearing or vision impairment, call Us at 1-800-942-0854.

NOTICE FOR RESIDENTS OF COLORADO

Domestic Partner

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

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

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

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

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

Definition of Child

The term also includes newborns.

Exclusions

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

COORDINATION OF THE GROUP POLICY'S BENEFITS WITH OTHER BENEFITS

With respect to coordination of benefits, the benefits will never be less than what is shown under the following language.

This coordination of benefits (COB) provision applies when a Covered Person has dental care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

A. A **"Plan"** is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   (1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Covered Person.

When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.]

D. **"Allowable Expense"** is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the Primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.

(5) If the Primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the Primary Plan because the covered person uses a non-panel provider, except for emergency services that are paid or provided by the primary.

NOTICE FOR RESIDENTS OF COLORADO (continued)

E. **"Claim Determination Period"** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **"Closed Panel Plan"** is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **"Custodial Parent"** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.]

Order-Of-Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B.

(1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
  (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage**. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan

NOTICE FOR RESIDENTS OF COLORADO (continued)

Effect On The Benefits Of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right To Receive And Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility Of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes 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 the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance; you may contact Us at:

MetLife
200 Park Avenue
New York, New York 10166

You may also file a consumer complaint online at the Illinois Department of Insurance's website idoi.illinois.gov or by mail.

The Department maintains a Consumer Division in the following offices:

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767
(217) 782-4515

Illinois Department of Insurance
115 South LaSalle Street, 13th Floor
Chicago, Illinois 60603
(312) 814-2420

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-438-6388

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at *www.in.gov/idoi*

NOTICE FOR RESIDENTS OF IOWA

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment. You may request additional explanation when your claim or request for coverage of a health care, service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guidelines, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Internal Appeal: All appeals to us for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to MetLife Dental Claims, P.O. Box 981282, El Paso, TX 79998-1282 within 180 days of the date you receive our denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim, and you may request copies of information that we have that pertains to your claim. We will notify you of our decision in writing within 30 days of receiving your appeal. If you do not receive our decision within 30 days of receiving your appeal, you may be entitled to file a request for external review.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may have a right to have our decision reviewed by health care professionals who have no association with us. Requests for external review may be submitted to the Commissioner of Insurance.

You may obtain an external review if:

- Our decision involved the admission, availability of care, continued stay, or other health care service that is a covered benefit; and
- We denied, reduced or terminated the requested service or treatment or payment for the service or treatment because we determined it did not meet our requirements for medical necessity, health care setting, level of care or effectiveness of the health care service or treatment you requested.
- You have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. In this situation, you may file a request for an expedited external review of our denial.
- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. In this situation, you or your authorized representative may request an expedited external review.
- Our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational. In addition, if your treating health care professional certifies in writing that the recommended or requested health care service or treatment that is the subject of the recommendation or request would be significantly less effective if not promptly initiated, then you or your authorized representative may request an expedited external review.

You can obtain a copy of the External Review Request Form from: the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; telephone 877-955-1212 or 515-654-6600; facsimile 515-654-6500; website iid.iowa.gov.

Within four months after receipt of our notice containing the final adverse determination and this Notice of

NOTICE FOR RESIDENTS OF IOWA (continued)

Appeal Rights, you should submit a request for external review to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; telephone 877-955-1212 or 515-654-6600; facsimile 515-654-6500; email iid.marketregulation@iid.iowa.gov.

For standard external review, a decision will be made within 45 days after the independent review. organization receives your request.

For details, please review your Benefit Plan Document, contact us, or contact the Iowa Insurance Division.

NOTICE FOR RESIDENTS OF MAINE

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

NOTICE FOR RESIDENTS OF MAINE

If You are a resident of Maine and live in a county where there is no In-Network Dentists and travel distance to an In-Network Dentist is more than 30 minutes travel time or 25 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Dentist as if the service was provided by an In-Network Dentist. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Dentist. Please call Us at 1-800-942-0854 for assistance.

NOTICE FOR RESIDENTS OF MASSACHUSETTS

CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Dental Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Dental Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

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

To continue Dental insurance under this provision:

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

The request form will be furnished by the Employer.

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

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

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

NOTICE FOR RESIDENTS OF MISSISSIPPI

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-438-6388.

Claim Submission

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

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

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

If Your claim is a Clean Claim and it is approved by MetLife, benefits will be paid within 25 days after MetLife receives due written proof in electronic form of a covered loss, or within 35 days after receipt of due written proof in paper form of a covered loss. Due written proof includes, but is not limited to, information essential for Us to administer coordination of benefits. If You provide Us with Written direction that all or a portion of any benefits provided under this certificate be paid to the Dentist, then We shall pay directly the Dentist providing the Covered Services. That payment shall be considered payment in full to the Dentist, who may not bill or collect from You any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by You that are not covered for benefits. Any dispute arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order for MetLife to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Clean Claim (Continued)

If MetLife is unable to pay a claim for Dental Insurance benefits because MetLife needs additional information or documentation, or there is a particular circumstance requiring special treatment, within 25 days after the date MetLife receives the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, MetLife will send You notice of what supporting documentation or information MetLife needs. Any claim or portion of a claim for Dental Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after MetLife receives it.

If MetLife does not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for clean claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 3% percent per month until such benefits are finally settled. If MetLife does not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. MetLife will pay benefits when MetLife receives satisfactory Written proof of Your claim.

Proof must be given to MetLife not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If MetLife denies the claim on appeal, MetLife will send You a final written decision that states the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

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

NOTICE FOR RESIDENTS OF MONTANA

Dental Insurance

In accordance with regulatory guidance, disregard any reference in this certificate to networks, including the terms In-Network and Out-of-Network.

Certain Dentists have entered into an agreement with Us to limit their charge for a Covered Service to a maximum allowed charge. You may be able to reduce Your out-of-pocket costs by using such a Dentist. To find a Dentist who has entered into an agreement with Us, please visit www.metlife.com/dental or dial 1-800-438-6388.

We will pay benefits for charges incurred by a Covered Person for a Covered Service in accordance with the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If a Dentist performs a Covered Service, You may be responsible for paying:

- the Deductible;
- any other part of the charge for which We do not pay benefits; and
- any additional amount charged by the Dentist if they have not entered into an agreement with Us to limit their charges for a Covered Service.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

All dental benefits, as defined by New Hampshire law when insured, are identified as being under the jurisdiction of the New Hampshire Insurance Commissioner.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

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

- the covered person is a Child under the age of 13 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition; or

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

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

NOTICE FOR RESIDENTS OF NORTH CAROLINA

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

NOTICE FOR RESIDENTS OF NEW YORK

If You are a resident of New York and live in a county where there is no In-Network Dentists and travel distance to an In-Network Dentist is more than 30 minutes travel time and 30 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Dentist as if the service was provided by an In-Network Dentist.

However, for the below-listed specialties, a travel distance standard of 45 minutes and 45 miles will apply in the following counties:

- **Pedodontist**: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins.
- **Oral Surgery:** Essex, Franklin, Lewis, Schoharie and Steuben.
- **Orthodontics:** Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.

In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Dentist. Please call Us at 1-800-942-0854 for assistance.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

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

NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF VIRGINIA

Reasonable Access to an In-Network Dentist

If You do not have an In-Network Dentist within 30 miles of Your legal residence, We will reimburse You for the cost of Covered Services and Materials provided by an Out-of-Network Dentist at the same benefit level as an In-Network Dentist.

NOTICE FOR RESIDENTS OF UTAH

NOTICE OF PROTECTION PROVIDED BY UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This disclaimer provides a **brief summary** of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - o $500,000 for health benefit plans
  - o $500,000 in disability income insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
450 S. Simmons Way, Suite 650
Kaysville, Utah 84037
(801) 320-9955

Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129
(801) 957-9200

CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.

- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.

- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- “Civil Union” means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled “Act Relating to Civil Unions”.

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of “dependent” as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in your certificate. It broadens definitions and terms only to the extent required by Vermont law.

DISCLOSURE:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine your rights under this notice and the certificate to which it is attached.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

Domestic Partner means each of two people, one of whom is an Employee of the Employer, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

NOTICE FOR RESIDENTS OF CONNECTICUT, IOWA, LOUISIANA, MINNESOTA, MONTANA, NEW MEXICO, TEXAS, UTAH AND WASHINGTON

The Definition of Child In The Definitions Section Of This Certificate Is Modified For The Coverage Listed Below:

For Connecticut Residents (Dental Insurance)

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

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

For Louisiana Residents (Dental Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 26, regardless of the child's or grandchild's marital status, student status or full-time employment status. Your natural child, adopted child, stepchild or grandchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. In addition, marital status will not prevent or cease the continuation of insurance for a mentally or physically disabled child or grandchild past the age limit.

For Montana Residents (Dental Insurance):

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

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

For Texas Residents (Dental Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

For Utah Residents (Dental Insurance):

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

Proof of such disability must be sent to Us within 31 days after:

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

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

For Washington Residents Dental Insurance:

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

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

BENEFIT — BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

For All Active Full-Time Employees who elect the High Option Dental Plan

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Type D Services (Orthodontic)	50%	50%
Deductibles for:	In-Network	Out-of-Network
Yearly Individual Deductible	$50 for the following Covered Services Combined: Type B & Type C	$50 for the following Covered Services Combined: Type B & Type C
Maximum Benefit:	In-Network	Out-of-Network
Yearly Individual Maximum	$1,000 for the following Covered Services: Type B & Type C	$1,000 for the following Covered Services: Type B & Type C
Lifetime Individual Maximum for Type D Covered Services (Orthodontic)	$1,000	$1,000

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a location to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

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

For Dental Insurance, Your natural or adopted child; Your stepchild or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

The definition of Child includes newborns.

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

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

The term includes an Employee's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

The term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

Contributory Insurance means insurance for which the Employer requires You to pay any part of the premium.

Contributory Insurance includes: Personal and Dependent Dental Insurance.

Covered Percentage means:

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

DEFINITIONS (continued)

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

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

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

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

Full-Time means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours a week. Full-Time does not include temporary or seasonal employees.

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

Maximum Allowed Charge means the lesser of:

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

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

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

Physician means:

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

DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) (the 'Actual Charge'); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the 'Usual Charge'); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 90th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife's Reasonable and Customary Charge records (the 'Customary Charge'). Where MetLife determines that there is inadequate charge information maintained in MetLife's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

  An example of how the 90th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Reasonable and Customary charge records. These 100 hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 90th percentile of charges is the charge that is equal to the charge numbered 90.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

The term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

We, **Us** and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly**, means the 12 month period that begins January 1.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Full-Time Employees who elect the High Option Dental Plan

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

For All Active Full-Time Employees who elect the High Option Dental Plan

If You are in an eligible class on January 1, 2026, You will be eligible for insurance on that date.

If You enter an eligible class after January 1, 2026, You will be eligible for insurance on the first day of the month coincident with or next following the date You complete the Waiting Period of 30 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dental Insurance only when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance you are a timely entrant, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the first day of the month coincident with or next following the enrollment period, if You are actively at Work on that date.

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

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. If You are not currently enrolled for Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

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

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month coincident with or next following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. the last day of the calendar month in which You retire in accordance with the Employer’s retirement plan.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Active Full-Time Employees who elect the High Option Dental Plan

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

For All Active Full-Time Employees who elect the High Option Dental Plan

If You are in an eligible class on January 1, 2026, You will be eligible for Dependent insurance on that date.

If You enter an eligible class after January 1, 2026, You will be eligible for Dependent insurance on the first day of the month coincident with or next following the date You complete the Waiting Period of 30 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

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

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance only when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process for Dependent Dental Insurance within 31 days of becoming eligible for Dependent Insurance you are a timely entrant, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the date You enroll

provided You are Actively at Work on that date. If You are not Actively at Work on that date, it will take effect on the day You return to Active Work.

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for Dependent Insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the first day of the month coincident with or next following the enrollment period, if You are actively at Work on that date.

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

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. If You are not currently enrolled for Dependent Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dependent Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

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

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible or change the amount of Your Dependent Insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month coincident with or next following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date Your Dental Insurance ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent except in the case of a Dependent Child who has reached the maximum age as defined in the DEFINITIONS section, Insurance will end on the last day of the calendar month;
9. for Utah residents, the last day of the calendar month the person ceases to be a Dependent;
10. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

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

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY DISABLED CHILDREN

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

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

- remains incapable of self-sustaining employment because of a mental or physical 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 insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL INSURANCE

The following applies to employers with 20 or more employees that are not church or government plans:

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

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff up to 2 months.
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 9 months.
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence up to 2 months.

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

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

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

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

DENTAL INSURANCE

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

This Dental Insurance gives 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, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from Us to choose a Dentist.

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

In-Network

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

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network

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

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

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

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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

If a charge is incurred for a Covered Service during the last 3 months of any Year and is applied to the Deductible of that Year, such charge will be applied to the Deductible for the next Year.

Alternate Benefit

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

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

For example:

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

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

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, we will only pay benefits for the root canal therapy.

Orthodontic Covered Services

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

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

The benefit payable for the periodic follow-up visits will be based on the lower of:
- the amount charged by the Dentist; and
- the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment if:
- Dental Insurance is in effect for the person receiving the orthodontic treatment; and
- proof is given to Us that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.
If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:
- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

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

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

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

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

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

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

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams twice every Year excluding problem-focused examinations.

2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice every 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 every Year.

4. Bitewing x-rays but not more than 1 set every Year.

5. Intraoral-periapical x-rays.

6. Dental x-rays except as mentioned elsewhere in this certificate.

7. 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 every Year.

8. Topical fluoride treatment for a Child under age 19, but not more than once in a Year.

9. Space maintainers for a Child under age 19.

Type B Covered Services

1. Problem-focused examinations once every Year.

2. Full mouth or panoramic x-rays once every 5 Years.

3. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.

4. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.

5. Diagnostic casts.

6. Sealants or sealant repairs for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 5 Years.

7. Preventive resin restorations, which are applied to non-restored first and second permanent molars, but not more than once per tooth every 5 Years.

8. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, but not more than once per tooth every 5 Years.

9. Protective (sedative) fillings.

10. Initial placement of amalgam fillings.

11. Replacement of an existing amalgam filling.

12. Initial placement of resin fillings.

13. Replacement of an existing resin filling.

14. 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.

15. Other consultations, but not more than once in a 12 month period.

16. Emergency palliative treatment to relieve tooth pain.

17. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.

18. Simple extractions.

19. 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 two times in any calendar year less the number of teeth cleanings received during such calendar year.

20. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period.

21. Simple Repairs of Cast Restorations.

22. Repair of Dentures.

23. Addition of teeth to fixed and permanent Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.

24. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.

25. Re-cementing of Cast Restorations or Dentures.

26. Repair of implant supported prosthetics.

27. Local chemotherapeutic agents.

28. Injections of therapeutic drugs.

29. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.

30. Occlusal adjustments, but not more than once in a 12 month period.

Type C Covered Services

1. Surgical extractions.

2. Oral surgery except as mentioned elsewhere in this certificate.

3. Pulp capping (excluding final restoration).

4. Pulp therapy.

5. Apexification/recalcification.

6. Therapeutic pulpotomy (excluding final restoration).

7. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 12 month period for the same tooth.

Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.

8. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.

9. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 36 month period.

10. Tissue Conditioning, but not more than once in a 12 month period.

11. Prefabricated crown, but no more than one replacement for the same tooth surface within 24 months.

12. Labial veneers, but no more than once per tooth in a period of 10 years.

13. Initial installation of Cast Restorations (except an implant supported Cast Restoration).

14. Replacement of Cast Restorations (except an implant supported Cast Restoration), but only if at least 10 years have passed since the most recent time that:

    - a Cast Restoration was installed for the same tooth surface; or
    - a Cast Restoration for the same tooth surface was replaced.

15. Core buildup, but no more than once per tooth in a period of 10 Years.

16. Post and cores, but no more than once per tooth in a period of 10 Years.

17. Initial installation of full or partial Dentures (other than implant supported prosthetics):

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

18. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.

19. 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.

20. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.

21. Adjustments of Dentures if at least 6 months have passed since the installation of the existing removable Denture.

22. Relinings and rebasings of existing removable Dentures:

    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 12 month period.

23. 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 10 Year period:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

24. Cleaning and inspection of a removable appliance twice every Year.

25. Repair of implants, but not more than once in a 12 month period.

26. Implant supported prosthetics, but no more than once for the same tooth position in a 10 Year period:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

27. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging, but cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period.

Type D Covered Services

Orthodontia, up to age 19, for such Child.

The Lifetime Individual Maximum Benefit Amount for orthodontia is shown in the SCHEDULE OF BENEFITS.

DENTAL INSURANCE: EXCLUSIONS

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

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;

2. Services for which You would not be required to pay in the absence of Dental Insurance;

3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;

4. Services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn child.

5. 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.

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, personalization or inscription of any tooth, device, appliance, crown or other dental work.

12. Missed appointments.

13. Services:

    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

14. Services covered under other coverage provided by the Employer.

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. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.

Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.

The term does not include:

- any plan, program or coverage provided by a government as an employer; or
- Medicare.

20. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
21. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
22. Caries susceptibility tests.
23. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
24. Other fixed Denture prosthetic services not described elsewhere in this certificate.
25. Precision attachments, except when the precision attachment is related to implant prosthetics.
26. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Addition of teeth to a partial removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
28. Addition of teeth to a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
29. Adjustment of a Denture.
30. Implants to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Implants supported prosthetics to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
32. Fixed and removable appliances for correction of harmful habits.
33. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
34. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota.
35. Repair or replacement of an orthodontic device.
36. Duplicate prosthetic devices or appliances.

DENTAL INSURANCE: EXCLUSIONS (continued)

37. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.

38. Intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Plan's network of providers; or
    - any other similar provisions.

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

Claim Determination Period means a period that starts on any 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 Plan.

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

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

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

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

- a group insurance plan;
- a group subscriber contact;
- 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;
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

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

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

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

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the employer (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 INSURANCE: 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, We determine which plan is primary by applying the rules in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-438-6388. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

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

Step 1
A claimant can request a claim form by calling Us at 1-800-438-6388.

Step 2
We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3
When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

Step 4
The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions For Dental Insurance. A legal action on a claim for Dental Insurance benefits may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-438-6388.

Claim Submission

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

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

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You of its decision to approve or deny Your claim.

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

If MetLife denies Your claim in whole or in part, the notification of the claims decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify You in writing of its final decision within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

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

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

"THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION"

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice "you" refers to these individuals.

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

Another source of information is MIB, LLC (“MIB”). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB’s

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

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

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

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

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

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

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website,www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.

- **For Health Care Operations:** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organizations, e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- **Where Required by Law or for Public Health Activities:** We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.

- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of

interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals:** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on PHI we

Use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

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PLAN PRIVACY INFORMATION

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

The term “Plan Sponsor” means Stephens County Board of Education.

The term “Plan Administrator” means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to be the Plan Administrator.

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

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

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.
- Other uses relating to plan administration, which are approved in writing by the Plan Administrator or Plan Privacy Officer.
- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

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

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

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

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

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

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

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

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

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

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

  Human Resources Coordinator, Benefits Specialist

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

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

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

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

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

Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

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

The following addenda apply to residents of New Hampshire.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

These notices are being provided to you pursuant to New Hampshire law.

Patient's Bill of Rights

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. Also, because the patient has the right to receive information from the facility and to discuss the benefits, risks, and costs of appropriate treatment alternatives, except for emergency admissions, every uninsured patient and prospective patient shall be fully informed in writing, upon his or her request, of the expected list price for services. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

This notice is being provided to you pursuant to New Hampshire law.

CONTINUATION OF DENTAL INSURANCE ON YOU

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it would otherwise end for any reason except solely due to Your employment ending on account of gross misconduct.

Metropolitan Life Insurance Company ("MetLife") will give You written notice of:

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

The written notice will be mailed to Your last known address, as provided by the Employer.

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

You will have 45 days after the date of the notice to elect to continue Your Dental Insurance. If You elect to continue Your Dental Insurance, You must provide a copy of this written notice to the Employer when the election is made.

To continue Your Dental Insurance, You must, within 45 days after the date of the notice:
- send a written request to MetLife to continue Your Dental Insurance; and
- pay the first premium.

If Dental Insurance ends because the Group Policy ends, the maximum continuation period will be 39 weeks.

If Dental Insurance ends for any other reason, the maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the Employer files for bankruptcy protection under Title 11 of the United States Code;

- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date You cease to be a member of an eligible class; or

- 18 months in all other cases.

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

- the end of the maximum continuation period;

- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;

- if You are eligible for Medicare, the date of the first Medicare open enrollment period following the date You become ineligible for continued coverage under the Employer's plan;

- the date You become eligible for coverage under any other group dental coverage; or

- if You do not pay the required premium to continue Your Dental Insurance. If You do not pay the required premium, You will be given a 31 day grace period before Your Dental Insurance terminates. You will be provided with a notice within 15 days of the date of termination that Your Dental Insurance will be cancelled if the required premium is not paid.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS

If You are a resident of New Hampshire, Your Dental Insurance on Your Dependents may be continued if it would otherwise end for any reason except solely due to Your employment ending on account of gross misconduct.

MetLife will give written notice of the right to elect continuation coverage to Your former Spouse if You have died or Your marriage has ended, or to You in all other circumstances.

Notices

If Dental Insurance on Your Dependents ends because Your marriage ends in divorce or legal separation, You must notify the Employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred.

MetLife will give Your former Spouse if You have died or Your marriage has ended, written notice of:

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

Premium Contributions

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

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

To continue Dental Insurance if Your marriage has ended, You or Your former Spouse must, within 45 days after the date of the notice:

- send a written request to MetLife to continue Dental Insurance on Your Dependents; and
- pay the first premium.

You must notify MetLife and the Employer of the mailing address of your former Spouse. MetLife will provide Your former Spouse with a separate notice of the right to continue insurance.

Your right to continue Dental Insurance on Your Dependents will be deemed waived if MetLife has made reasonable efforts in good faith to contact You or Your former Spouse, if applicable; such notice complies with applicable New Hampshire law; and such person:

- fails to provide any required notification; or
- fails to request to continue Dental Insurance on Your Dependents and pay the first premium within the time limits stated in this section.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Divorce Decree or Legal Separation Decree

Unless your divorce decree or legal separation decree provides otherwise, Your former Spouse shall remain as a covered person under Your insurance under this Policy if your marriage ends in divorce or legal separation.

You must notify MetLife within 30 days of the date of the final decree of divorce or legal separation of the right to continue coverage as an eligible person.

Your former Spouse's coverage under Your insurance under this subsection shall end on the first of the following:

(1) The 3-year anniversary of the final decree of divorce or legal separation, unless the decree specifies an earlier ending;

(2) The date of remarriage of Your former Spouse;

(3) The date of Your remarriage;

(4) Your death; or

(5) Such earlier time as provided by the final decree of divorce or legal separation.

If Your former Spouse's coverage under your insurance ends due to (2) Your former spouse's remarriage, there shall be no further continuation. However, if Your former Spouse's coverage under your insurance ends due to (1), (3), (4), or (5), Your former Spouse will be able to continue coverage under their own insurance under this policy in accordance with the subsection below entitled Maximum Continuation Period

Maximum Continuation Period

If Dental Insurance on Your Dependents ends because the Group Policy ends, the maximum continuation period will be 39 weeks.

If Dental Insurance on Your Dependents ends for any other reason, the maximum continuation period will be the longest of the following that applies:

- for a former spouse whose coverage was continued under the above section "Divorce Decree or Legal Separation Decree", an additional 36 months beyond the date such continued coverage ends, unless that coverage ended due to remarriage of the former Spouse; however, for a Spouse who is 55 or older on the date of the final decree of divorce or legal separation, coverage will continue until the earlier of the date on which the former Spouse is eligible for Medicare or coverage under another employer's group policy;

- 36 months if Dental Insurance on Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Maximum Continuation Period (Continued)

- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;

- 36 months if Your employment ends because You retire, and within 12 months of retirement You or Your Dependents have a substantial loss of coverage because the Employer files for bankruptcy protection under Title 11 of the United States Code;

- 29 months if the Covered Person becomes entitled to disability benefits under Social Security within 60 days of the date the Covered Person's coverage under the Group Policy would otherwise end; or

- 18 months in all other cases.

Cessation of Dental Insurance on Your Dependents

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

- the end of the maximum continuation period;

- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of employees to which You belong;

- if the Dependent is eligible for Medicare, the date of the first Medicare open enrollment period following the date the Dependent becomes ineligible for continued coverage under the Employer's plan;

- the date the Dependent becomes eligible for coverage under any other group dental coverage; or

- if You do not pay a required premium to continue Dental Insurance on Your Dependents. If You do not pay the required premium, You will be given a 31 day grace period before Dental Insurance on Your Dependents terminates. You will be provided with a notice within 15 days of the date of termination that Dental Insurance on Your Dependents will be cancelled if the required premium is not paid.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

CONSUMER GUIDE TO EXTERNAL APPEAL

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- The completed External Review Application Form - signed and dated on page 6.
- ** The Department cannot process this application without the required signature(s) **
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.
- If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department's mailing address.

What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application
Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a

consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

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INDEPENDENT EXTERNAL REVIEW
Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-

852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- The enclosed, completed application form - signed and dated on page 6.
- ** The Department cannot process this application without the required signature(s) **
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service
- at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its
- review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

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EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____State:_____Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize_____to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City:_____State:_____Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: (_____) _____
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes_____No _____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

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_____

Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

_____

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VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

Sign Here

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

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PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____) _____.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date