YOUR BENEFIT PLAN

NEW YORK UNIVERSITY

Option 1 for Residents of All States Other than Louisiana
Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2018
CERTIFICATE RIDER

Group Policy No.: 84542-1-G
Policyholder: NEW YORK UNIVERSITY
Effective Date: January 1, 2012

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 a Retired 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 Retired Employee.

For residents of New Jersey, **Domestic Partner** means each of two people, one of whom is a Retired Employee of the Policyholder, who:

- have registered as each other’s domestic partner, or reciprocal beneficiary with a government agency where such registration is available or who are in a same-sex relationship from another jurisdiction which provides some, but not all of the rights and obligations of marriage; 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 Retired Employee.
This rider is to be attached to and made a part of the Certificate
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: NEW YORK UNIVERSITY

Group Policy Number: 84542-1-G

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):
For Claim Information FOR DENTAL CLAIMS: 1-800-438-6388

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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 Residents of West Virginia: If You are not satisfied with Your certificate, You may return it to Us within 10 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 10 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

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.
GCERT2000
fp as amended by GEND16-NM-DSC
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:

1-800-438-6388

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.
NOTICE FOR RESIDENTS OF ALASKA, ARKANSAS, ILLINOIS, MARYLAND, MONTANA, NEW HAMPSHIRE, NEW JERSEY, NORTH CAROLINA, TEXAS, UTAH AND WASHINGTON

The Definition Of Child Is Modified As Shown Below:

For Alaska Residents:

The term “Child” also includes newborns.

For Arkansas Residents:

The term “adopted child” includes a minor child for whom you have filed a petition to adopt and from birth, it includes a child for whom you have filed a petition to adopt within 60 days of the child’s birth.

For Illinois Residents:

The term “Child” also includes a child who is between ages 26 and 30, unmarried, and a military veteran who has served in the active or reserve components of the U.S. Armed Forces (which includes the National Guard) and has received a release or discharge other than a dishonorable discharge.

For Maryland Residents:

The term “Child” also includes a child for whom you or your Spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance; grandchildren, under the limiting age, who are unmarried, reside with and are principally supported by you, and are in your court ordered custody; and a child who resides with and is principally supported by you and is under your testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration.

For Montana Residents:

The term “Child” includes the natural or adopted child of any person insured under this certificate.

For New Hampshire Residents:

Stepchildren not residing with you are covered the same as stepchildren residing with you. In addition, married children are included on the same basis as unmarried children.

For New Jersey Residents:

The term “stepchild” also includes a child of your Civil Union Partner or Domestic Partner who lives with you.

For North Carolina Residents:

The term “Child” also means a foster child. A foster child includes a child who has been placed in your physical custody as the appointed guardian or custodian as long as you have assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with you on more than a temporary or short-term basis.

For Texas Residents:

The term “Child” also includes your grandchild who is under age 26, unmarried and who was able to be claimed by you as a dependent for federal income tax purposes at the time you applied for dental insurance. A child also 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.
For Utah Residents:

The term “Child” includes an unmarried 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:

Married Children are included on the same basis as unmarried Children.
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

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.

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 appeal the denial. 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, or as soon as reasonably possible for situations in which You cannot reasonably meet the deadline. 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, 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. Your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. 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.
NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

MetLife will notify You in writing of its final decision within 18 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.

Second Level Appeal

If You disagree with the response to the initial appeal of the denied claim, You have the right to a second level appeal. We shall communicate Our final determination to You within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to You shall include the specific reasons for the determination.

External Appeal

If You disagree with the response to the second appeal of the denied claim, You have the right to an external appeal. We will communicate the decision of the external appeal agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer’s decision. Decisions made by an external appeal agency are binding on Us and You unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by You or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

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

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Insurance benefits is more than the total of the benefits due to You under this certificate; or

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

If such overpayment occurs, You have an obligation to reimburse Us.
NOTICE FOR RESIDENTS OF ALASKA

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

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.

IMPORTANT NOTICE

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

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904
1-800-438-6388

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

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
WEBSITE: http://www.insurance.ca.gov/
1-800-927-4357 (within California)
1-213-897-8921 (outside California)
NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

"Domestic Partner means each of two people, one of whom is an employee of the 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 DELAWARE

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

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 30 calendar days after receipt of Your Clean Claim.

If MetLife denies Your Clean Claim in whole or in part, the notification of the claims decision will state the reason why Your Clean Claim was denied and reference the specific Plan provision(s) on which the denial is based. If a portion of Your Clean Claim is approved, We will pay that portion of the claim.

If additional information is required, We will request, in writing, the specific additional information and explain why such information is needed. Within 15 calendar days of Our receipt of the requested information, MetLife will either:

- pay benefits if Your Clean Claim is approved; or
- notify You of the denial of Your claim.

“Clean Claim” means a claim that is submitted using MetLife’s standard form with all of the required fields completed. In order to constitute a Clean Claim, any claim submitted that includes an unspecified, unclassified or miscellaneous code or data element must also include appropriate supporting documentation or narrative which explains such codes and describes the diagnosis and treatments or the service rendered.

For a claim that is not a Clean Claim, 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.
NOTICE FOR RESIDENTS OF DELAWARE (continued)

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

Appealing the Initial Determination

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

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

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

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

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

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

If You are still concerned after contacting 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 ILLINOIS

If You reside in Illinois, note the following procedures for appealing the initial determination of a claim will be followed:

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 after receiving MetLife’s decision. Appeals must be in writing and must include at least the following information:

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

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

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

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

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

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-438-6388

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

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

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

Complaint can be filed electronically at www.in.gov/doi
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 RESIDENTS OF MISSISSIPPI

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

If Your claim is a Clean Claim and it is approved by MetLife, benefits will be paid within 25 days after MetLife receives due written proof in electronic form of a covered loss, or within 35 days after receipt of due written proof in paper form of a covered loss. Due written proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

“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.
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 RESIDENTS OF NEBRASKA

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 15 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 15 day period, state the reason why the extension is needed, and state when it will make its determination. If the claim still remains incomplete, MetLife will, 30 days from the date of the initial notification of claim is resolved and every 30 days thereafter, send you a letter explaining the reasons additional time is needed. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife’s notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

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

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

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

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

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

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of 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. You will be provided upon request, and without charge, reasonable access to, and copies of all documents, records, and other information relevant to or considered in making the initial claim determination. 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. You may authorize a representative to pursue an appeal by submitting a written statement to MetLife that acknowledges the representation. Upon Your written request for an appeal, 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 certificateholder;
- 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. The identity and qualifications of any health care professional, whose advice was considered, without regard to whether it was relied upon in making the initial claim decision, will be made available to You upon request.

MetLife will notify You in writing of its final decision within 15 days after Our receipt of Your written request for review. If the appeal is not resolved to Your satisfaction, You can appeal the action to a second level of review for reconsideration. The second level of review will be completed within a 60 day time period beginning from the initial date of receiving the appeal.

If Your appeal is in regard to an Emergency Dental Condition, MetLife will notify You regarding its final decision within 72 hours after the request for a second level of review was received. If notification of MetLife’s final decision regarding an Emergency Dental Condition is not made in writing, MetLife will send You written confirmation of its final decision within 2 business days of providing notification of that decision.

If Your appeal is in regard to an Emergency Dental Condition, You may submit information to MetLife by telephone, facsimile, or other expeditious method. If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-438-6388.

“Emergency Dental Condition means a dental condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of dentistry and health, could reasonably expect the absence of immediate dental attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy;
- serious impairment to such person’s bodily functions;
- serious impairment or dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

The period of time within which a decision shall be rendered on an appeal shall begin to run at the time MetLife receives Your written request for review, without regard to whether You have submitted all the information necessary to make a decision on the appeal.
NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

If We notify You in writing regarding specific information that is needed to decide Your appeal, the period for making the decision on appeal will not include the period of time from when You were notified of the request for additional information until the date You respond to the request. If more information is required to make a decision on Your request for review, MetLife will provide You with notification of incompleteness as soon as possible. If the appeal involves an Emergency Dental Condition, MetLife will provide You with notification of incompleteness within 24 hours after submitting the appeal.

MetLife may deny the appeal if You fail to provide sufficient information within a 45 day period from the date of notification to provide the necessary information.

If You should need assistance in preparing the appeal, You may contact:

- the New Hampshire Insurance Department either by dialing 1-800-852-3416 or mailing the Insurance Department at New Hampshire Insurance Department / 56 Old Suncook Rd. / Concord NH 03301-7317;

- MetLife by dialing 1-800-438-6388.

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.

EXTERNAL PROCEDURES FOR CLAIM REVIEW OUTSIDE OF METLIFE

If You have received a final written decision and the appeal was not resolved to Your satisfaction, You can request an external appeal in writing to the New Hampshire Insurance Department at Independent External Review / New Hampshire Insurance Department / 56 Old Suncook Road / Concord, NH 03301.

Eligibility for an External Appeal

To be eligible for an external appeal the cost of Your dental service that is the subject of the appeal is at least $400 and:

- You have completed MetLife’s internal review procedures and have submitted a request for external review in writing to the New Hampshire Insurance Department within 180 days of MetLife’s second level denial; or

- You have submitted a request for external review in writing to the New Hampshire Insurance Department within 180 days of the date a decision was due regarding a first level, second level, or an Emergency Dental Condition through MetLife’s internal review procedures, but such a decision was not made within the required time frames.

For further information regarding Your right to an external appeal, please see the pages entitled Managed Care Consumer Guide to External Appeal and Request for Independent External Appeal of a Health Care Decision.
NOTICE FOR RESIDENTS OF OKLAHOMA

If you reside in Oklahoma, the following procedures for Overpayment of Dental Insurance benefits will be followed:

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 benefits is more than the total of the benefits due to You under this certificate; or

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

If such overpayment occurs and We request a refund within 24 months, You have an obligation to reimburse Us. We may request a refund after 24 months if:

- the payment was made because of fraud committed by You or the Dentist; or
- You or the Dentist has otherwise agreed to make a refund to Us for overpayment of a claim.

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.
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.
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 1-800-438-6388.

Claim Submission

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

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

Initial Determination

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

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

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

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

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. Defeference 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
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits

- Annuities
  - $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 31A, 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 FOR RESIDENTS OF VERMONT

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within 15 working days from the date We received Your claim; except for situations requiring an extension of time 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 15 working days, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife’s notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

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

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

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

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

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

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

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

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 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 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 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
1-800-438-6388

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.

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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.

**Child** means the following: (for residents of Alaska, Arkansas, Illinois, Maryland, Montana, New Hampshire, New Jersey, North Carolina, Texas, 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) who lives with You; or
- a child who resides with and is fully supported by You;

who, in each case, is under age 26 and unmarried. A child will be considered to be under 26 throughout the calendar year in which his or her 26th birthday occurs.

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 a certificateholder.

For residents of New Jersey, **Civil Union** means the legally recognized union of two individuals of the same sex entered into in New Jersey pursuant to the New Jersey Civil Union Act. It also includes a same-sex relationship entered into outside of New Jersey which is valid under the laws of the jurisdiction under which the same-sex relationship is created.

**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 You or Your Dependents must pay before We will pay for Covered Services.

**Dental Hygienist** means a person trained to:
- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

**Dentally Necessary** means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:
- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

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

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.

**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.
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); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- the usual charge of most other Dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies.

Retired Employee means a person who was employed and paid for services by the Policyholder but who has retired from that employment, as determined by the Policyholder.

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 a Retired Employee.
DEFINITIONS (continued)

For New Jersey residents Spouse means the following:

Spouse means Your lawful spouse or Civil Union Partner. 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;
- is insured under the Group Policy as a Retired 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 1st to the day before the next January 1st.

You and Your mean a certificateholder who is insured under the Group Policy for the insurance described in this certificate.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

The insurance for residents of Louisiana is provided for under other certificates. Therefore, for purposes of this certificate, residents of Louisiana are not deemed to be members of the Eligible Classes set forth below:

ELIGIBLE CLASS(ES)

Eligible Class 1 - Retired Employees of the Policyholder whose retirement date is August 31, 2011 or earlier.

Eligible Class 2 - Retired Employees of the Policyholder whose retirement date September 1, 2011 or later.

Eligible Class 3 - Retired Employees of the Policyholder whose COBRA continuation of dental insurance under the Policyholder's dental benefits plan for active employees ends on or after January 1, 2012.

Eligible Class 4 - Retired Employees of the Policyholder who are covered as a dependent under other dental insurance on their date of retirement and whose coverage as a dependent ends on or after January 1, 2012.

Eligible Class 5 - Retired Employees of the Policyholder who, after retiring from the Policyholder, become insured under a subsequent employer's dental insurance as an active employee of the subsequent employer and whose coverage as an active employee of the subsequent employer ends on or after January 1, 2012.

Eligible Class 6 - Ex-spouses, ex-domestic partners, widows or widowers of Retired Employees who were covered for Dental Insurance as Dependents under the Group Policy but whose coverage under a Retired Employee’s certificate under the Group Policy ceased due to their divorce, annulment, dissolution of domestic partnership or the Retired Employee’s death.

Eligible Class 7 - Persons who were Children of Retired Employees and were covered for Dental Insurance as Dependents under the Group Policy when that coverage ceased at the time they reached the limiting age.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance shown in the SCHEDULE OF BENEFITS.

For Eligible Class 1, Retired Employees of the Policyholder whose retirement date is August 31, 2011 or earlier, You will be eligible for the Dental Insurance described in this certificate on January 1, 2012.

For all other Eligible Classes, You will be eligible for the Dental Insurance described in this certificate on the later of January 1, 2012 and the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

Enrollment for Eligible Class 1

The Group Policy’s Initial Enrollment Period applies to persons who belong to Eligible Class 1, Retired Employees of the Policyholder whose retirement date is August 31, 2011 or earlier. The Initial Enrollment Period begins on November 8, 2011 and ends on December 8, 2011.

If You are a member of Eligible Class 1, You may enroll for Dental Insurance by completing the required form in Writing on a Timely Basis and by sending that form to Us for such insurance.

The terms “Timely Enrollment” and “Timely Basis” for members of Eligible Class 1 mean that You submit the enrollment form in Writing and We receive it on or before December 8, 2011.

If You make a Timely Enrollment, Dental Insurance will take effect as of January 1, 2012.

If You do not make a Timely Enrollment, You cannot enroll at a later date as a member of Eligible Class 1.

Dental Insurance for You will not take effect unless We receive the initial premium payment.
Enrollment for Eligible Classes 2, 3, 4, 5, 6, and 7

If You become eligible as a member of Eligible Classes 2, 3, 4, 5, 6, and 7, You may enroll for Dental Insurance by completing the required form in Writing on a Timely Basis and by sending that form to Us for such insurance.

The terms “Timely Enrollment” and “Timely Basis” for members of Eligible Class 2, 3, 4, 5, 6, and 7 mean that We receive the enrollment form in Writing within 60 days of the date the enrollment kit was sent to You.

The effective date of the Dental Insurance will depend on when We receive the enrollment form. If We receive the enrollment form on or before the 15th of a month, Dental Insurance for You will take effect on the first day of the following month. If We receive the enrollment form on or after the 16th of a month, Dental Insurance for You will take effect on the first day of the second following month. For example, if You make a Timely Enrollment and we receive the enrollment form on February 15, Your Dental Insurance will take effect on March 1. If You make a Timely Enrollment and we receive the enrollment form on February 16, Your Dental Insurance will take effect on April 1.

Dental Insurance for You will not take effect unless We receive the initial premium payment.

Effect of Not Enrolling on a Timely Basis

If You did not enroll on a Timely Basis after joining an Eligible Class, You cannot enroll at a later date as a member of that Eligible Class.

However, if You later become a member of a different Eligible Class, You may enroll as a member of that Eligible Class if You enroll on a Timely Basis. For example, if You retire on March 1, 2014 and did not enroll as a member of Eligible Class 1 on a Timely Basis but continue dental benefits under COBRA continuation as part of the Policyholder’s plan for active employees and that coverage ceases on August 31, 2015, You may enroll as a member of Eligible Class 3 if You enroll on a Timely Basis with respect to Your joining Eligible Class 3.

Enrollment Period

Starting with the fall of 2017 and every year after that the Group Policy will allow certificateholders to revise the option for which they are covered. If Dental Insurance is in effect for You under this certificate, You will be given the opportunity to change the Option under which You are covered, including to discontinue the insurance.

If you change the option for which You are covered, the new option will take effect on the January 1st after You elected to change the option. For example, if You elect during the annual enrollment period in the fall of 2017 to change Your option, Your new option will take effect on January 1, 2018.

Effect of Discontinuing Dental Insurance

If You discontinue Dental Insurance at any time, including through the failure to pay required premiums by the end of the grace period, You will not be able to re-enroll at any time.

Grace Period

Each premium due after the effective date of the Dental Insurance may be paid up to 60 days after its premium due date. This period is the grace period. During this grace period Your insurance will stay in effect, and You will still be obligated to Us to pay the premium for Your coverage that was in effect during the grace period.

If You do not pay the full premium by the end of the grace period, Your insurance will end on the last day of the grace period and You will be obligated to Us to for the premium for Your coverage that was in effect during the grace period.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You do not remit to Us the premium within 60 days of the date the premium payment is due, the amount of the premium will be deducted from the benefits amount payable for the applicable period.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the day before the date Your new option starts, if You switch to the other option;
2. the date of Your death;
3. the date the Group Policy ends;
4. the date insurance ends for Your class;
5. the last day of the month of the later of:
   • the date stated in Your cancellation notice; or
   • the date We have received Your cancellation notice; or
6. on the date premium is not paid when due, subject to the Grace Period provisions.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

The insurance for residents of Louisiana is provided for under other certificates. Therefore, for purposes of this certificate, residents of Louisiana are not deemed to be members of the Eligible Classes set forth below:

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

Eligible Class 1 - Retired Employees of the Policyholder whose retirement date is August 31, 2011 or earlier.

Eligible Class 2 - Retired Employees of the Policyholder whose retirement date is September 1, 2011 or later.

Eligible Class 3 - Retired Employees of the Policyholder whose COBRA continuation of dental insurance under the Policyholder's dental benefits plan for active employees ends on or after January 1, 2012.

Eligible Class 4 - Retired Employees of the Policyholder who are covered as a dependent under other dental insurance on their date of retirement and whose coverage as a dependent ends on or after January 1, 2012.

Eligible Class 5 - Retired Employees of the Policyholder who, after retiring from the Policyholder, become insured under a subsequent employer's dental insurance as an active employee of the subsequent employer and whose coverage as an active employee of the subsequent employer ends on or after January 1, 2012.

Eligible Class 6 - Ex-spouses, ex-domestic partners, widows or widowers of Retired Employees who were covered for Dental Insurance as Dependents under the Group Policy but whose coverage under a Retired Employee's certificate under the Group Policy ceased due to their divorce, annulment, dissolution of domestic partnership or the Retired Employee's death.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for Dependent Insurance available for Your Eligible Class as shown in the SCHEDULE OF BENEFITS.

If You are in Eligible Classes 1, 2, 3, 4, or 5, i.e., You are a Retired Employee of the Policyholder, You will be eligible for Dependent Insurance on the first day on or after January 1, 2012 on which You have a Dependent.

If You are an ex-spouse, ex-domestic partner, widow or widower who belongs to Eligible Class 6 and if You have a Child whose coverage under the Retired Employee's certificate ceased at the same time Yours did, You will be eligible for Dependent Insurance for that Child on the first day on or after January 1, 2012 on which You are in Eligible Class 6. Members of Eligible Class 6 are not eligible to cover as Dependents any persons other than Children whose coverage under the Retired Employee's certificate ceased at the same time theirs did.

No person other than members of Eligible Classes 1, 2, 3, 4, 5, or 6 is eligible for Dependent Insurance under this certificate.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

In order to enroll for Dependent Insurance, You must be eligible for Dependent Insurance under this certificate and You must be either:

- currently enrolled for Dental Insurance for You under this certificate; or
- enrolling for Dental Insurance for You under this certificate at the same time.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During the Group Policy's Initial Enrollment Period for Members of Eligible Class 1

The Group Policy's Initial Enrollment Period applies to persons who belong to Eligible Class 1, Retired Employees of the Policyholder whose retirement date is August 31, 2011 or earlier and who have one or more Dependents. The Initial Enrollment Period begins on November 8, 2011 and ends on December 8, 2011.

If You are eligible for Dependent Insurance as a member of Eligible Class 1 during the Initial Enrollment Period, You may enroll for Dependent Insurance under this certificate by completing the required form in Writing on a Timely Basis and by sending that form to Us for such insurance.

The terms “Timely Enrollment” and “Timely Basis” during the Initial Enrollment Period mean that You submit the enrollment form in Writing and We receive it on or before December 8, 2011.

If You make a Timely Enrollment during the Initial Enrollment Period, Dental Insurance on the Dependents for which You have enrolled will take effect as of January 1, 2012 and premiums will begin to be charged as of that date.

Dependent Insurance will not take effect unless We receive the initial premium payment.

Enrollment for Members of Eligible Class 1 Outside of the Initial Enrollment Period

If You are a member of Eligible Class 1 and acquire Your first Dependent on or after September 1, 2011, You may enroll for Dependent Insurance under this certificate by completing the required form in Writing on a Timely Basis and by sending that form to Us for such insurance.

The terms “Timely Enrollment” and “Timely Basis” mean that We receive the enrollment form in Writing within 60 days of the date the enrollment kit was sent to You.

The effective date of the Dependent Insurance will depend on when We receive the enrollment form. If We receive the enrollment form on or before the 15th of a month, Dependent Insurance will take effect on the first day of the following month. If We receive the enrollment form on or after the 16th of a month, Dependent Insurance will take effect on the first day of the second following month. For example, if You make a Timely Enrollment and we receive the enrollment form on February 15, Your Dependent Insurance will take effect on March 1. If You make a Timely Enrollment and we receive the enrollment form on February 16, Your Dependent insurance will take effect on April 1.

Dependent Insurance will not take effect unless We receive the initial premium payment.

Enrollment for Dependent Insurance for Members of Eligible Classes 2, 3, 4, 5, and 6

If You become eligible for Dependent Insurance under this certificate as a member of Eligible Class 2, 3, 4, 5, and 6, You may enroll for such insurance by completing the required form in Writing on a Timely Basis and by sending that form to Us for such insurance.

The terms “Timely Enrollment” and “Timely Basis” for members of Eligible Class 2, 3, 4, 5, and 6 means that We receive the enrollment form in Writing within 60 days of the date the enrollment kit was sent to You.

The effective date of the Dependent Insurance will depend on when We receive the enrollment form. If We receive the enrollment form on or before the 15th of a month, Dependent Insurance will take effect on the first day of the following month. If We receive the enrollment form on or after the 16th of a month, Dependent Insurance will take effect on the first day of the second following month. For example, if You make a Timely Enrollment and we receive the enrollment form on February 15, Your Dependent Insurance will take effect on March 1. If You make a Timely Enrollment and we receive the enrollment form on February 16, Your Dependent insurance will take effect on April 1.

Dependent Insurance will not take effect unless We receive the initial premium payment.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment Period

Starting with the fall of 2017 and every year after that the Group Policy will allow certificateholders to revise the option for which they are covered. If Dependent Insurance is in effect under this certificate, You will be given the opportunity to change the Option under which Your Dependents are covered, including to discontinue the insurance.

If you change the option for which You are covered, the new option will take effect on the January 1st after You elected to change the option. For example, if You elect during the annual enrollment period in the fall of 2017 to change Your option, Your new option will take effect on January 1, 2018.

Effect of Discontinuing Dental Insurance

If You discontinue Dependent Insurance at any time, including through the failure to pay required premiums by the end of the grace period, You will not be able to re-enroll at any time.

Grace Period

Each premium due after the effective date of the Dental Insurance may be paid up to 60 days after its premium due date. This period is the grace period. During this grace period Your insurance will stay in effect, and You will still be obligated to Us to pay the premium for Your coverage that was in effect during the grace period.

If You do not pay the full premium by the end of the grace period, Your insurance will end on the last day of the grace period and You will be obligated to Us to for the premium for Your coverage that was in effect during the grace period.

If You do not remit Us the premium within 60 days of the date the premium payment is due, the amount of the premium will be deducted from the benefits amount payable for the applicable period.

Enrollment Due to a Qualifying Event

If You are a Retired Employee in Eligible Classes 1, 2, 3, 4, or 5 You may enroll for Dependent Insurance for which You are eligible if You have a Qualifying Event and acquire a new Dependent or Your Spouse loses dental insurance under an employer’s dental plan for active employees. This enrollment will only pertain to the new Dependent and Your Spouse who loses dental insurance under an employer’s dental plan for active employees.

Ex-spouses, ex-domestic partners, widows and widowers in Eligible Class 6 are continuing insurance which existed under the Retired Employee’s certificate and cannot add Dependent Insurance after their enrollment. Qualifying Events do not apply to Eligible Class 6.

If You have a Qualifying Event, You will have 60 days from the date of that event to make a request to add Dependent Insurance for Your new Dependent or for Your Spouse who loses dental insurance under an employer's dental plan for active employees. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request.

Qualifying Event includes:

- You get married;
- You acquire a new Child; or
- Your Spouse loses dental insurance under an employer’s dental plan for active employees.
DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the day before the date Your new option starts, if You switch to the other option;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the last day of the month of the later of:
   - the date stated in Your cancellation notice; or
   - the date We have received Your cancellation notice;
6. on the date premium is not paid when due, subject to the Grace Period provisions;
7. the end of the calendar year in which the Dependent Child reaches the limiting age; or
8. the last day of the month the person ceases to be a Dependent for any reason other than the Dependent Child reaching the limiting age.

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

AT THE POLICYHOLDER'S OPTION

Dental Insurance for Your Dependents may be continued under a separate certificate under This Policy if such coverage under Your certificate would cease because:

1. You die;
2. Your marriage ends in divorce or annulment or Your domestic partnership ends; or
3. Your Child attains the limiting age.

To continue Dental Insurance under this provision:

1. You or Your Dependents must notify Us of the event within 60 days after the date of the event;
2. after We receive such notice, We will send Your Dependents a form to elect to continue such coverage, information regarding the amount of premium required to continue such coverage, and instruction for returning the election form; and
3. Your Dependents must return the election form to Us within 60 days of the date the enrollment kit is sent.

If Your Dependent Spouse continues coverage under this provision, he or she may also include coverage for any Child whose coverage under Your certificate ceases at the same time. Coverage for additional children or for a new Spouse are not available to your former Spouse.

If Your Dependent Child continues coverage under this provision, he or she may include coverage only on himself or herself. Coverage for his or her Dependents is not available.

If Your Dependent fails to notify Us of the event within 60 days of the event, or fails to return the election form within 60 days of the date the enrollment kit is sent and pay the amount of premium required to continue such coverage, eligibility for that Dependent to continue Dental Insurance under this provision will end.
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 1-800-438-6388 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.

In-Network

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

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

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

Out-of-Network

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

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

- the Deductible; 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 and each Dependent 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 an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base Our benefit determination upon the amalgam filling 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.

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.
DENTAL INSURANCE (continued)

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 and problem-focused exams once every 6 months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, once every 6 months.
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), once every 6 months.
4. Full mouth or panoramic x-rays once every 60 months.
5. Bitewing x-rays:
   • 1 set every 6 months for a Child; and
   • 1 set every Year for everyone else.
6. 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) once every 6 months.
7. Topical fluoride treatment for a Child under age 14, once in 12 months.

Type B Covered Services

1. Intraoral-periapical and extraoral x-rays.
2. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
3. Diagnostic casts.
4. Emergency palliative treatment to relieve tooth pain.
5. Initial placement of amalgam or resin fillings.
6. Replacement of an existing amalgam or resin fillings, but only if:
   • at least 24 months have passed since the existing filling was placed; or
   • a new surface of decay is identified on that tooth.
7. Protective (Sedative) Fillings.
8. 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 12 month period.
9. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
10. Space maintainers for a Child under age 14 once per lifetime per tooth area.
11. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
12. Preventive resin restorations which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
13. Interim caries arresting medicament application applied to permanent bicuspid and 1st and 2nd molar teeth, once per tooth every 60 months.
DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child or for the treatment of a congenital cleft in the lip or palate or both;
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. major restorative services such as inlays, onlays, veneers, crowns, and Dentures;
13. temporary or provisional restorations;
14. temporary or provisional appliances;
15. prescription drugs;
16. services for which the submitted documentation indicates a poor prognosis;
17. 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;
18. caries susceptibility tests;
19. fixed and removable appliances for correction of harmful habits;
20. appliances or treatment for bruxism (grinding teeth);
21. precision attachments associated with fixed and removable prostheses;
22. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
23. duplicate prosthetic devices or appliances;
24. orthodontic services or appliances;
25. repair or replacement of an orthodontic device;
26. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging;
27. intra and extraoral photographic images;
28. cleaning and inspection of a removable appliance.
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 1-800-438-6388. 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

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 1-800-438-6388.

Claim Submission

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

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

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 1-800-438-6388. 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.
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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 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.
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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.

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 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.
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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.

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.
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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.

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.
DENTAL INSURANCE: GRIEVANCE PROCEDURES

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 1-800-438-6388 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:

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

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:

- **Expedited/Urgent Grievances:** 72 hours of receipt of Your appeal.
- **Pre-Service Grievances:** 15 calendar days of receipt of Your appeal.
  (A request for a service or treatment that has not yet been provided.)
- **Post-Service Grievances:** 30 calendar days of receipt of Your appeal.
  (A claim for a service or a treatment that has already been provided.)
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
105 East 22nd Street
New York, NY 10010
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.
THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE NEW YORK UNIVERSITY DENTAL INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER

NEW YORK UNIVERSITY
7 East 12th Street
New York, NY 10003

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

New York University
Benefits Office
7 East 12th Street
New York, NY 10003
2129981270

EMPLOYER IDENTIFICATION NUMBER: 13-5562308

PLAN NUMBER: 506
COVERAGE: All Coverages
PLAN NAME: New York University Benefits Office

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for all life

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 FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy 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

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

All claim forms needed to file for 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.

Routine Questions

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

Claim Submission

For claims for dental 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 benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

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

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria 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 make 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 criteria 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.

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.
Urgent Care Claim Submission

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 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 time frames above and then mail you a written notice.

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.

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.

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.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but NEW YORK 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 NEW YORK UNIVERSITY shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.