YOUR BENEFIT PLAN

School Board of Broward County

All Full-Time Employees

Dental Insurance for You and Your Dependents

Basic Plan Option

Certificate Date: January 1, 2012
School Board of Broward County
600 S.E. Third Avenue
Fort Lauderdale, FL 33301

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

School Board of Broward County
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: School Board of Broward County

Group Policy Number: 120791-1-G

Type of Insurance: Dental Insurance

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

PLEASE AFFIX THE STICKER SHOWING THE EMPLOYEE’S NAME AND EFFECTIVE DATE IN THIS SPACE.

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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 North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 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.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.
NOTICE FOR RESIDENTS OF MINNESOTA, MONTANA, NEW MEXICO, UTAH, AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Minnesota Residents (Dental Insurance):

The term also includes Your grandchildren who are financially dependent upon You and reside with You continuously from birth. The age limit for children and grandchildren will not be less than 25 regardless of the child’s or grandchild’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For Montana Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

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

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

For Utah Residents (Dental Insurance):

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

For Washington Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child’s marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.
NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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

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

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

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

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 INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357
NOTICE FOR RESIDENTS OF FLORIDA

Dental Insurance benefits for Covered Services are subject to a Deductible.
NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 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 MASSACHUSETTS RESIDENTS

CONTINUATION OF DENTAL INSURANCE

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

2. If Your Dental Insurance ends because:
   - You cease to be in an Eligible Class; or
   - Your employment terminates;

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

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

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

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

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

To continue Dental insurance under this provision:

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

The request form will be furnished by the Employer.

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

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

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

CONTINUATION OF YOUR DENTAL INSURANCE

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

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

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

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

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

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

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

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

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

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

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

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

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

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

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.
CONTINUATION OF YOUR DEPENDENT’S DENTAL INSURANCE (Continued)

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

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer’s group plan;

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

- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer’s group dental coverage;

- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer’s group dental coverage;

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

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

- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or

- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

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

- the end of the maximum continuation period;

- the date this Dental Insurance ends;

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

- the date the Dependent becomes entitled to enroll for Medicare;

- if You do not pay a required premium to continue Dental Insurance for Your Dependents; or

- the date the Dependent becomes eligible for coverage under any other group dental coverage.
NOTICE FOR RESIDENTS OF NORTH CAROLINA

Read your Certificate Carefully.

This Certificate Contains a Pre-existing Condition Limitation.
NOTICE FOR RESIDENTS OF NORTH CAROLINA

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

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

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

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.
NOTICE FOR RESIDENTS OF 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 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.  Utah Insurance Department
60 East South Temple, Suite 500 3110 State Office Building
Salt Lake City UT 84111 Salt Lake City UT 84114-6901
(801) 320-9955 (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 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 been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9691 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)
3600 West Broad St
Suite 216
Richmond, VA 23230
1-800-955-1819

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.
NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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.

You may contact the Virginia Office of the Managed Care Ombudsman either by dialing toll free at (877) 310-6560, or locally at (804) 371-9691, via the internet at Web address www.scc.virginia.gov, email at ombudsman@scc.virginia.gov, or mail to:

The Office of the Managed Care Ombudsman
Bureau of Insurance, P.O. Box 1157
Richmond, VA 23218

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

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

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

Appealing the Initial Determination

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

- 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
NOTICE TO RESIDENTS OF VIRGINIA (continued)

You prior to the expiration of the 30 day period, state the reason(s) why an extension is needed, and state when it will make its determination.

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

Policies and Procedures for Emergency and Urgent Care

Urgent care and Emergency services: All member dentists of the MetLife Preferred Dentist Program (PDP) are required to have 24-hour emergency coverage or have alternate arrangements for emergency care for their patients. Since the MetLife PDP 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, NY 10166-0188
1-800-638-5433

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

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

Missing fraud notice
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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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**Deductibles for:**

- Yearly Individual Deductible
  - $25 for the following Covered Services Combined: Type B; Type C $50 for the following Covered Services Combined: Type B; Type C
- Yearly Family Deductible
  - 3 Yearly Individual Deductibles 3 Yearly Individual Deductibles

**Maximum Benefit:**

- Yearly Individual Maximum
  - $1,250 for the following Covered Services: Type A; Type B; Type C $1,250 for the following Covered Services: Type A; Type B; Type C
DEFINITIONS

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

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

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

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

**Cast Restoration** means an inlay, onlay, or crown.

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

- Your natural, adopted, or stepchild (including the child of a Domestic Partner) who is under age 26, supported by and living with You. The term also includes Your natural, adopted or stepchild (including the child of a Domestic Partner) under age 26 who is:
  - supported by You; and
  - a full-time or part-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

The definition of Child includes newborns, adopted children from the time of placement in Your home; adopted newborns if an agreement to adopt is entered into prior to birth, and the child is placed in Your home; and children placed in Your home pursuant to a court order including foster children.

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

**The term does not include** any person who: outside of US or Canada has been removed

- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

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

Contributory Insurance includes: Dental Insurance.

**Covered Percentage** means:

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

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

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

Deductible means the amount 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 means each of two people, one of whom is an Employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

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

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.

Physician means:

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

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

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

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lowest of:

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

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

Further information on how We determine the Reasonable and Customary Charge for a particular claim is available upon request.

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.
DEFINITIONS (continued)

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 in the military of any country or subdivision of any country; or
- is insured under the Group Policy as an employee.

We, Us and Our mean MetLife.

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

Year or Yearly, for Dental Insurance, means the 12 month period that begins January 1.

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

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder who select the Basic Plan Option instead of the Enhanced Plan Option.

You are eligible for insurance if You were Actively at Work and covered for insurance on the day immediately preceding the date of Your retirement and have retired in accord with the Policyholder’s retirement plan. Please be aware that:

• references to Active Work and Actively at Work will not apply; and
• end of employment will mean the end of the person's status as a retiree, as stated in the Policyholder’s retirement plan.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on January 1, 2012, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2012, You will be eligible for insurance on the later of:

• the date You enter that class; and
• the first day of the month following the date of Your first full paycheck.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

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

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

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

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

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

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until an enrollment period for Dental Insurance, as determined by the Policyholder, following the date Your first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

The insurance enrolled for will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

During an enrollment period, You may choose a different option for which You are eligible than the option for which You are currently enrolled. Changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

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

Enrollment Due to a Qualifying Event

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

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

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage; or
  3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
• Your or Your dependent’s loss of coverage under any group health coverage sponsored by a governmental or educational institution.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time employees of the Policyholder who select the Basic Plan Option instead of the Enhanced Plan Option.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

You will be eligible for Dependent insurance on the latest of:

1. January 1, 2012;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the first day of the month following the date of Your first full paycheck.

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

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

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

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

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

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.
Enrollment During Any Annual Enrollment Period

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Insurance until an enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible. The insurance enrolled for will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

You may choose a different option of Dependent Insurance for which You are eligible than the option for which Your Dependents are currently enrolled. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that day.

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

Enrollment Due to a Qualifying Event

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

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

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage;
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

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

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

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date the Group Policy ends;
4. the date insurance for Your Dependents ends under the Group Policy;
5. the date insurance for Your Dependents ends for Your class;
6. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
7. the end of the period for which the last premium has been paid; or
8. the last day of the calendar month in which the person ceases to be a Dependent, except that for Utah residents the coverage on a Child will cease at the end of the month in which that person ceases to be a Dependent.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.
SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

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

2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
   - the loss of a tooth; and
   - the accumulation of amounts toward:
     - Annual Deductibles;
     - Annual Maximum Benefits;

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

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

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

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

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

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

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

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

AT THE POLICYHOLDER’S OPTION

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

Insurance will continue for the following periods:

1. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to part-time work, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
5. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

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

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

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

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

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

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

When requesting a Covered Service from an In-Network Dentist, We recommend that You:
• identify Yourself as an insured in the Preferred Dentist Program; and
• confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

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

You can obtain a customized listing of MetLife’s In-Network Dentists either by calling 1-800-942-0854 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

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

In-Network

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

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:
• the Deductible; and
• any other part of the Maximum Allowed Charge for which We do not pay benefits.
DENTAL INSURANCE (continued)

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.

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.

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.

When 3 individual Deductibles have been satisfied, the Yearly Family Deductible will be considered satisfied and no further amount will be applied to Individual Deductibles in that Year.

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

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

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

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 90 day period after Your insurance ends for Covered Services other than routine examinations, prophylaxis, x-rays, sealants, if:

- the Covered Service was recommended in Writing by a Dentist or Physician;
- the Covered Service was begun prior to the date Your Dental Insurance ended; and
- You did not voluntarily end this Dental Insurance.

We will not pay for benefits for Covered Services after the date You are insured for similar benefits by a plan that replaces this Dental Insurance, unless an elimination period under that plan prevents You from receiving benefits for Covered Services.
DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams, up to 4 every 12 months.
2. Full mouth or panoramic x-rays once every 3 Years.
3. Bitewing x-rays, one set every 12 months.
4. Intraoral-periapical and extraoral x-rays.
5. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.
6. Diagnostic casts.
7. Cleaning of teeth (oral prophylaxis), up to 4 every 12 months.
8. Emergency palliative treatment to relieve tooth pain.
9. Topical fluoride treatment for a Child under age 16, up to 2 every 12 months.
10. Space maintainers for a Child under age 16.
11. Sealants for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.

Type B Covered Services

1. Initial placement of amalgam or resin fillings.
2. 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.
3. Sedative Fillings.
4. Oral Surgery except as mentioned elsewhere in this certificate.
6. Provisional splinting.
7. Periodontal scaling and root planing.
8. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery.
10. Surgical extractions.
11. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to twice in any 12 month period.
12. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
13. Pulp therapy and apexification/recalcification.
14. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
15. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.
17. Re-cement fixed partial denture.
18. Full mouth debridement.
19. Analgesia, anxiolysis, inhalation of nitrous oxide.
20. Repair resin denture base, but not more than once in a 12 month period.
21. Repair cast framework, but not more than once in a 12 month period.
22. Repair or replace broken clasp, but not more than once in a 12 month period.
23. Replace broken teeth - per tooth, but not more than once in a 12 month period.
24. Fixed partial Denture sectioning, but not more than once in a 12 month period.
25. Brush biopsy.

Type C Covered Services

1. Initial installation of full or removable Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth that are lost while the person receiving such benefits was
     insured for Dental Insurance under this certificate.
2. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental
   Insurance was in effect for the person receiving such services, but not more than once in any 12 month
   period.
3. Replacement of a non-serviceable Denture if such Denture was installed more than 5 years prior to
   replacement.
4. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate,
   temporary full Denture cannot be made permanent.
5. Relinings and rebasings of existing removable Dentures, if at least 12 months have passed since the
   installation of the existing removable Denture and not more than once in any 12 month period.
6. Other Denture Repairs not mentioned elsewhere, but not more than once in a 12 month period.
7. Adjustments of Dentures, if at least 12 months have passed since the installation of the Denture and not
   more than once in any 12 month period.
8. Precision attachments.
9. Initial installation of Inlays and Onlays.
10. Initial installation of Crowns for You and Your Dependent, if such person is at least 16 years old.
11. Replacement of any Inlay and Onlay with the same or a different type of Cast Restoration but no more
    than one replacement for the same tooth surface within 5 years of a prior replacement.
12. Simple Repairs of Cast Restorations, but not more than once in a 12 month period.
13. For You and Your Dependent, if such person is at least 16 years old, replacement of any Crown with the
    same or a different type of Cast Restoration but no more than one replacement for the same tooth surface
    within 5 years of a prior replacement.
14. Prefabricated stainless steel crowns, but no more than one replacement for the same tooth surface every
    period greater than 5 years interval, for a Child up to age 16.
15. Prefabricated resin crowns, but no more than one replacement for the same tooth surface every period
    greater than 5 years interval, if such person is at least 16 years old.
16. Core buildup, but no more than once per tooth every period greater than 5 years interval.
17. Posts and cores, but no more than once per tooth every period greater than 5 years interval.
18. Labial veneers, but no more than once per tooth in a period of 12 months.
20. Occlusal adjustments when performed with periodontal surgery or non-surgical treatment of
    temporomandibular joint disorders.
21. Local chemotherapeutic agents.
22. Tissue Conditioning.
23. Implant supported prosthetic devices, but not more than once for the same tooth position in a 5 year period.
24. Repair of implant supported prosthetics, but not more than once in a 12 month period.
25. Pin retention - per tooth, in addition to restoration, but not more than once in a 5 year period.
27. Re-cement cast or prefabricated post/core.
28. Canal preparation and fitting of pre-formed dowel or post.
29. Interim complete and partial upper and lower Dentures, but no more than once in any 2 year period.
30. Implant services (including sinus augmentation and graft for ridge preservation), when needed to replace congenitally missing teeth or to replace natural teeth that are lost while the person receiving such benefit was insured for Dental Insurance, but no more than once for the same tooth position in a 5 year period.
31. Repair of implants, but not more than once in a 12 month period.
32. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5 year period.
33. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5 year period.
34. Implant supported removable Dentures, but no more than once for the same tooth position in a 5 year period.
35. Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments, and reinsertion of prosthesis.
36. Implant removal, by report.
37. Coping - metal.
38. Repair broken complete denture base, but not more than once in a 12 month period.
39. Replace missing/broken teeth complete Denture per tooth, but not more than once in a 12 month period.
40. Replace all teeth and acrylic on cast metal framework (maxillary or mandibular), but not more than once in a 12 month period.
41. Repair of Bridge, but not more than once in a 12 month period.
42. Temporary crown.
DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments;
5. services which are primarily cosmetic unless such service is:
   - required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part;
   - required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect; or
6. services or appliances which restore or alter occlusion or vertical dimension, except for occlusal adjustments when performed with periodontal surgery;
7. restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
8. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
9. personal supplies or devices including, but not limited to: water pics, toothbrushes, or dental floss;
10. initial installation of a Denture or implant to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
   - paid under any workers' compensation or occupational disease law;
   - paid under any employer liability law;
   - for which You are not required to pay; or
   - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. other temporary or provisional appliances not mentioned elsewhere;
16. prescription drugs;
17. services for which the submitted documentation indicates a poor prognosis;
18. services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first;

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

**The term does not include:**
- any plan, program or coverage provided by a government as an employer; or
- Medicare.

19. the following when charged by the Dentist on a separate basis:
- claim form completion;
- infection control such as gloves, masks, and sterilization of supplies; or
- local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide;

20. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;

21. caries susceptibility tests;

22. modification of removable prosthodontic and other removable prosthetic services;

23. injections of therapeutic drugs;

24. fixed and removable appliances for correction of harmful habits;

25. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;

26. adjustment of a Denture made within 12 months after installation by the same Dentist who installed it;

27. duplicate prosthetic devices or appliances;

28. replacement of a lost or stolen appliance, Cast Restoration or Denture;

29. orthodontic services or appliances;

30. repair or replacement of an orthodontic device;

31. non-surgical treatment of temporomandibular joint disorders, except for occlusal adjustments when performed with non-surgical treatment of temporomandibular joint disorders;

32. intra and extraoral photographic images;

33. other temporary or provisional appliances not mentioned elsewhere;

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

**DEFINITIONS**

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

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

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

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

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

The term does not include:

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

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

**Claim Determination Period** means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

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

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

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

- for which You are entitled to benefits under a workers’ compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.
DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

The term does not include any of the following:

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

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

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

will not be affected by these Coordination of Benefits provisions.

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

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the Policyholder (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the “Rules to Decide Which Plan Is Primary” section. A Primary Plan pays benefits as if the Secondary Plans do not exist.
DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-942-0854. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

**Step 1**
A claimant can request a claim form by calling Us at 1-800-942-0854.

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

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

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

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

**Time Limit on Legal Actions.** 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 5 years after the date such Proof is required.
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of 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.
Appealing the Initial Determination

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

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

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

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

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

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

Assignment

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

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 IS THE END OF THE CERTIFICATE

THE FOLLOWING IS ADDITIONAL INFORMATION
Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

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

Group Policy No.: 120791-1-G

Policyholder: School Board of Broward County

Effective Date: January 1, 2012

The certificate is changed as shown below:

Applicable to All Employees with Dental Insurance (Excluding TX LA MS and MT Employees)

The attached NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA, form number GCERT2000 notice/dp/ca is added to Certificates Numbered 9 and 10.

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

For purposes of determining who may become a Covered Person, the term does not include any person who:

- is in the military of any country or subdivision of a country;
- is insured under the Group Policy as an employee.”

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

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

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