

YOUR BENEFIT PLAN

MetLife Illinois MULTIPLE ASSOCIATION BENEFITS TRUST

All Full-Time Members in Good Standing residing in Alaska

High Plan and Low Plan with Orthodontia

Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2025



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

CERTIFICATE OF INSURANCE

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

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

Policyholder:	U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust
Participating Association	American Postal Workers Union
Group Policy Number:	122705-2-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s): For Claim Information	FOR DENTAL CLAIMS: 1-800-422-4492

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

IF THERE IS ANY CONFLICT BETWEEN THE POLICY AND THE CERTIFICATE LANGUAGE, THE CERTIFICATE WILL CONTROL.

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.

FOR RESIDENTS OF ALASKA

GCERT2025-APWU-DEN-AK-ORTHO

NOTICE FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

High Option:

Covered Percentage for:	Covered Percentage of the Reasonable and Customary Charge* for:
Type A Covered Services	100%
Type B Covered Services	80%
Type C Covered Services	50%
and for Orthodontic Covered Services	50%

*Reasonable and Customary Charge is determined based on a 90th percentile of dental charges.

Deductibles for:

Yearly Individual Deductible	\$100 for the following Covered Services Combined: Type B; Type C Covered Services
Yearly Family Deductible	\$300 for the following Covered Services Combined: Type B; Type C Covered Services

Maximum Benefit:

Yearly Individual Maximum	\$1,500 for the following Covered Services: Type A; Type B; Type C Covered Services
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$1,000

Benefit Waiting Periods

Type A Covered Services	No waiting period
Type B Covered Services	No waiting period
Type C Covered Services	12 month waiting period
Orthodontic Covered Services.....	24 month waiting period

SCHEDULE OF BENEFITS (continued)

Low Option:

Covered Percentage for:	Covered Percentage of the Reasonable and Customary Charge* for:
Type A Covered Services	100%
Type B Covered Services	50%
Type C Covered Services	50%
and for Orthodontic Covered Services	50%

*Reasonable and Customary Charge is determined based on a 90th percentile of dental charges.

Deductibles for:

Yearly Individual Deductible	\$100 for the following Covered Services Combined: Type B; Type C Covered Services
Yearly Family Deductible	\$300 for the following Covered Services Combined: Type B; Type C Covered Services

Maximum Benefit:

Yearly Individual Maximum	\$1,500 for the following Covered Services: Type A; Type B; Type C Covered Services
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$1,000

Benefit Waiting Periods

Type A Covered Services	No waiting period
Type B Covered Services	No waiting period
Type C Covered Services	18 month waiting period
Orthodontic Covered Services	24 month waiting period

DEFINITIONS

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

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

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

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

Administrator means Alliant/Voluntary Benefits Plan.

Cast Restoration means an inlay, onlay, or crown.

Certificateholder means a member of an eligible class who is insured under the Group Policy. If an insured member of an eligible class dies and a surviving Spouse elects to continue Dependent Insurance in effect on the date of the insured member's death, such surviving Spouse will be deemed the Certificateholder thereafter for purposes of determining payment of benefits. Only Dependents covered on the date of the insured member's death are eligible for continued coverage.

Child means the following:

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

The definition of Child includes newborns.

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

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

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

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

DEFINITIONS (continued)

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

Contributory Insurance includes: Dental Insurance.

Covered Percentage means the percentage of the Reasonable and Customary Charge that We will pay for Covered Services after any required Deductible.

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 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.

DEFINITIONS (continued)

Domestic Partner means each of two people, one of whom is a Member of the Participating Association, 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 Member.

Full-Time means Active Work of at least 20 hours per week on the employer's regular work schedule.

Member means a person who is a member in good standing with the American Postal Workers Union.

Participating Association means the American Postal Workers Union.

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.

DEFINITIONS (continued)

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 of other Dentists or other providers in the same geographic area equal to the 90th percentile of charges as determined 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 it is determined 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 the Reasonable and Customary Charge is determined 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.

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

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

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

We, Us and Our mean MetLife.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic 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 a Certificateholder 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 Members in good standing residing in Alaska.

High Plan and Low Plan with Orthodontia

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 employer'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 employer'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, 2025, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2025, You will be eligible for insurance on the date when first premium is collected.

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 Administrator Written permission to deduct premiums from Your pay for such insurance. You will be notified how much You will be required to contribute.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Contributory Insurance

When You complete the enrollment process for Contributory Dental Insurance, such insurance will take effect on the latest of:

- the date You become eligible for such insurance;
- the date You enroll; and
- the date You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS.

provided You are Actively at Work on that date.

If You are not Actively at Work on that date, such insurance will take effect on the later of:

- the day You return to Active Work; and
- the date You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the date You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the date You cease to be a Member; or
6. the date the Participating Association ceases to participate in the Trust.

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 Members in good standing residing in Alaska.

High Plan and Low Plan with Orthodontia

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 described in this certificate on the latest of:

1. January 1, 2025; and
2. the date You enter a class eligible for insurance; and
3. the date You obtain a Dependent; and
4. the date when first premium is collected.

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

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 Administrator Written permission to deduct premiums from Your pay for such insurance. You will be notified 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.

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Rules for Contributory Insurance

When You complete the enrollment process for Contributory Dependent Dental Insurance, such insurance will take effect on the latest of:

- the date You become eligible for such insurance;
- the date You enroll; and
- the date You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS

provided You are Actively at Work on that date.

If You are not Actively at Work on that date, such insurance will take effect on the later of:

- the day You return to Active Work; and
- the date You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die; except that insurance for a surviving Spouse will continue;
2. the date Dental Insurance for You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the end of the period for which the last premium has been paid; or
8. the date 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:
 - a) Annual Deductibles;
 - b) Annual Maximum Benefits;
 - c) Lifetime Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
 - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
 - the date this Dental Insurance ends.

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

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, We will pay the insurance in effect on the date that service was completed.

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 amount We will pay for a Covered Services will be based on the Reasonable and Customary Charge.

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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

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

Alternate Benefit

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

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

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, its benefit determination may be based 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, its benefit determination may be based 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, its benefit determination may be based 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.

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

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed \$500 for Orthodontia in effect when the course of treatment begins.

The benefit payable for the periodic follow-up visits will not exceed \$500. This amount will be payable in the second year of the orthodontic treatment if:

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

Pretreatment Estimate of Benefits

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

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

DENTAL INSURANCE (continued)

Benefits We Will Pay After Insurance Ends

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

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

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

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

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

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

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than two exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Full mouth or panoramic x-rays once every 60 months.
5. Bitewing x-rays:
 - 1 set every 6 months for a Child; and
 - 1 set every Year for everyone else.
6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
7. Emergency treatment for the alleviation of pain.
8. Emergency palliative treatment and other non-routine, unscheduled visits.
9. Topical fluoride treatment for a Child under age 18, once in 12 months.
10. Fixed and removable appliances for correction of harmful habits for a Child under age 16.
11. Sealants or sealant repairs for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.

Type B Covered Services

1. Intraoral-periapical x-rays.
2. X-rays, except as mentioned elsewhere.
3. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
4. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
5. Diagnostic casts.
6. Amalgam fillings.
7. Resin-based composite fillings.
8. Protective (sedative) fillings.
9. Biopsies of hard or soft oral tissue.
10. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
11. Other consultations, but not more than once in a 12 month period.
12. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
13. Surgical extractions (erupted teeth). Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
14. Simple repairs of Cast Restorations or Dentures other than recementing.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

15. Space maintainers for a Child under age 16, once per lifetime per tooth area.
16. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
17. Office visits, but not more than once in a 12 month period.
18. Restoration of tooth structure damaged by attrition, abrasion or erosion caused by disease.
19. Synthetic restorations to restore diseased or accidentally broken teeth.
 - Silicate cement
 - Acrylic
 - Plastic
 - Porcelain fillings or
 - Composite resin.

Type C Covered Services

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the benefit waiting period that applies.

1. Pulp capping (excluding final restoration).
2. Therapeutic pulpotomy (excluding final restoration).
3. Pulp therapy.
4. Apexification/recalcification.
5. Pulpal regeneration, but not more than once per lifetime.
6. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
7. Local chemotherapeutic agents.
8. Injections of therapeutic drugs.
9. Initial installation of full or partial Dentures (other than implant supported prosthetics):
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
10. Addition of teeth to a partial removable Denture to replace teeth removed while this Dental Insurance was in effect for the person receiving such services.
11. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
12. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
13. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
14. Relinings and rebasings of existing removable Dentures but not more than once in any 12 month period.
15. Re-cementing of Cast Restorations or Dentures.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

16. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 6 month period.
17. Initial installation of Cast Restorations (except implant supported Cast Restorations).
18. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:
 - a Cast Restoration was installed for the same tooth; or
 - a Cast Restoration for the same tooth was replaced.
19. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.
20. Core buildup, but no more than once per tooth in a period of 10 Years.
21. Posts and cores, but no more than once per tooth in a period of 10 Years.
22. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.
23. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
24. Periodontal scaling and root planning, but not more 4 quadrants in any 24 month period.
25. Full mouth debridements, but not more than once in any 12 month period, 12 months apart from prophylaxis.
26. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure in 4 quadrants in any 24 month period.
27. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such 1 Year period.
28. Tissue conditioning, but not more than 2 treatments per arch in a 12 month period.
29. Occlusal adjustments, but not more than once in a 12 month period.
30. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards for a Child under age 16, once per lifetime.
31. Oral surgery, except as mentioned elsewhere in this certificate.
32. Surgical impacted extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
33. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 5 Year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
34. Repair of implants, but no more than once in a 12 month period.
35. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

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

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

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

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

Orthodontic Covered Services

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the benefit waiting period that applies.

Orthodontia for You, Your Spouse and Your Children up to age 26.

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are 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 are excluded unless required for the treatment or correction of a congenital defect of a newborn Child;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restorations or appliances used for the purpose of periodontal splinting;
8. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
9. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
10. decoration or inscription of any tooth, device, appliance, crown or other dental work;
11. missed appointments;
12. services:
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law;
 - for which the employer of the person receiving such services is required to pay; or
 - received at a facility maintained by the Participating Association, labor union, mutual benefit association, or VA hospital;
13. services covered under other coverage provided by the Policyholder;
14. temporary or provisional restorations;
15. temporary or provisional appliances;
16. prescription drugs;
17. services for which the submitted documentation indicates a poor prognosis;
18. 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;
19. 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;
20. caries susceptibility tests;
21. preventive resin restorations;
22. interim caries arresting medicament application;
23. labial veneers;

DENTAL INSURANCE: EXCLUSIONS (continued)

24. modification of removable prosthodontic and other removable prosthetic services;
25. initial installation of a Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
26. precision attachments associated with fixed and removable prostheses;
27. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
28. duplicate prosthetic devices or appliances;
29. replacement of a lost or stolen appliance, Cast Restoration or Denture;
30. replacement of an orthodontic device;
31. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
32. cleaning and inspection of a removable appliance;
33. other fixed Denture prosthetic services not described elsewhere;
34. intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

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

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

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

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

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

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 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. If two people are both insured under This Plan as employees, each person's insurance will be treated as a separate Plan.

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, it is determined 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 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.

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.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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.

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

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

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-422-4492. 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.

The claim form will be sent to the claimant within 15 days of the request. If the claimant has not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Both the notice of claim and the required Proof described in the claim form should be sent to Us within 90 days of the date of a loss.

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

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 1-800-422-4492.

Claim Submission

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

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

Initial Determination

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

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

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Appealing the Initial Determination

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

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

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

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

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

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

Prospective and Retrospective Utilization Review Determinations

Utilization Review-MetLife Consultant Review Manual

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Licensure and Compensation Requirements

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

Initial Determinations-Prospective Review (Pretreatment Estimate)

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

Prospective Adverse Review-Notification Requirements

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

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

The notification of a prospective Adverse Determination shall contain:

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

Retrospective Adverse Review-Guideline Requirements

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Retrospective Adverse Review-Notification Requirements

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

Notice of a retrospective Adverse Determination will:

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

Adverse Determinations-Urgent Care Claims (Expedited Dental Review)

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

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

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

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

Grievance Review of Adverse Determinations

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

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

- Notify You, Your Authorized Representative or health care provider that We cannot proceed with its review until additional information is received.
- We will assist You, Your Authorized Representative, or health care provider in gathering the information without delay.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Expedited Dental Review

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

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

Grievance Procedure

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

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

New Reviewer Requirement

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

Notification of Decision of Grievance

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

In addition, the notice shall contain the following:

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Notification of Right to External Review

Availability of External Review

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

You may have the right to have Our decision reviewed by health care professionals who have no association with Us if Our decision involved making a judgment as to the Dental Necessity, appropriateness, health care setting, level of care, or effectiveness of the dental service or treatment You requested by submitting a request for External Review to:

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

External Appeal-Effect

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

Additional Definitions

As used in this section, the terms listed below will have the meanings set forth below.

Adverse Determination means a rescission of coverage determination and means:

- Based upon the information provided, a request for a benefit under Your plan upon application of a Utilization Review technique does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational, and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit. Or a service or treatment that is a covered benefit has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination that a covered person's eligibility to participate in the plan.
- A Prospective Review or Retrospective Review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.

Authorized Representative means:

- A person to whom You have given express Written consent to represent You;
- A person authorized by law to provide substituted consent for You;
- If You are unable to provide consent, Your family member or Your treating health care professional; or
- If making an urgent care request, a health care professional with knowledge of the medical condition.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

Director means the director of the Division of Insurance.

External Review means the review of Adverse Determinations and Final Adverse Determinations completed by an independent review organization.

Final Adverse Determination means:

- An Adverse Determination that has been upheld by Us at the completion of the internal review process; or
- An Adverse Determination that, with respect to the internal review process, has been considered exhausted.

Grievance means a Written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by You or on Your behalf regarding:

- The availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made under Utilization Review;
- Claims payment, handling, or reimbursement for services; or
- Matters pertaining to the contractual relationship between You and Us.

Prospective Review means Utilization Review conducted before the course of treatment.

Retrospective Review means review of medical necessity conducted after services have been provided. It does not include the review of a claim that is limited to the veracity of documentation or the accuracy of coding.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of services and supplies provided under the plan using specified guidelines, including the application of practice guidelines, and Retrospective Review.

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 is determined to be an overpayment, within 180 days from the date of service whether for services received by You or Your Dependents.

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Insurance 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, within 180 days from the date of service, from You by:

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

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

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

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



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

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

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

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

SECTION 5: Using Your Information

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

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

SECTION 6: Sharing Your Information With Others

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

Other reasons we may share your information include:

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

SECTION 7: HIPAA

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

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

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

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

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

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

HIPAA Notice of Privacy Practices for Protected Health Information

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

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

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

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

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

NOTICE SUMMARY

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

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

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

In addition, we may use or disclose PHI:

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

You have the right to:

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

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

We are required by law to:

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

NOTICE DETAILS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Protected Health Information That We Maintain About You

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

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy

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

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

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

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

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

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

- **Right to Request Confidential**

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

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

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

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.