YOUR BENEFIT PLAN

Trustees of Princeton University

Full-Time Faculty Employees, Staff Employees and Post-Doctoral Fellows except those residing in Massachusetts, Montana and Texas

Dental Insurance for You and Your Dependents

High Plan

Certificate Date: July 1, 2020
TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Trustees of Princeton University
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: Trustees of Princeton University

Group Policy Number: 138262-1-G

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):
For Claim Information FOR DENTAL CLAIMS: 1-866-832-5756

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

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

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF NEW JERSEY.

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

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

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

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

GCERT2000
fp as amended by GEND16-NM-DSC 1
NOTICE FOR RESIDENTS OF ALASKA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

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

For Alaska Residents (Dental Insurance):

The term also includes newborns.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

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

For New Hampshire Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

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

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

For Utah Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes a child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

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

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

For Washington Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child’s marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.
Notice 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.
- You have the right to be provided with information concerning our policies and procedures regarding products, services, providers, appeal procedures and other information about the organization and the care provided.
- Under the Dental Insurance, services may be received from any licensed Dentist. The Dental insurance does not involve the selection of a primary care provider, much less require that You designate a primary care provider. Also, the Dental Insurance does not require referrals before services may be sought from a specialist.
- You have the right to obtain a current directory of preferred providers in the MetLife Preferred Dentist Program upon request, including addresses and telephone numbers, and a listing of providers who accept covered persons who speak languages other than English.
- You will receive descriptions of any changes in coverage in a separate document.

Responsibilities:

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

Reasonable and Customary Charges

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

Reasonable Access to an In-Network Dentist

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

Exclusions

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

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

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

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

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

Claim forms must be submitted in accordance with the instructions on the claim form.
Procedures For Dental Claims (Continued)

Initial Determination

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

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

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

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

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

Appealing the Initial Determination

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

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

As part of each appeal, You may submit any Written comments, documents, records, or other information relating to Your claim.
NOTICE FOR RESIDENTS OF ALASKA (continued)

Procedures For Dental Claims (Continued)

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

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

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

Prospective and Retrospective Utilization Review Determinations


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

Licensure and Compensation Requirements

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

Initial Determinations-Prospective Review (Pretreatment Estimate)

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

Prospective Adverse Review-Notification Requirements

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

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

The notification of a prospective Adverse Determination shall contain:

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

Retrospective Adverse Review-Guideline Requirements

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

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

Retrospective Adverse Review-Notification Requirements

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

Notice of a retrospective Adverse Determination will:

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

Adverse Determinations-Urgent Care Claims (Expedited Dental Review)

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

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

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

Grievance Review of Adverse Determinations

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

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

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

Expedited Dental Review

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

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

Grievance Procedure

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

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

New Reviewer Requirement

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

Notification of Decision of Grievance

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

In addition, the notice shall contain the following:

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

Notification of Right to External Review

Availability of External Review

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

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

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

External Appeal-Effect

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

Recovery of Overpayments

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

An overpayment occurs if it is determined that:

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

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

How We Recover Overpayments

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

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

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

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.
NOTICE FOR RESIDENTS OF ARKANSAS

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

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

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202
NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904
1-866-832-5756

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

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

WEBSITE: http://www.insurance.ca.gov/
1-800-927-4357 (within California)
1-213-897-8921 (outside California)
NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

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

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

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

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.
NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov
IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767
NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-866-832-5756

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

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

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

Complaint can be filed electronically at www.in.gov/doi
NOTICE FOR RESIDENTS OF MAINE

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

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

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

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

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

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

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

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

To continue Dental insurance under this provision:

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

The request form will be furnished by the Employer.

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

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

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

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

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

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

- the covered person is a Child under the age of 13 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition; or
- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or
- We determine such anesthesia is necessary in accordance with generally accepted dental standards.
Consumer Complaint Notice

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

CIVIL UNIONS
The New Jersey Civil Union Act grants Civil Union partners the same benefits, protections and responsibilities that flow from marriage under New Jersey state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to Civil Union Partners. For example, a federal law, controls group health insurance continuation rights under 'COBRA' for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, Civil Union Partners and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.
NOTICE FOR RESIDENTS OF NEW MEXICO

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

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

“Oral surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ) and craniomandibular disorder. This includes cone beam imaging, but cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period.”
NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

- the insurance has been continued for a period of time equal to the duration of the child’s service on active duty; or
- the child is no longer a full-time student.
Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

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

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

The basic protections provided by the Association are:

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

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

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

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

Utah Life and Health Insurance Guaranty Assoc.  Utah Insurance Department
60 East South Temple, Suite 500  3110 State Office Building
Salt Lake City UT 84111  Salt Lake City UT 84114-6901
(801) 320-9955  (801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

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

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

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

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

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

Claim Submission

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

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

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

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

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

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

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

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

Policies and Procedures for Emergency and Urgent Care

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

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

The benefit amount will be consistent with the terms contained in the insured’s contract.
Urgent Care Submission:

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

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

Washington law provides that the following apply to Your certificate:

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

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

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

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-866-832-5756

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

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

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

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

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<td>Orthodontic Covered Services</td>
<td>50%</td>
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Deductibles for:

- Yearly Individual Deductible: $50 for the following Covered Services Combined: Type B; Type C; $50 for the following Covered Services Combined: Type B; Type C
- Yearly Family Deductible: $150 for the following Covered Services Combined: Type B; Type C; $150 for the following Covered Services Combined: Type B; Type C

Maximum Benefit:

- Yearly Individual Maximum: $2,000 for the following Covered Services: Type A; Type B; Type C; $1,500 for the following Covered Services: Type A; Type B; Type C
- Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services: $2,000; $1,500

NOTE: The In-Network Maximum Benefit Amount and the Out-of-Network Maximum Benefit Amounts are combined. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.
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.

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "relative," "survivor", "immediate family", and any other such terms include the relationship created by a Civil Union as described under the New Jersey Civil Union Act.

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

Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "relative", "survivor", and any other such terms include family relationships created by a Civil Union. For example, the term "stepchild" includes the child of a Civil Union Partner.

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

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

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

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

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

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

The definition of Child includes newborns.

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

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

The term includes an unmarried newly eligible employee’s child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law, and has been so handicap continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after the date the Child becomes eligible for insurance and at reasonable intervals after such date.

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

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.
Civil Union means the legally recognized union of two individuals of the same sex entered into New Jersey pursuant to the New Jersey Civil Union Act. It also includes a same-sex relationship entered into outside of New Jersey which is valid under the laws of the jurisdiction under which the same-sex relationship is created.

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

Contributory Insurance includes: Dental Insurance.

Covered Percentage means:

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

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

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

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

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

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

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

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

Full-Time means Active Work on the Policyholder's regular work schedule for bi-weekly or monthly-paid employees as follows:

- If You are regularly scheduled to work at least 36.25 hours per week, You must work a minimum of 18.25 hours per week for 4.5 months or longer within an academic year; or
- If You are regularly scheduled to work at least 40 hours per week, You must work a minimum of 20 hours per week for 4.5 months or longer within an academic year.

If You are a post-doctoral research fellow, any amount of duty time will be deemed Full-Time.

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

Maximum Allowed Charge means the lesser of:

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

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

Physician means:

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

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

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

Proof must be provided at the claimant’s expense.
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 by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the ‘Usual Charge’); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 80th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife’s Reasonable and Customary Charge records (the ‘Customary Charge’). Where MetLife determines that there is inadequate charge information maintained in MetLife’s Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

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

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

Spouse means Your lawful spouse or Civil Union Partner.

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

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

We, Us and Our mean MetLife.

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

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

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

ELIGIBLE CLASS(ES)

All Full-Time faculty employees, staff employees and post-doctoral fellows of the Policyholder except those residing in Massachusetts, Montana and Texas.

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 July 1, 2020, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after July 1, 2020, You will be eligible for insurance on the first day of the month coincident with or next following the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

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

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

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

Enrollment During an Annual Enrollment Period

Enrollment periods for dental insurance occur once every two years. During any subsequent enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. Otherwise the changes to Your insurance made during a subsequent enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, insurance will take effect on the date You resume Active Work.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event for birth, adoption or placement for adoption of a dependent child, You will have 90 days from the date of that change to make a request. For all other Qualifying Events, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the calendar month coincident with or next following the date of the Qualifying Event, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage; or
  3. COBRA Continuation of the other group coverage was exhausted; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

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

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

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time faculty employees, staff employees and post-doctoral fellows of the Policyholder except those residing in Massachusetts, Montana and Texas.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

If You are in an eligible class on July 1, 2020, You will be eligible for Dependent insurance on the later of:
1. the first day of the month following the date You enter a class eligible for insurance;
2. the date You obtain a Dependent.

If You enter an eligible class after July 1, 2020, You will be eligible for Dependent insurance on the later of:
1. the first day of the month coincident with or next following the date You enter a class eligible for insurance; and
2. the date You obtain a Dependent.

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

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

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

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

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

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

Enrollment periods for dental insurance occur once every two years. During any subsequent enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. Otherwise the changes to Your Dependent Insurance made during a subsequent enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event for birth, adoption or placement for adoption of a dependent child, You will have 90 days from the date of that change to make a request. For all other Qualifying Events, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the calendar month coincident with or next following the date of the Qualifying Event, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
  1. loss of eligibility for the other group coverage;
  2. termination of employer contributions for the other group coverage;
  3. COBRA Continuation of the other group coverage was exhausted; or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

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

AT THE POLICYHOLDER’S OPTION

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

Insurance will continue for the following periods:

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

The Policyholder’s general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

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

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

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

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

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

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

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

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

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

You can obtain a customized listing of MetLife’s In-Network Dentists either by calling 1-866-832-5756 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

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

In-Network

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

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

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

Out-of-Network

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

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

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

If you cannot reasonably reach an In-Network Dentist, benefits for an Emergency Dental Condition performed by an Out-of-Network Dentist will be paid as if the Covered Service had been performed by an In-Network Dentist. You must confirm to us in writing that the Covered Service was obtained from an Out-of-Network Dentist solely because you required treatment for an Emergency Dental Condition and an In-Network Dentist was not available.

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

The Yearly Individual Deductible is the amount that you must pay for Covered Services to which such Deductible applies each Year before we will pay benefits for such Covered Services.

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

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

Alternate Benefit

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

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

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we may base our benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, we may base our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, we may base our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, we may base our benefit determination upon the partial denture which is the less costly service.
If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

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

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed 20% of the amount charged by the Dentist when the course of treatment begins.

The benefit payable for the periodic follow-up visits will also be based on the amount charged by the Dentist when the course of treatment begins. It will be payable on a quarterly basis during the course of the orthodontic treatment if:

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

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

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

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

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

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $350.00, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

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

We will pay benefits for a 90 day period after Your insurance ends if:

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

If You are Fully Disabled on the date Your Dental Insurance ends because this policy ends, We will pay benefits for Covered Services if:

- the Covered Service was recommended in Writing by a Dentist or Physician;
- the Covered Service was begun prior to the date Your Dental Insurance ended;
- the Covered Service was performed within 90 days after this Dental Insurance ends.

"Fully Disabled" for purposes of Dental Insurance means that because of a sickness or injury: You can not do Your job; or a Dependent can not do his or her usual activities.
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 3 Years.
5. Bitewing x-rays 1 set in a Year.
6. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
7. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
8. Diagnostic casts.
9. 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.
10. Topical fluoride treatment for a Child under age 16 once in a Year.
11. Space maintainers for a Child under age 26 once per lifetime per tooth area.
12. Sealants or sealant repairs for a Child under age 16 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.
13. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 3 Years.
14. Interim caries arresting medicament application applied to permanent bicuspsids and 1st and 2nd molar teeth, once per tooth every 3 Years.

Type B Covered Services

1. Intraoral-periapical x-rays.
2. X-rays, except as mentioned elsewhere.
3. Emergency palliative treatment to relieve tooth pain.
4. Amalgam fillings.
5. Resin-based composite fillings.
6. Protective (sedative) fillings.
7. Oral surgery, except as mentioned elsewhere in this certificate.
8. 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.
9. Other consultations, but not more than once in a 12 month period.
10. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.
11. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
12. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
13. Full mouth debridements.
14. Periodontal surgery, including gingivectomy, gingivoplasty, but no more than one surgical procedure per quadrant in any 3 year period.
15. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.

16. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.

17. Pulp therapy.

18. Apexification/recalcification.

19. Pulpal regeneration, but not more than once per lifetime.

20. Injections of therapeutic drugs.

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

22. Prefabricated crown, but no more than one replacement for the same tooth within 60 consecutive months.

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

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

25. Bone replacement and graft for ridge preservation, but no more than once in a lifetime.

26. Pin retention once in 60 months.

Type C Covered Services

1. Pulp capping (excluding final restoration).

2. Therapeutic pulpotomy (excluding final restoration).

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

4. 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.

5. 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.

6. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 60 months prior to replacement.

7. Replacement of a non-serviceable removable Denture if such Denture was installed more than 60 months prior to replacement.

8. 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.

9. Relinings and rebasings of existing removable Dentures:
   - if at least 6 months have passed since the installation of the existing removable Denture; and
   - not more than once in any 36 month period.

10. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.

11. Initial installation of Cast Restorations (except implant supported Cast Restorations).

12. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 60 months 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.
13. Core buildup, but no more than once per tooth in a period of 60 months.
14. Posts and cores, but no more than once per tooth in a period of 60 months.
15. Labial veneers, but no more than once per tooth in a period of 60 months.
16. Fixed and removable appliances for correction of harmful habits.
17. Periodontal surgery, including osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
18. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
19. Implant services (including sinus augmentation), but no more than once for the same tooth position in a 60 month 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.
20. Repair of implants, but no more than once in a 12 month period.
21. Implant supported Cast Restorations, but no more than once for the same tooth position in a 60 month 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.
22. Implant supported fixed Dentures, but no more than once for the same tooth position in a 60 month 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.
23. Implant supported removable Dentures, but no more than once for the same tooth position in a 60 month 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.
24. Tissue conditioning, but not more than once in a 36 month period.
25. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
26. Cleaning and inspection of a removable appliance twice in a Year.
27. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
28. Repair/reline and adjustments of occlusal guards and night guards, 1 in a lifetime.

Orthodontic Covered Services

Orthodontia for You, Your Spouse or Civil Union Partner 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, unless required for the treatment or correction of a congenital defect or birth anomaly;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
   - covered under any workers' compensation or occupational disease law;
   - covered under any employer liability law;
   - for which the Employer of the person receiving such services is required to pay; or
   - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
   - claim form completion;
   - infection control, such as gloves, masks, and sterilization of supplies; or
   - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. local chemotherapeutic agents;
24. modification of removable prosthodontic and other removable prosthetic services;
25. initial installation of a Denture or implant or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
26. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
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. intra and extraoral photographic images.
DENTAL INSURANCE: COORDINATION OF BENEFITS

You or Your Dependent may be covered for health benefits or services by more than one Plan. For instance, You may be covered by this Policy as an employee and by another Plan as a Dependent of Your spouse or civil union partner. If You or Your Dependent is, this provision allows Us to coordinate what We pay with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the covered person is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

“Allowable Expense” means the charge for any dental service, supply or other item of expense for which the covered person is liable when the dental service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

“Claim Determination Period” means a calendar Year, or portion of a calendar Year, during which You or Your Dependent is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

“Plan” means coverage with which coordination of benefits is allowed. Plan includes:

- group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice Plans, including insurance continued pursuant to a Federal or State continuation law;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or nongovernmental Plan.

Plan does not include:

- individual or family insurance contracts or subscriber contracts;
- individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice Plans;
- group or group-type coverage where the cost of coverage is paid solely by the covered person except when coverage is being continued pursuant to a Federal or State continuation law;
- school accident -- type coverage
- a State Plan under Medicaid

“Primary Plan” means a Plan whose benefits for a covered person's dental coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "1" or "2" below exist:

1. the Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
2. all Plans which cover the covered person use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the Plan determines its benefits first.
"Reasonable and Customary" means, for the purposes of this Coordination of Benefits provision only, an amount that is not more than the usual or customary charge for the service or supply as determined by the Plan, based on a standard which is most often charged for a given service by a Dentist within the same geographic area.

"Secondary Plan" means a Plan which is not a Primary Plan. If a covered person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

**Primary And Secondary Plan**

We consider each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan (s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

As is always true, we will not reduce Allowable Expenses for dentally necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

**Rules For The Order Of Benefit Determination**

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the covered person as a dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

1. The benefits of the Plan that covers the covered person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the covered person as a laid off or retired employee, or as such a person's dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

2. The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the Plan that covers the covered person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

3. If a child is covered as a dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:
   a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
   b. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
   c. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
   d. If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.
4. If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
   a. The benefits of the Plan of the parent with custody of the child shall be determined first.
   b. The benefits of the Plan of the spouse or civil union partner of the parent with custody shall be determined second.
   c. The benefits of the Plan of the parent without custody shall be determined last.
   d. If the terms of a court decree state that one of the parents is responsible for the dental expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding dental expenses, this portion of this provision shall be ignored.

5. If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

**Procedures to be Followed by the Secondary Plan to Calculate Benefits**

In order to determine which procedure to follow, it is necessary to consider:

- the basis on which the Primary Plan and the Secondary Plan pay benefits; and
- whether the Dentist who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan. For the purpose of applying the following provisions, if the Plan does not have a network, the Dentist will be considered on the same basis as an in-network Dentist.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Dentist bills a charge and the covered person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Dentist, called a network Dentist, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the covered person uses the services of a non-network Dentist, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the Dentist may be based on a capitation. This means that the health maintenance organization (HMO) pays the Dentist a fixed amount per covered person. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of a non-network Dentist, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays Dentists based upon capitation is called a "Capitation Plan."

In the rules below, "Dentist" refers to the Dentist who provides or arranges the services or supplies and HMO refers to a health maintenance organization Plan.

**The Primary Plan is an R&C Plan and the Secondary Plan is an R&C Plan:** The Secondary Plan shall pay the lesser of:

- the difference between the amount of the billed charges and the amount paid by the Primary Plan; and
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.
DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is a Fee Schedule Plan: If the Dentist is a network Dentist in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Dentist receives from the Primary Plan, the Secondary Plan and the covered person shall not exceed the fee schedule of the Primary Plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

The Primary Plan is an R&C Plan and the Secondary Plan is a Fee Schedule Plan: If the Dentist is a network Dentist in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The covered person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the covered person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the Dentist's billed charges. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is an R&C Plan: If the Dentist is a network Dentist in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is an R&C Plan or Fee Schedule Plan: If the Primary Plan is an HMO Plan that does not allow for the use of non-network Dentists except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network Dentist is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

The Primary Plan is a Capitation Plan and the Secondary Plan is a Fee Schedule Plan or R&C Plan: If the covered person receives services or supplies from a Dentist who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

- a) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.
Facility Of Payment

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

Right Of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, We may recover the excess from one or more of:

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

The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.
FILING A CLAIM

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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-866-832-5756. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

Step 1
A claimant can request a claim form by calling Us at 1-866-832-5756 within 20 days of the date of the loss.

Step 2
We will send a claim form to the claimant within 15 days of the request. The person making such claim shall be deemed to have complied with the requirements of the policy as to Proof of loss upon submitting within the time fixed in the policy for filing Proof of loss, written Proof covering the occurrence, character and extent of the loss for which claim is made. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

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

However, failure to give notice and Proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such and notice and Proof and that notice and Proof was given as soon as was reasonably possible.

Time Limit on Legal Actions for Dental Insurance. 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.
Procedures for Presenting Claims for Dental Insurance Benefits

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.

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.

Under New Jersey law, we must require that Dentists file all claims for dental services, but You are permitted, at Your option to submit a claim on behalf of yourself or Your Dependent. Under New Jersey law, all claims shall be filed using the standard dental claim form applicable to this policy.

Acknowledgement of Receipt of Claims

We shall acknowledge receipt of all claims and include the date We received the claim.

If a claim is submitted by electronic means, an “Electronic Claim”, the claim shall be acknowledged electronically no later than two working days following Our receipt of the claim. The acknowledgement of receipt shall go to the entity from which or from whom We received the claim.

If a claim is submitted by written notice, a “written claim”, the claim shall be acknowledged no later than 15 working days following Our receipt of the claim.

If We pay benefits on the claim within two days of Our receipt of an Electronic Claim or within 15 days of Our receipt of a Written Claim, the payment shall include the date of our receipt of the claim and the payment shall be deemed to be the acknowledgement of Our receipt of the claim.

When Dentists are offered web-based access to the status of claims, the available information shall include the date of Our receipt of the claims. If provided on a timely basis under the time frames described above, such information shall be deemed to be the acknowledgement of Our receipt of the claim.

When Dentists are provided access to claims status via an automated telephone system and the available information includes the date of Our receipt of the claims and that information is made available on a timely basis under the time frames described above, the posting of that information shall be deemed to be the acknowledgement of receipt of those claims.

Claim Submission Requirements

We shall notify Participating Dentists at least annually and shall make available to You or Your Dependent upon request, a listing of the type of information and documentation that must be submitted with an Electronic Claim or a Written Claim, including a standard claim form and any other claim submission requirements. We may change the required information and documentation as long as Participating Dentists are given at least 30 days prior notice of the change in requirements. We shall also provide Participating Dentists with a street address where a claim submission can be delivered by hand or registered/certified mail.

Prompt payment of claims

A Clean Claim is a claim:

- which is an eligible claim for a Covered Service provided by a Dentist to a covered person under the policy;
- which has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- on which there is no dispute regarding the amount claimed;
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

- which We have no reason to believe that the claim has been submitted fraudulently; and
- which requires no special treatment that prevents timely payments from being made on the claim under the terms of the policy.

We shall pay benefits for Clean Electronic Claims within the earlier of:

- 30 calendar days after receipt of the claim or
- the time established for the Federal Medicare program.

We shall pay benefits for Electronic Claims that are disputed or denied because of missing information or documentation within 30 calendar days of receipt of the missing information or documentation.

We shall pay benefits for Clean Written Claims within 40 calendar days after Our receipt of the claim.

We shall pay benefits for Written Claims that are disputed or denied because of missing information or documentation within 40 calendar days of receipt of the missing information or documentation.

Payment of a claim shall be considered to have been made:

- on the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or
- on the date of delivery of a draft or other valid instrument equivalent to payment.

Denied and disputed claims

If only a portion of a claim is disputed or denied, We shall pay benefits for the uncontested portion on the same basis as for a clean claim. The pending of a claim does not constitute a dispute or denial.

For a denied or disputed claim, within 30 or 40 calendar days of Our receipt of the claim, whichever applies, We shall notify You or the Dentist, as appropriate, of the basis for Our decision to deny or dispute the claim. This notice will identify and explain all reasons why the claim was denied or disputed. If a claim is denied because it cannot be entered into the claims system, then the notice will include all reasons why the claim cannot be entered into the claims systems. Examples of reasons why a claim cannot be entered into the claims system include:

- the group is not covered on the date of service;
- You or Your dependent are not covered on the date of service;
- non-payment of premium;
- missing data fields;
- missing or incorrect data (for example, CDT code, date of service, Dentist name); and
- ineligible provider.

If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, Our first review after the claim is entered shall identify all applicable reasons why the claim is being denied or disputed.

We shall deny or dispute a claim only for:

- reasons identified in the first review after the claim is entered; or
- additional reasons which We were led to by information or documentation relevant to the claim where such information or documentation was received after the first review.
Where missing information or documentation is a reason to deny or dispute the claim, within 30 or 40 calendar days of Our receipt of the claim, whichever applies, We shall notify You or the Dentist, as appropriate, of the basis for Our decision to deny or dispute the claim. Such notice shall also specify the additional information or documentation that is required.

If the amount of the claim is disputed, the notice will include an explanation of the reason for the dispute, including any change of coding performed by Us and the reasons for such change of coding. The notice will also include a toll free telephone number for the Dentist or claimant to call to discuss the claim with Us.

Under New Jersey law, if We do not provide the notice required above We waive our right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with Our Fraud Prevention and Detection Plan.

If We fail to pay a clean claim within the time limits set forth above, We shall include simple interest on the claim amount at the rate of 12 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by Us. We may aggregate interest amounts up to $25.00, with the consent of the Dentist.

If We have reason to believe that the claim has been submitted fraudulently, We shall investigate the claim in accordance with Our fraud prevention plan established under New Jersey law or refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

Unless otherwise provided by law, We shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by Us or the date of the performance by You or the Dentist of any conditions to payment set forth in the agreement, whichever is later.

We shall adjust claims previously paid only on the basis of actual identifiable error(s) in the submission, processing or payment of a particular claim(s). We shall not adjust previously paid claims based on extrapolation, with the following exceptions:

- Where the extrapolation, including the method, is non-binding;
- In judicial or quasi-judicial proceedings, including arbitration;
- In governmental administrative proceedings;
- Where relevant records required to be maintained by the Dentist have been improperly altered or reconstructed, or a material number of such records are unavailable; or
- Where there is clear evidence of claim fraud or abuse by the Dentist.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-866-832-5756.

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.
DENTAL INSURANCE: GRIEVANCE PROCEDURES

The following is a description of the MetLife Preferred Dentist Program’s Grievance procedures that will apply in the event You wish to submit a Grievance regarding an adverse experience that may have occurred.

DEFINITIONS

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

Grievance means any verbal or written communication from You regarding an adverse experience or outcome related to an interaction with Our personnel or an encounter with a Dentist.

Explanation of Benefits means the written explanation of how dental benefits are paid after a claim has been submitted for benefits under this Dental Insurance.

Grievance Review Committee means a committee which operates within the Preferred Dentist Program, and consists of dental management personnel. The Grievance Review Committee is chaired by the National Dental Director.

SUBMISSION OF A GRIEVANCE

You can file a Grievance by:

- contacting the customer service unit at the telephone number shown on the Explanation of Benefits; or
- writing to the customer service unit at the address shown on the Explanation of Benefits.

A customer service representative will research the Grievance and, when possible, resolve it by telephone to Your satisfaction within three working days of the receipt of the Grievance.

If the Grievance is not so resolved, the customer service representative will forward the Grievance to the appropriate unit of MetLife to address the issue. Examples of these units are:

- provider relation unit for network issues;
- claim department or dental product area for claim review issues; and
- claim department or account management for claim determination issues.

The appropriate unit will advise You and the customer service representative, in writing, of its review and any actions it has taken within 15 working days of receipt of the Grievance from the customer service representative. The appropriate unit may also, within the 15 working days, request added time to more fully consider the Grievance.

If the Grievance is not resolved to Your satisfaction, You can appeal the action of the particular unit to the Grievance Review Committee within 30 working days of the date You were notified of their decision. You will be given the information needed to make such an appeal at the time You are notified of the particular unit’s decision.

The Grievance Review Committee will advise You and the customer service representative, in writing, of its review of the appeal and any actions it has taken on the appeal within 15 working days of receipt of the appeal from You. The Grievance Review Committee may also, within the 15 working days, request added time to more fully consider the Grievance.

Action of the Grievance Review Committee will be considered final.
ADDITIONAL ADDRESSES AND PHONE NUMBERS

MetLife Corporate Customer Relations
P.O. Box 789
Johnstown PA 15904
Telephone: 1-814-269-8371

New Jersey Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360
Telephone: 1-877-222-3737

New Jersey Department of Banking
Division of Insurance
Consumer Protection Services
P.O. Box 329
Trenton NJ 08625-0329
Telephone: 1-800-446-7467 (if calling from New Jersey) or 1-609-292-5316 (if calling from outside New Jersey)
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, attached to the Group Policy; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.
THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.
Our Privacy Notice

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

1. Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, “you” refers to these individuals.

2. Protecting Your Information

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

3. Collecting Your Information

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

4. How We Get Your Information

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

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

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

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

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

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

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

5. Using Your Information

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

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

6. Sharing Your Information With Others

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

Other reasons we may share your information include:

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

7. HIPAA

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

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

8. Accessing and Correcting Your Information

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

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

9. Questions

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

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

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.
THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE TRUSTEES OF PRINCETON UNIVERSITY DENTAL INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Trustees of Princeton University
Office of Human Resources
2 New South Building
Princeton, NJ 08544
(609) 258-6075

EMPLOYER IDENTIFICATION NUMBER: 21-0634501

<table>
<thead>
<tr>
<th>PLAN NUMBER</th>
<th>COVERAGE</th>
<th>PLAN NAME</th>
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<tbody>
<tr>
<td>603</td>
<td>Dental Insurance</td>
<td>Health Care Plans</td>
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TYPE OF ADMINISTRATION

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

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

PLAN TERMINATION OR CHANGES

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

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

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

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

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

Premium rates are set by MetLife.

PLAN YEAR

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-866-832-5756.

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to you within a 30 day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.
If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

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

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

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

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

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

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

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

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

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

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

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

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

COBRA is a federal law that requires most group health plans to give their employees and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Plan for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Plan for up to 36 months. Also, your covered children may be able to continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan. Group health plans for employers with fewer than 20 employees, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.
This continuation will terminate on the earliest of:

a. the end of the 18, 29 or 36 month continuation period, as the case may be;

b. the date of expiration of the last period for which the required payment was made;

c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent’s preexisting condition;

d. the date your employer ceases to provide any group health plan for its employees.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Plan. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Employer within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Employee does not make that election. However, covered Employees may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

**Qualifying Event Due To Bankruptcy Of Employer**

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under This Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s covered spouse and covered dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under This Plan.

**If You Elect COBRA**

If you choose COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active Employees, spouses or dependent children. This means that if the coverage for similarly situated Employees, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.
Duration Of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Employee’s termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

Disability. If any person entitled to COBRA coverage (the covered Employee, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Employee, covered spouse or covered dependent child must notify the Employer’s COBRA Administrator within 60 days of the latest of: (1) the Social Security Administration’s determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Employee’s coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration’s determination must be provided to the COBRA Administrator. If these procedures are not followed, there will be no disability extension of COBRA.

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or
- The last day of the 29th month of total coverage.

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

Subsequent Qualifying Events. If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Employee and the spouse divorce, the covered Employee dies, the covered Employee becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Plan, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Employer’s COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.
Premiums For COBRA Coverage

A person entitled to COBRA coverage is entirely responsible for paying the premiums for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

Initial Premium Payment

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

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Dental Plan Insurance

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

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

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

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

Assistance with Your Questions

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

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means Trustees of Princeton University.

The term "Plan Administrator" means Trustees of Princeton University.
I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
• If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

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

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

  - Office of Human Resources
  - Office of Risk Management

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

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

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

**IV. Participants Rights**

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

**V. Privacy Complaints/Issues**

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

**VI. Security**

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

• Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
• Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;

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

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

FUTURE OF THE PLAN

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

The Board of Directors of Trustees of Princeton University shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.
Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) while you have dental insurance coverage under your employer’s group dental insurance policy pursuant to USERRA. Contact your employer for more information.
The following addenda apply to residents of New Hampshire.
NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

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

Patient's Bill of Rights

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

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

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

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

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

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

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

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

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
X. The patient shall be ensured confidential treatment of all information contained in the patient’s personal and clinical record, including that stored in an automatic data bank, and the patient’s written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient’s medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

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

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

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

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

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

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient’s sexual orientation.

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

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

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

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

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

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

CONTINUATION OF DENTAL INSURANCE ON YOU

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

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

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

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

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

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

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

To continue Your Dental Insurance, You must, within 45 days after the date of the notice:

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

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

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

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the Policyholder files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date You cease to be a member of an eligible class; or
- 18 months in all other cases.

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

- the end of the maximum continuation period;
- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- if You are eligible for Medicare, the date of the first Medicare open enrollment period following the date You become ineligible for continued coverage under the Policyholder’s plan;
- the date You become eligible for coverage under any other group dental coverage; or
- if You do not pay the required premium to continue Your Dental Insurance. If You do not pay the required premium, You will be given a 31 day grace period before Your Dental Insurance terminates. You will be provided with a notice within 15 days of the date of termination that Your Dental Insurance will be cancelled if the required premium is not paid.
CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS

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

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

Notices

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

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

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

Premium Contributions

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

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

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

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

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

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

• fails to provide any required notification; or
• fails to request to continue Dental Insurance on Your Dependents and pay the first premium within the time limits stated in this section.
NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Divorce Decree or Legal Separation Decree

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

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

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

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

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

(3) The date of Your remarriage;

(4) Your death; or

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

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

Maximum Continuation Period

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

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

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

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

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Maximum Continuation Period (Continued)

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

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

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

- 18 months in all other cases.

Cessation of Dental Insurance on Your Dependents

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

- the end of the maximum continuation period;

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

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

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

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

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

What are the eligibility requirements for External Appeal?
To be eligible for External Appeal the following conditions must be met:

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

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

Can someone else represent me in my External Appeal?
Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled “Appointment of Authorized Representative.”

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

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

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

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

Expedited External Review Applications
- May be faxed to (603)-271-1406, or
- Sent by overnight carrier to the Department’s mailing address.
What is the Standard External Appeal Process and Time Frame for receiving a Decision?
It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

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

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

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer’s Expedited Internal Appeal.
What happens when the Independent Review Organization makes its decision?

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

Have a question or need assistance?

Staff at the Insurance Department is available to help. Call 800-852-3416 to speak with a consumer services officer.
INDEPENDENT EXTERNAL REVIEW
Appealing a Denied Medical or Dental Claim

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

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

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

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

For more information about external reviews, see the Insurance Department’s Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?
Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.
SUBMITTING A REQUEST FOR EXTERNAL REVIEW

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

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

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

Mailing Address:

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

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

Patient’s Name: __________________________ Patient’s Date of Birth: ________________

Applicant’s Name: ________________________ Applicant’s Email: ____________________

Applicant’s Mailing Address: ____________________________________________________________________________________________

City: __________________________ State: __________ Zip Code: __________

Applicant’s Phone Number(s): Daytime: (____) __________ Evening: (____) __________

Section II – Appointment of Authorized Representative

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

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

I hereby authorize ________________________________ to pursue my appeal on my behalf.

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

Representative’s Mailing Address: ____________________________________________________________________________________________

City: __________________________ State: __________ Zip Code: __________

Representative’s Phone Number(s): Daytime: (____) __________ Evening: (____) __________
Section III - Insurance Plan Information

Member’s Name: __________________________ Relationship to Patient: __________________
Member’s Insurance ID #: __________________ Claim/Reference #: __________________
Health Insurance Company’s Name: __________________________
Insurance Company’s Mailing Address: __________________________
City: __________________________ State: _____ Zip Code: ______
Insurance Company’s Phone Number: (___) __________________________
Name of Insurance Company representative handling appeal: __________________________

Is the member’s insurance plan provided by an employer? Yes ___ No ___
• Name of employer: __________________________
• Employer’s Phone Number: (___) __________________________
• Is the employer’s insurance plan self-funded? Yes* ___ No ___
  * If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.

New Hampshire Premium Assistance Program

Is the patient’s health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services? Yes___ No ___

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: __________________________

I, __________________________, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.
Section IV – Information about the Patient’s Health Care Providers

Name of Primary Care Provider (PCP): __________________________

PCP’s Mailing Address: ________________________________________

  City: ___________________ State: ______ Zip Code: ______

PCP’s Phone Number: (___) ____________

Name of Treating Health Care Provider: __________________________

Provider’s clinical specialty: ____________________________________

Treating Provider’s Mailing Address: _____________________________

  City: _________________ State: _____ Zip Code: ______

Treating Provider’s Phone Number: (___) ____________

Section V – Health Care Decision in Dispute

Describe the health insurer company’s decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:
• Additional pages, if necessary;
• Pertinent medical records;
• If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

Continued on next page
Section VI – Expedited Review

**Complete this section, only if you would like to request expedited review**

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function.

Do you request an expedited review? Yes ___ No ___

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.
Section VII – Request for a Telephone Conference

**Complete this section, only if you would like to request a telephone conference**

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select “Yes” below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**Telephone conferences often cannot be completed within the timeframe for expedited reviews**

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
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____________________________________________________________________________________
____________________________________________________________________________________
VIII – Authorization and Release of Medical Records

I, ______________________________, hereby request an external review and authorize the patient’s insurance company and the patient’s health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer’s denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient’s health care plan. This release is valid for one year.

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

Before submitting this application, please verify that you have ...

☐ Completed all relevant sections of the External Review Application Form
  • If appointing an authorized representative, the patient must complete Section II.
  • If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
  • If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
  • A photocopy of the front and back of the patient’s insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
  • A copy of the Health Insurance Company’s letter, denying the requested treatment or service at the final level of the company’s internal appeals process.
  • Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
  • If requesting an Expedited External Review, the treating Provider’s Certification Form.
The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261  Fax: (603) 271-1406  TDD Access Relay NH: 1-800-735-2964

PROVIDER’S CERTIFICATION FORM
For Expedited Consideration of a Patient’s External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, only if the patient’s treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function. The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

** Expedited External Review is not available, when services have already been rendered **

GENERAL INFORMATION

Name of Treating Health Care Provider: ________________________________

Mailing Address: ____________________________________________________

City: __________________ State: ______ Zip Code: ________________

Phone Number: (____)_________________ Fax Number: (____)____________

Email Address: ______________________________________________________

Licensure and Area of Clinical Specialty: ________________________________

Name of Patient: ____________________________________________________

______________________________________________________________
PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for ____________________________
(hereafter referred to as "the patient"); that adherence to the time frame for conducting a
standard review of the patient’s external review would, in my professional judgment, seriously
jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain
maximum function; and that for this reason, the patient’s appeal of the denial by the patient’s
health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during
non-business hours for medical information and that a decision will be made by the IRO within
72 hours of receiving this Expedited External Review request, regardless of whether or not I
provide medical information to the IRO.

During non-business hours I may be reached at: (____) ________________________________

I certify that the above information is true and correct. I understand that I may be subject to
professional disciplinary action for making false statements.

Treating Health Care Provider’s Name (Please Print)

__________________________  __________________________
Signature                           Date