

YOUR BENEFIT PLAN

Cornell University

Regular hourly employees in the Endowed Colleges who are appointed to work at least 20 hours per week, or salaried employees (faculty/ staff) in the Endowed Colleges who are appointed to work 50% full time equivalent for a period of 6 months or more

Dental Insurance for You and Your Dependents

Standard Plan

Certificate Date: January 1, 2020

Cornell University
395 Pine Tree Rd., EHOB, Suite 101
Ithaca, NY 14853

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Cornell University



Metropolitan Life Insurance Company
New York, New York

CERTIFICATE RIDER

Group Policy No.: 114831-1-G
Policyholder: Cornell University
Effective Date: January 1, 2020

The certificate is changed as shown below:

The definition of Domestic Partner is added as follows:

Domestic Partner means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other;
 4. sharing a primary residence with the other; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

This rider is to be attached to and made a part of the Certificate



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Cornell University

Group Policy Number: 114831-1-G

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):

For Claim Information FOR DENTAL CLAIMS: 1-800-942-0854

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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.

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: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.

For New Hampshire Residents: 30 Day Right to Examine Certificate.

Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

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.

New York Required Disclosure Statement: The insurance evidenced by this certificate provides dental insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-800-942-0854

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-800-942-0854

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O

RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICE FOR RESIDENTS OF ALL STATES

In accordance with the Conformity With Law provision in GENERAL PROVISIONS, the provisions relating to the dental insurance claim process, external procedures for claims review are supplemented by the following additional explanations:

Urgent Care Claim Submission and Appeals

- Urgent care claims are claims for reimbursement of dental expenses for services which 1) which could seriously jeopardize the life, health, or ability of the patient to regain maximum function, or 2) which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- If Your urgent care claim is denied but You receive the care, You may appeal the denial using the normal claim procedures. If Your urgent care claim is denied and You do not receive the care, You can request an expedited appeal of Your claim denial in writing or by dialing 1-800-942-0854. MetLife will provide You any necessary information to assist You in your appeal. MetLife will then notify You of its decision as soon as possible, but no later than 72 hours after receiving Your request. However, MetLife may notify You by phone within the time frames above and then mail You a written notice.

Initial Determination for Claims Other Than Urgent Care Claims

- If a claim was denied on the basis that the services were not Dentally Necessary or that the services were experimental or investigational, the claims decision will contain either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

Appealing the Initial Determination - First Level of Review

- If the initial denial is based in whole or in part on a dental 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. The identity of the health care professional engaged for consultation will be provided to you upon request.
- If MetLife denies a claim on appeal on the basis that the services were not Dentally Necessary or that the services were experimental or investigational, the appeal decision will contain either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
- You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Your Right to an External Appeal.

- Under New York State law, in some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Dentally Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.
- In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

NOTICE FOR RESIDENTS OF ALL STATES (continued)

1. The service, procedure, or treatment must otherwise be a Covered Service under this certificate; and
2. In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - a. We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - b. You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - c. We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

Your Right to Appeal a Determination that a Service is Not Dentally Necessary

- If We have denied coverage on the basis that the service is not Dentally Necessary, You may appeal to an External Appeal Agent if You meet the requirements above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational

- If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal above and Your attending Physician must certify that Your condition or disease is one for which:
 1. Standard health services are ineffective or medically inappropriate; or
 2. There does not exist a more beneficial standard service or procedure Covered by Us; or
 3. There exists a clinical trial or rare disease treatment (as defined by law).
- In addition, Your attending Physician must have recommended one (1) of the following:
 1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
 2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
 3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.
- For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

NOTICE FOR RESIDENTS OF ALL STATES (continued)

The External Appeal Process

- You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.
- We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.
- You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.
- In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.
- If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.
- If the External Appeal Agent overturns Our decision that a service is not Dentally Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.
- The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

NOTICE FOR RESIDENTS OF ALL STATES (continued)

Fees for the External Appeal Process

- We may charge You a fee of up to \$25 for each external appeal, not to exceed \$75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

Your Responsibilities

- It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.
- Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Grievances

- Our grievance procedure applies to any issue not relating to a Dental Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance

- You can contact Us by phone at 1-800-942-0854 or in writing to file a grievance. You may designate a representative to file a grievance on Your behalf. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the grievance.

Grievance Determination

- Qualified personnel will review Your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information, or 72 hours of receipt of Your grievance. Written notice will be provided within 72 hours of receipt of Your grievance

Pre-Service Grievances:

(A request for a service or a treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your grievance.

Post-Service Grievances:

(A claim for a service or a treatment that has already been provided.)

In writing, within 30 calendar days of receipt of Your grievance.

All Other Grievances:

(That are not in relation to a claim or request for a service or treatment)

In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your grievance.

NOTICE FOR RESIDENTS OF ALL STATES (continued)

Grievance Appeals

- If You appeal the resolution of Your Grievance, We will decide the appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your appeal

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

15 calendar days of receipt of Your appeal.

Post-Service Grievances:

(A claim for a service or treatment that has already been provided.)

30 calendar days of receipt of Your appeal.

All Other Grievances:

(That are not in relation to a claim or request for a service or treatment.)

30 business days of receipt of all necessary information to make a determination.

NOTICE FOR RESIDENTS OF ALASKA, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, TEXAS, UTAH AND WASHINGTON
The Definition Of Child Is Modified For The Coverages Listed Below:

For Alaska Residents (Dental Insurance):

The term also includes newborns.

For 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 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

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

For 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 Hampshire Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

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

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

For 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. A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child. 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.

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

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 a child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

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

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

For Washington Residents (Dental Insurance):

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

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

Reasonable Access to an In-Network Dentist

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

Exclusions

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

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

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

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

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

NOTICE FOR RESIDENTS OF ALASKA (continued)

Procedures For Dental Claims (Continued)

Initial Determination

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

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.

NOTICE FOR RESIDENTS OF ALASKA (continued)

Procedures For Dental Claims (Continued)

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.

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.

NOTICE FOR RESIDENTS OF ALASKA (continued)

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.

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:

NOTICE FOR RESIDENTS OF ALASKA (continued)

- 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

NOTICE FOR RESIDENTS OF ALASKA (continued)

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

NOTICE FOR RESIDENTS OF ALASKA (continued)

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

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

Overpayments (Continued)

How We Recover Overpayments

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

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

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

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

1-800-942-0854

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 Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

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

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF IDAHO

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-800-942-0854

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 LOUISIANA, MISSISSIPPI, MONTANA, AND TEXAS

For all residents of Louisiana, Mississippi, Montana, and Texas, the Covered Percentage and Deductible for any Covered Service done by an Out-of-Network Dentist will be the same as the Covered Percentage and Deductible which would have applied if that same Covered Service had been done by an In-Network Dentist. For Type A Covered Services, the Covered Percentage will be 100% for both In-Network Dentists and Out-of-Network and for Type B Covered Services, the covered percentage will be 90% for both In-Network Dentists and Out-of-Network Dentists. The Yearly Individual Deductible and the Yearly Family Deductible will be \$0 for both the In-Network Dentist and the Out-of-Network Dentist.

NOTICE FOR RESIDENTS OF MAINE

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

NOTICE FOR MASSACHUSETTS RESIDENTS

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 OF INSURANCE 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 1-800-942-0854.

Claim Submission

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

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

Initial Determination

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

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.

"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.

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.

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Clean Claim (Continued)

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 1½ 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 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 NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

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

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

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

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

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

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

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

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

- the covered person is a Child under the age of 6 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition;
- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or
- We determine such anesthesia is necessary in accordance with generally accepted dental standards.

NOTICE FOR RESIDENTS OF 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 MEXICO

The exclusion of diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders will not apply.

The following is added to the description of Type C Covered Services:

“Oral surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ) and craniomandibular disorder. 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.”

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 TEXAS

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

NOTICE FOR RESIDENTS OF TEXAS

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 1-800-942-0854.

Claim Submission

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

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

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will 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.

Appealing the Initial Determination

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

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

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

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

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - o \$500,000 in death benefits
 - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$500,000 in long-term care insurance benefits
 - o \$500,000 in disability income insurance benefits
 - o \$500,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

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

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

Or:

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

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

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

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

Appealing the Initial Determination

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

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

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

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

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

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

Policies and Procedures for Emergency and Urgent Care

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

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

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

Urgent Care Submission:

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-942-0854

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

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	90%
Type B Services	90%	70%
Type C Services	50%	50%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	None	\$50 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	None:	\$150 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$1,250 for the following Covered Services: Type B; Type C	\$1,250 for the following Covered Services: Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$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 or Part-Time basis. This must be done at:

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

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

Cast Restoration means an inlay, onlay, or crown.

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

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

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

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

For the purposes of determining who may become covered for insurance, the term does not include any person who:

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

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

Contributory Insurance includes: 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 a Covered Person 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.

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

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

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

Domestic Partner - For the Domestic Partner Definition, please refer to the Domestic Partner Definition Rider in the front of this certificate.

Full-Time means Active Work of at least 40 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

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.

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

Part-Time means Active Work of at least 20 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

DEFINITIONS (continued)

Physician means:

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

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

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

Proof must be provided at the claimant's expense.

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 80th 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 80th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Reasonable and Customary charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 80th percentile of charges is the charge that is equal to the charge numbered 80.

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

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

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; 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, for Dental Insurance, means the 12 month period that begins January 1.

DEFINITIONS (continued)

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)

Regular hourly employees in the Endowed Colleges who are appointed to work at least 20 hours per week, or salaried employees (faculty/ staff) in the Endowed Colleges who are appointed to work 50% full time equivalent for a period of 6 months or more.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on January 1, 2020, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2020, You will be eligible for insurance on the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

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

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

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 60 days of becoming eligible for insurance, such insurance will take effect on the first day of the pay period following the date of Your request, 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 insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 60 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

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 60 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 pay period following Your qualifying event. If the qualifying event is the first day of the pay period, Your effective date is the date of the qualifying event, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Policyholder's plan or a new benefit option under the Policyholder's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 1. loss of eligibility for the other group coverage;
 2. termination of employer contributions for the other group coverage; or
 3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
 - You to provide health coverage for Your child; or
 - Your spouse, former spouse or other individual to provide coverage for Your child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

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 last day of the pay period in which You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the last day of the pay period 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
6. the last day of the month following the date You retire unless the date of retirement is the first day of the month, then coverage ends on that date.

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

Regular hourly employees in the Endowed Colleges who are appointed to work at least 20 hours per week, or salaried employees (faculty/ staff) in the Endowed Colleges who are appointed to work 50% full time equivalent for a period of 6 months or more.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

If You are in an eligible class on January 1, 2020, You will be eligible for Dependent insurance on the later of:

1. That date and;
2. the date You obtain a Dependent.

If You enter an eligible class after January 1, 2020, You will be eligible for Dependent insurance on the later of:

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

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 Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder 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 Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 60 days of becoming eligible for Dependent Insurance, such insurance will take effect on the first day of the pay period following 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 insurance will take effect on the day You resume Active Work.

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 60 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date 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 60 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 pay period following the Qualifying Event. If the Qualifying Event is the first day of the pay period, the effective date is the date of the Qualifying Event, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- a significant curtailment in Your current option, a significant improvement in an option for which You are not enrolled, a significant increase or decrease in cost for one or more of the options under the Policyholder's plan or a new benefit option under the Policyholder's plan;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
 1. loss of eligibility for the other group coverage;
 2. termination of employer contributions for the other group coverage;
 3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
 - You to provide health coverage for Your child; or
 - Your spouse, former spouse or other individual to provide coverage for Your child if that other person does in fact provide that coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines);
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

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

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Insurance for You ends;
3. the end of the pay period in which You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the pay period following the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the end of the pay period for which the last premium has been paid;
9. the end of the pay period the person ceases to be a Dependent, except that in the case of a Child who has reached the maximum age, insurance will end on the last day of the calendar year.
10. the last day of the month following the date You retire unless the date of retirement is the first day of the month, then coverage ends on that date.

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

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;
2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
 - the loss of a tooth; and
 - the accumulation of amounts toward:
 - a) Annual Deductibles;
 - b) Annual Maximum Benefits;
 - c) Lifetime Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
 - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
 - the date this Dental Insurance ends.

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

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;
2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and
3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL INSURANCE

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the Notice of Your Right and Your Dependent's Right to COBRA Continuation Coverage section under ERISA Information in this booklet for more information.

AT YOUR OPTION: CONTINUATION OF DENTAL INSURANCE FOR DEPENDENT CHILDREN

You may continue Dental Insurance for a Child who ceases to be a full-time student if such Child is required because of illness, to take a medical leave of absence from school. Insurance may be continued during the medical leave of absence for a period of up to 12 months. During this period You must continue to pay any premiums You were required to pay for such insurance. This continuation will end upon the earliest of:

- 12 months after the date the leave of absence begins;
- the date You fail to pay any required premium when due;
- the date the medical leave of absence ends;
- the date the child fails to satisfy the definition of Child for any reason other than status as a full-time student; or
- the date Your insurance ends.

Proof Requirements

You must send Us Proof documenting the illness and medical necessity of the leave of absence. Proof includes furnishing us with a Physician's statement certifying the medical necessity of the leave.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below provided You continue to pay any premiums You were required to pay for such insurance. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. if You cease Active Work due to a Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

2. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

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

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

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

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

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

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

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

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

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

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

BENEFIT AMOUNTS

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

The Covered Percentage for Covered Services performed by an In-Network Dentist is higher than the Covered Percentage for Covered Services performed by an Out-of-Network Dentist.

In-Network

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

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

Out-of-Network

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

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

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

DENTAL INSURANCE (continued)

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 must pay for Covered Services to which such Deductible applies each Year before We will pay benefits for such Covered Services.

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

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

Alternate Benefit

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

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

For example:

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

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

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 Lifetime Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins.

DENTAL INSURANCE (continued)

The benefit payable for the periodic follow-up visits will also be based on the Lifetime Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins. It will be payable on a quarterly basis during the course of the orthodontic treatment if:

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

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

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

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

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

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your Insurance ends if:

- the Covered Service was begun by a Dentist while You are insured for Dental Insurance; and
- the treatment requires more than one visit to complete.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral Exams, 4 times per year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, 4 times per 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), 4 times per year.
4. Full mouth or panoramic x-rays once every 3 Years.
5. Bitewing x-rays 2 sets in a Year.
6. Intraoral-periapical x-rays.
7. X-rays, except as mentioned elsewhere.
8. 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) four times in a Year.
9. Topical fluoride treatment for a Child through age 18 twice in a Year.
10. Space maintainers .
11. Sealants or sealant repairs for a Child through age 16 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.
12. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 3 Years.
13. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 3 Years.
14. Fixed and removable appliances for correction of harmful habits.
15. Cleaning and inspection of a removable appliance, 4 times in one year.

Type B Covered Services

1. Problem-focused exams.
2. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
3. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
4. Diagnostic casts.
5. Emergency palliative treatment to relieve tooth pain.
6. Initial placement of amalgam fillings.
7. Replacement of an existing amalgam filling, but only if:
 - at least 6 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
8. Initial placement of resin-based composite fillings.
9. Replacement of an existing resin-based composite filling, but only if:
 - at least 6 months have passed since the existing filing was placed; or
 - a new surface of decay is identified on that tooth.
10. Protective (sedative) fillings.
11. Biopsies of hard or soft oral tissue.
12. Oral surgery, except as mentioned elsewhere in this certificate.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

13. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image.
14. Other consultations.
15. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
16. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
17. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
18. Injections of therapeutic drugs.
19. Re-cementing of Cast Restorations or Dentures.
20. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
21. Occlusal adjustments.
22. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards including adjustments and night guards.
23. Repair/reline and adjustments of occlusal guards and night guards, 1 in 36 months.
24. Gold Foil, once in 6 months.

Type C Covered Services

1. Pulp capping (excluding final restoration).
2. Therapeutic pulpotomy (excluding final restoration).
3. Pulp therapy.
4. Apexification/recalcification.
5. Pulpal regeneration.
6. Local chemotherapeutic agents.
7. Initial installation of full or partial Dentures (other than implant supported prosthetics).
8. Addition of teeth to a partial removable Denture.
9. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 Years prior to replacement unless due to accidental injury.
10. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 Years prior to replacement unless due to accidental injury.
11. 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.
12. Relinings and rebasings of existing removable Dentures, if at least 6 months have passed since the installation of the existing removable Denture.
13. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
14. Initial installation of Cast Restorations (except implant supported Cast Restorations).
15. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least a 5 Year period have passed, unless due to accidental injury, since the most recent time that:
 - a Cast Restoration was installed for the same tooth; or
 - a Cast Restoration for the same tooth was replaced.
16. Prefabricated crown, but no more than one replacement for the same tooth within 12 months.
17. Core buildup.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

18. Posts and cores.
19. 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.
20. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
21. Periodontal scaling and root planing, but not more than once per quadrant in any 2 Years.
22. Full mouth debridements, but not more than once in any 5 Year period.
23. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 3 Year period.
24. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
25. 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 5 Year period.
26. Repair of implants, but no more than twice in 12 months.
27. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5 Year period unless due to accidental injury.
28. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5 Year period unless due to accidental injury.
29. Implant supported removable Dentures, but no more than once for the same tooth position in a 5 Year period unless due to accidental injury.
30. Tissue conditioning.
31. Simple repair of Cast Restorations or Dentures other than recementing.
32. temporary or provisional appliances, once in 5 year period.
33. Stress Breakers.
34. temporary or provisional restorations.

Orthodontic Covered Services

Orthodontia for Your Children through the age of 18, (to age 19).

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are primarily cosmetic;
5. services or appliances which restore or alter occlusion or vertical dimension;
6. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
7. restorations or appliances used for the purpose of periodontal splinting;
8. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
9. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
10. decoration or inscription of any tooth, device, appliance, crown or other dental work;
11. missed appointments;
12. services:
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law;
 - for which the Employer of the person receiving such services is required to pay; or
 - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
13. services covered under other coverage provided by the Policyholder;
14. prescription drugs;
15. services for which the submitted documentation indicates a poor prognosis;
16. 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;
17. caries susceptibility tests;
18. labial veneers;
19. modification of removable prosthodontic and other removable prosthetic services;
20. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
21. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
22. duplicate prosthetic devices or appliances;
23. replacement of a lost or stolen appliance, Cast Restoration or Denture;
24. replacement of an orthodontic device;
25. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
26. 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.

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

The term does not include any of the following:

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

The provisions of This Plan, which limit benefits based on benefits or services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

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

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 plans which the Policyholder (or an affiliate) contributes to or sponsors.

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

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

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.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

All claim forms needed to file for benefits under the group insurance program can be obtained by downloading from www.metlife.com/dental or by calling 1-800-942-0854. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

The claim form will be sent to the claimant within 15 days of the request. If the claimant has not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Us with the required Proof. The claim form or Proof may be submitted to Us electronically by sending it to the fax number 1-859-389-6505.

Both the notice of claim and the required Proof described in the claim form should be sent to Us within 120 days of the date of a 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 or Proof are given as soon as is reasonably possible.

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.

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (see NOTICE FOR RESIDENTS OF ALL STATES)

INTERNAL PROCEDURES FOR CLAIM REVIEW BY METLIFE

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Urgent Care Claim Submission and Appeals

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

If Your urgent care claim is denied but You receive the care, You may appeal the denial using the normal claim procedures. If Your urgent care claim is denied and You do not receive the care, You can request an expedited appeal of Your claim denial by dialing 1-800-942-0854. MetLife will provide You any necessary information to assist You in your appeal. MetLife will then notify You of its decision within 72 hours of Your request in writing. However, MetLife may notify You by phone within the time frames above and then mail You a written notice.

Initial Determination for Claims Other Than Urgent Care Claims

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

writing within 15 calendar days of the earlier of MetLife's receipt of the information or the end of the 45 day period.

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.

The denial will also include a statement of your right to make an appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

It will also describe Your right to bring civil action to enforce Your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

Appealing the Initial Determination - First Level of Review

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 such as diagnostic materials, x-rays, or narrative.

MetLife will acknowledge Your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. 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 dental 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.

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

A denial of Your first request for appeal will also include a statement of your right to make a second appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

Each denial of an appeal will also describe Your right to bring civil action to enforce Your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

Finally, each denial of an appeal will describe Your right to request an additional, external review under New York state law.

Second Level of Review

If the appeal is not resolved to Your satisfaction, You can appeal the action to second level of review for reconsideration. Decisions on Your appeal in the second level of review will be made no later than 30 days after receipt of the request for reconsideration.

After MetLife receives Your written request for a second level of review, MetLife will conduct a full and fair review of Your claim. Deference will not be given to the initial denial or the initial appeal, and MetLife's review will look at the claim anew. The review on the second 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 or on the initial appeal. The person who will review Your second appeal will not be the same person as the person who made the initial decision or the person who made the decision on the initial appeal to deny Your claim. In addition, the person who is reviewing the second appeal will not be a subordinate of the person who made the initial decision or the person who made the decision on the initial appeal to deny Your claim. If the initial denial or the denial on the initial appeal is based in whole or in part on a dental 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 or on the initial appeal, and will not be a subordinate of any person who was consulted on the initial determination or the initial appeal.

If Your second level of review also denies Your claim, Your Written notice of denial will contain the same items of information that were contained in Your initial appeal notice.

Please note, by undertaking a second level review You may foreclose Your right to an external appeal as an external appeal must be filed within four months of the Final Adverse Determination of the first level review.

EXTERNAL PROCEDURES FOR CLAIM REVIEW OUTSIDE OF METLIFE

New York state law gives You the right to an external appeal when payment of benefits for dental services have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational. This applies both to Urgent Care Claims and non-Urgent Care Claims.

If You have received a Final Adverse Determination after Our first level of review, You can request an external appeal by completing an application form and sending it to the New York State Insurance Department within four months:

- of when You received the Final Adverse Determination; or
- of receiving written confirmation from Us that the internal appeal process has been waived.

Final Adverse Determination means a written notification from Us that Your claim for dental benefits has been denied through Our appeal process.

You may obtain an application form or any additional information by calling Us at 1-800-275-4638 or by calling the New York Insurance Department at 1-800-400-8882. You may also obtain an application or further information by visiting the New York Insurance Department's web site at www.ins.state.ny.us.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Eligibility for an External Appeal

To be eligible for an external appeal, payment of benefits for dental services must have been denied on the basis that the services are not Dentally Necessary or that the services are experimental or investigational and:

- You must have received a Final Adverse Determination as a result of Our internal utilization review appeal process; or
- You and MetLife must have agreed to waive that appeal process.

If services are denied as experimental or investigational, You must have a life-threatening or disabling condition or disease to be eligible for an external appeal and Your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

You may only appeal a service or procedure that is a Covered Service under this certificate. The external appeal process may not be used to expand Your dental coverage.

Submission of Information

If Your case is determined to be eligible for external review, You will be notified by the New York Insurance Department of the certified external appeal agent assigned to review Your case.

MetLife will send Your dental and treatment records to the external appeal agent.

When the external appeal agent reviews Your case, the agent may request additional information from You or Your Dentist. This information should be sent immediately to the external appeal agent.

You and Your Dentist can submit information even when the external appeal agent has not requested specific information. You must submit this information to the Insurance Department within four months:

- of when You received the Final Adverse Determination; or
- of receiving written confirmation from Us that the internal appeal process has been waived.

Once the external appeal agent makes a determination or Your four month time period ends, You will not be able to submit additional information.

The external appeal application contains a release of medical records provision that You must sign to authorize the release of medical and treatment records, including HIV, mental health and alcohol and drug abuse records to the certified external appeal agent assigned to review Your appeal.

Eligibility For an Expedited External Appeal

If Your attending Dentist attests that a delay in providing the treatment or service poses an imminent or serious threat to Your health You may request an expedited appeal. When requesting an expedited appeal, make sure You give the Attending Physician Attestation form to Your Dentist to complete. Your appeal will not be forwarded to the external appeal agent until Your Dentist sends this attestation to the Insurance Department.

Time Periods for External Appeals

For standard appeals, the external appeal agent must make a determination within 30 days of receiving Your request for an external review from the state. If additional information is requested, the external appeal agent has five additional business days to make a determination.

For expedited appeals, the external appeal agent must make a determination within three days of receiving Your request for an external review from the state.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

The Cost to You for an External Appeal

We may charge You a fee of up to \$25.00 for an external appeal with an annual limit on filing fees for an insured of \$75.00. If We determine that the fee will pose a hardship, You will not be required to pay a fee. We may charge the Dentist a fee of up to \$50.00 for an external appeal.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to You or to the Dentist, depending on who paid the fee.

Notification of a Decision

When the external appeal agent has made the decision:

- for standard appeals, You and MetLife will be notified in writing within two business days; or
- for expedited appeals, You and MetLife will be notified immediately by telephone or fax. Written notification will follow.

The decision of the external appeal agent is binding on You and MetLife.

Grievances

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

Filing a Grievance

You can contact Us by phone at 1-800-942-0854 or in writing to file a grievance. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the grievance.

When We receive Your grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited grievances, depending on the nature of Your inquiry.

Grievance Determination

Qualified personnel will review Your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify You in writing within the following timeframes:

<u>Expedited/Urgent Grievances:</u>	72 hours of receipt of Your grievance.
<u>Pre-Service Grievances:</u> (A request for a service or a treatment that has not yet been provided.)	15 calendar days of receipt of Your grievance.
<u>Post-Service Grievances:</u> (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your grievance.

Grievance Appeals

If You are not satisfied with the resolution of Your grievance, You or Your designee may file an appeal by phone at 1-800-438-6388 or in writing. However, urgent appeals may be filed by phone. You have up to 60 business days from receipt of the grievance determination to file an appeal.

When We receive Your appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the appeal and notify You in writing within the following timeframes:

<u>Expedited/Urgent Grievances:</u>	72 hours of receipt of Your appeal.
<u>Pre-Service Grievances:</u> (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your appeal.
<u>Post-Service Grievances:</u> (A claim for a service or a treatment that has already been provided.)	30 calendar days of receipt of Your appeal.

DENTAL INSURANCE: GRIEVANCE PROCEDURES (continued)

Assistance

If You remain dissatisfied with Our appeal determination, or at any other time You are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a grievance or appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400; or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

GENERAL PROVISIONS

Assignment

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

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

Gender

Male pronouns will be read as female where applicable.

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

GENERAL PROVISIONS (continued)

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.**

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife 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.

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, or as an executive benefit. In this notice, “you” refers to these individuals.

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.

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, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

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 Group, Inc. (“MIB”). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at www.mib.com.

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

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

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.

8. Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, 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.

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. 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.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE CORNELL UNIVERSITY ENDOWED DENTAL CARE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO, TOGETHER WITH THE CERTIFICATE AND POLICY, CONSTITUTE THE DENTAL BENEFITS COMPONENT OF THE CORNELL UNIVERSITY ENDOWED COLLEGES HEALTH AND WELFARE BENEFIT PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Cornell University
395 Pine Tree Road., EHOB, Suite101
Ithaca, NY 14853

EMPLOYER IDENTIFICATION NUMBER: 15-0532082

PLAN NUMBER	COVERAGE	PLAN NAME
539	All Coverages	Cornell University Endowed Colleges Health and Welfare Benefit Plan

THE DENTAL CARE COMPONENT

Cornell University, as your employer, maintains the Cornell University Endowed Colleges Health and Welfare Benefit Plan, a Cafeteria Plan under Section 125 of the Internal Revenue Code, for the benefit of its eligible employees and their eligible dependents. One component benefit of the Cafeteria Plan is the Cornell University Endowed Dental Care Plan. This Summary Plan Description (the "SPD") provides you with an overview of only the dental care benefits component of the Cafeteria Plan. Cornell University has selected Metropolitan Life Insurance Company ("MetLife") as your dental care benefits insurer. MetLife has issued an insurance certificate and policy (together, the "Certificate") for these benefits.

TYPE OF ADMINISTRATION

The above listed benefits are insured by MetLife.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY/ ENROLLMENT FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife Certificate describes the eligibility requirements and enrollment processes for insurance provided by MetLife under the Plan. If You or Your Dependent is eligible, you may enroll in the Plan by completing an enrollment request in Workday when first eligible, during any annual open enrollment period, or following a Qualifying Event (see Your MetLife Certificate for more information on Qualifying Events). Your MetLife Certificate also includes a detailed description of the insurance benefits provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The Certificate sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your Certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife Certificate.

CONTRIBUTIONS TO PREMIUM

If you enroll for Dental Insurance coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Please refer to the DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS section of your Certificate for complete information on filing a claim, appealing a claim determination, and requesting an external review.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Participants and beneficiaries can obtain, without charge, a copy of the Plan procedures governing QMCSO determinations from the Plan administrator.

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group dental coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, as well as to obtain a COBRA enrollment packet and materials, you may contact the Plan Administrator or the PayFlex COBRA Unit at 888-678-7825.

You may have other options available to you when you lose group dental coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group dental plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you elect COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time the coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active Employees, spouses, or dependent children. This means that if coverage for similarly situated Employees, spouses, or dependent children changes, coverage for qualified beneficiaries will likewise change.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced by a certain amount, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced by a certain amount;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced by a certain amount;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

During the continuation period, a child of yours that is born, adopted by you, or placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to a qualifying event.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.

Employees placed on a Layoff Status

Employees placed on Layoff are able to continue the dental plan by enrolling in COBRA. PayFlex will send COBRA enrollment materials. If COBRA enrollment is elected, employees on layoff will be billed by PayFlex for the employee premium for up to 12 months. At the end of 12 months, employees will be billed the full COBRA rate for the remaining 6 months for a total of 18 months of continuation coverage.

What COBRA premiums will be due?

A qualified beneficiary is entirely responsible for paying the premiums for COBRA coverage, plus any additional amounts allowed by law. The required payment for each continuation coverage period will be described in the notice that is sent when an individual experiences a qualifying event.

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under this Plan will end. A qualified beneficiary is responsible for making sure that the amount of the first payment is correct.

You will be notified of the amount due for each subsequent coverage period for each qualified beneficiary when coverage is elected.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. However, covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Each qualified beneficiary will have 60 days to elect to continue coverage. If a qualified beneficiary does not notify the Plan Administrator within the 60-day period of his or her election(s), the option to elect continuation coverage will be lost.

However, if you initially waive COBRA coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election window.

How long does COBRA coverage last?

COBRA continuation coverage generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

How can COBRA coverage be extended?

There are ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must start at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. In order to be eligible for the extension, you must notify the Plan Administrator within 60 days of the latest of (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the

covered Employee's coverage initially was or will be lost; or (4) the date the COBRA eligible person is provided the initial COBRA notice or this SPD. Written notice to the Plan Administrator must be received before the end of the initial 18 month period. A copy of the Social Security Administration's determination must be provided to the Plan Administrator. If these procedures are not followed, there will be no disability extension of COBRA.

Your premiums may increase during the disability extension to your continuation coverage.

A person entitled to COBRA coverage must notify the Plan Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. The Plan reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage ends.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

When does COBRA coverage end?

The continuation coverage will terminate on the earliest of:

- The end of the 18, 29, or 36 month continuation period, as the case may be
- The date of expiration of the last period for which the required payment was made
- The date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent's preexisting condition
- The date your employer ceases to provide any group dental plan for its employees

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Insurance

Continue dental insurance for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means Cornell University.

The term "Plan Administrator" means Cornell University.

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 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:

Sr. Director, Benefit Services & Administration
Associate Director, Health & Welfare Plans
Sr. Consultant, Life & Education Plans
Consultant, Health & Welfare Plans
Benefit Associate, Health & Welfare Plans
Associate Director, HR Services & Transitions
HR Services and Transitions Counselor
Associate Director, Benefits Business Analysis
Business Analyst, Benefits Business Analysis

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Cornell University reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Cornell University shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

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