YOUR BENEFIT PLAN

University of Maryland Baltimore

All Students enrolled in the 12-Month Dental Plan

Dental Insurance for You and Your Dependents

Certificate Date: August 1, 2024

University of Maryland Baltimore
620 W Lexington St
Baltimore, MD 21201

TO OUR STUDENTS:

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.

University of Maryland Baltimore

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

CERTIFICATE RIDER

Group Policy No.: 260578-1-G

Policyholder: University of Maryland Baltimore

Effective Date: August 1, 2024

The Group Dental Insurance Certificate is changed as follows:

To add the following definition of Child to the certificate:

Child means the following:

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

The definition of Child includes newborns.

The definition of Child includes a child for whom You or Your Spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance.

The definition of Child includes grandchildren, under the limiting age, who are unmarried, reside with and are principally supported by You, and are in Your court ordered custody.

The definition of Child includes a child who resides with and is principally supported by You and is under Your testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration.

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.

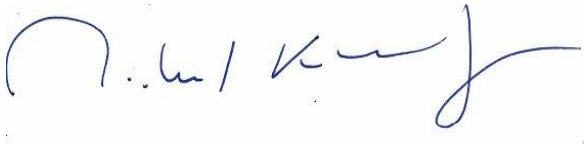
If You provide Us notice, a Child also includes a child for whom You must provide Dental Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term includes a Student's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled 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 disability 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 a Student.

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



Michel Khalaf
President

Metropolitan Life Insurance Company
New York, New York

CERTIFICATE RIDER

Group Policy No.: 260578-1-G

Policyholder: University of Maryland Baltimore

Effective Date: August 1, 2024

The certificate is changed as shown below:

The definition of Domestic Partner is added as follows:

Domestic Partner means each of two people, one of whom is a Student of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

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

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

Michel Khalaf
President

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

CERTIFICATE RIDER

Group Policy No.: 260578-1-G

Policyholder: University of Maryland Baltimore

Effective Date: August 01, 2024

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this certificate rider to the Dental Insurance certificate under the above policy in order to add the following provision:

By replacing the definition of Maximum Allowed Charge of the section entitled DEFINITIONS with the following wording:

Maximum Allowed Charge means:

1. with respect to In-Network Dentists, the lesser of:

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

2. with respect to Out-of-Network Dentists, the lesser of:

    a. the amount charged by the Out-of-Network Dentist; or
    b. the amount paid to an In-Network Dentist for the geographic region where the dental service is performed.

Michel Khalaf, President

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

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

CERTIFICATE OF INSURANCE

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

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

Policyholder:	University of Maryland Baltimore
Group Policy Number:	260578-1-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s):	
For Claim Information	FOR DENTAL CLAIMS: 1-800-438-6388

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.
- In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance On You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Orthodontic Covered Services	50%	50%
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	$2,000 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$1,500	$1,500

DEFINITIONS

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

Administrator means HUB International.

Cast Restoration means an inlay, onlay, or crown.

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

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 the percentage of the Maximum Allowed Charge that We will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist 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 a specified dollar amount You or Your Dependents must pay the Dentist or other provider for Covered Services as described in the SCHEDULE OF BENEFITS.

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 service is performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

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

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

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

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

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

DEFINITIONS (continued)

Maximum Allowed Charge - For the Maximum Allowed Charge definition, please refer to the rider in the front of this certificate.

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 the service is performed and must act within the scope of that license. Such person 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.

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

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

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

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

Student means a student enrolled at the University of Maryland Baltimore who is eligible for the insurance described in this certificate.

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 August 1.

You and **Your** mean a Student who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Students enrolled in the 12-month Dental Plan.

This certificate describes the 12-month plan option under the Policyholder's plan of Dental Insurance. You may be eligible for a different option under another certificate of the Group Policy. You may not be enrolled for Dental Insurance under more than one certificate of the Group Policy.

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 August 1, 2024, You will be eligible for the insurance described in this certificate on that date.

If You are in an eligible class after August 1, 2024, You will be eligible for the insurance described in this certificate on that date.

ENROLLMENT PROCESS

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 will be notified how much You will be required to contribute.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Contributory Insurance

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

- the date You become eligible for such insurance; and
- the date You enroll.

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance if You have a Qualifying Event.

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

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; 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; or
5. the date You cease to be a Student.

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 Students enrolled in the 12-month Dental Plan.

This certificate describes the 12-month plan option under the Policyholder's plan of Dental Insurance. You may be eligible for a different option under another certificate of the Group Policy. You may not be enrolled for Dental Insurance under more than one certificate of the Group Policy.

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 August 1, 2024, You will be eligible for Dependent insurance on the later of:

1. August 1, 2024; and
2. the date You obtain a Dependent.

If You enter an eligible class after August 1, 2024, You will be eligible for Dependent insurance on the later of:

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

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

ENROLLMENT PROCESS FOR DEPENDENT COVERAGE

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 will be notified how much You will be required to contribute.

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

You may also enroll Your Dependents for Dental Insurance under this plan if you did not enroll them when they were first eligible and:

- Your Dependents had coverage under your Spouse’s plan and Your Spouse dies or Your Spouse’s employment was involuntarily terminated for reasons other than cause;
- You notify us within 6 months that coverage under the other plan has ended;
- You elect to enroll Your Dependents for Dental Insurance under this policy; and
- for any contributory Dental Insurance for Your Dependents, You give Written permission to deduct premiums from your pay.

If You or Your Spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance for a Child and:

- You are not enrolled for dental insurance; and/or
- Your child is not enrolled for dental insurance,

We will enroll You and/or Your Child without regard to enrollment period restrictions.

If You do not make a request for coverage on a dependent child as required by a Child Health Enforcement Order; and:

- You are insured for dental insurance; and
- no other reasonable dental insurance is in effect on the child,

then a request for dental insurance may be made by:

- another parent of the child;
- the Maryland Support Enforcement Agency; or
- the Maryland Department of Health and Mental Hygiene.

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Rules for Contributory Insurance

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

- the date You become eligible for such insurance; and
- the date You enroll.

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

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance if You have a Qualifying Event.

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

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; 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.

You may also enroll Your Dependents for Dental Insurance under this plan if you did not enroll them when they were first eligible and:

- Your Dependents had coverage under your Spouse's plan and Your Spouse dies or Your Spouse's employment was involuntarily terminated for reasons other than cause;
- You notify us within 6 months that coverage under the other plan has ended;
- You elect to enroll Your Dependents for Dental Insurance under this policy; and
- for any contributory Dental Insurance for Your Dependents, You give Written permission to deduct premiums from your pay.

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 date You cease to be a Student;
8. the end of the period for which the last premium has been paid for the Dependent; or
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.

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY INCAPACITATED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-support because of a mental or physical incapacity as defined by applicable law. Proof of such incapacity 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-support because of a mental or physical incapacity; and
- continues to qualify as a Child, except for the age limit.

DENTAL INSURANCE

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

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

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

In-Network

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

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

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

Out-of-Network

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

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

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

Maximum Benefit Amounts

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

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 an amount shown in the Schedule of Benefits that You and each Dependent must pay for Covered Services to which such Deductible applies each Year.

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

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

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

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

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

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

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

Benefits for Orthodontic Services We Will Pay After Insurance Ends

We will pay for benefits for orthodontic covered services for a course of treatment in effect at the time your insurance ends for:

- 60 days after the date insurance ends if the orthodontist has agreed to or is receiving monthly payments; or
- until the later of 60 days after insurance ends or the end of the quarter in progress if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

We will pay benefits for Covered Services received within 90 days of the day on which your insurance ends if the treatment:

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a Dentist's office.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than three 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 three times 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 three times in a Year.
4. Bitewing x-rays 1 set every 12 months.
5. 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) three times in a Year.
6. Topical fluoride treatment for a Child under age 14 twice in a Year.

Type B Covered Services

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
5. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
6. Diagnostic casts.
7. Emergency palliative treatment to relieve tooth pain.
8. Initial placement of amalgam fillings.
9. Replacement of an existing amalgam filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
10. Initial placement of resin-based composite fillings.
11. Replacement of an existing resin-based composite filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
12. Protective (sedative) fillings.
13. 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 three times in any Year less the number of teeth cleanings received during such 1 Year period.
14. Pulp capping (excluding final restoration).
15. Pulp therapy.
16. Space maintainers for a Child under age 14 once per lifetime per tooth area.
17. 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 60 months.
18. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
19. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.

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

Type C Covered Services

1. Therapeutic pulpotomy (excluding final restoration).
2. Apexification/recalcification.
3. Pulpal regeneration.
4. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
5. Local chemotherapeutic agents.
6. 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.
7. 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.
8. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 84 months prior to replacement.
9. Replacement of a non-serviceable removable Denture if such Denture was installed more than 84 months prior to replacement.
10. 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.
11. 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.
12. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
13. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
14. Initial installation of Cast Restorations (except implant supported Cast Restorations).
15. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 84 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.
16. Prefabricated crown, but no more than one replacement for the same tooth within 84 consecutive months.
17. Core buildup, but no more than once per tooth in a period of 84 months.
18. Posts and cores, but no more than once per tooth in a period of 84 months.
19. Labial veneers, but no more than once per tooth in a period of 84 months.
20. Oral surgery, except as mentioned elsewhere in this certificate.
21. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
22. Other consultations, but not more than twice in a 12 month period.
23. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.

24. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
25. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
26. Full mouth debridements, but not more than once per lifetime.
27. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
28. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
29. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
30. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 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.
31. Repair of implants, but no more than once in a 12 month period.
32. Implant supported Cast Restorations, but no more than once for the same tooth position in a 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.
33. 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.
34. 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.
35. Tissue conditioning, but not more than once in a 36 month period.
36. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
37. Occlusal adjustments, but not more than once in a 12 month period.
38. Cleaning and inspection of a removable appliance once every 6 months.

Orthodontic Covered Services

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

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments;
5. services which are primarily cosmetic unless such service is:
   - required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part; or
   - required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect;
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. modification of removable prosthodontic and other removable prosthetic services;
24. injections of therapeutic drugs;
25. fixed and removable appliances for correction of harmful habits;

DENTAL INSURANCE: EXCLUSIONS (continued)

26. appliances or treatment for bruxism (grinding teeth);
27. 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;
28. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
29. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
30. duplicate prosthetic devices or appliances;
31. replacement of a lost or stolen appliance, Cast Restoration or Denture;
32. replacement of an orthodontic device;
33. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
34. intra and extraoral photographic images;
35. services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- personal injury protection benefits which applicable state or federal law requires to be afforded without regard to fault under motor vehicle insurance policies.
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

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

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

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

The Administrator should have a supply of claim forms. Obtain a claim form from the Administrator and fill it out carefully. Return the completed claim form with the required Proof to the Administrator. The Administrator 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 1-877-247-8817. 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 1-877-247-8817.

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

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

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate. We will pay any benefits payable within 30 days of Our receipt of such Proof.

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

Initial Determination

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

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

If We deny 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 policy provision(s) on which the denial is based. If the claim is denied because We 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.

Benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately (and no later than 30 days) upon receipt of due written Proof of such loss. Subject to due Written Proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due Written Proof.

If We fail to pay a clean claim, We will pay interest on the amount of the claim that remains unpaid 30 days after receipt of the initial clean claim for reimbursement at the monthly rate of:

- 1.5% from the 31st day through the 60th day;
- 2% from the 61st day through the 120th day; and
- 2.5% after the 120th day.

GRIEVANCES

If You, Your Representative, or Your Dentist on Your behalf disagrees with Our decision, such person may submit a Written protest (Grievance) to Us via Our internal Grievance process. Contact information for Our internal Grievance process representative is as follows:

MetLife
Dental Claims
P.O. Box 981282
El Paso, Texas 79998-1282
1-800-438-6388

If We need additional information to review the Grievance, We will notify You, Your Representative, or Your Dentist on Your behalf within 5 working days of the Grievance Filing Date that We cannot proceed with reviewing the Grievance unless additional information is provided. The Filing Date is the earlier of 5 days after the date of mailing, or the date We receive the Grievance. We will assist You, Your Representative, or Your Dentist on Your behalf in gathering any additional information without further delay.

After We have reviewed the Grievance, We will render Our Grievance Decision. A notice of Our decision will be sent within 5 working days after the decision is made. The Grievance Decision is Our final determination that arises from the Grievance filed through Our internal Grievance process.

Grievance Review for Adverse Decision (Emergency Cases)

If Your case is an Emergency Case, We will render Our final Grievance Decision within 24 hours of the date You, Your Representative, or Your Dentist on Your behalf filed the Grievance. We will communicate Our decision to You, Your Representative, or Your Dentist on Your behalf, orally. Written notice of Our decision will be sent to You, Your Representative, or Your Dentist on Your behalf within one day after Our decision has been communicated orally.

Our Written decision shall include the following:

1. the specific factual basis for Our decision, stated in detail in clear, understandable language;
2. references to the specific criteria and standards, including interpretive guidelines, on which the decision was based, and does not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not medically necessary”;
3. the name, business address, and business telephone number of Our internal Grievance process representative;
4. Written details of Our internal grievance process and procedures, including the following information:
   (a) that You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner within 4 months after receipt of Our Grievance decision;
   (b) that a complaint may be filed without first filing a grievance if You, Your Representative, or Your Dentist filing a grievance on Your behalf can demonstrate a compelling reason to do so as determined by the Commissioner;
   (c) the Commissioner’s address, telephone number, and facsimile number; and
   (d) a statement that the Health Advocacy Unit is available to assist You or Your Representative in both mediating and filing a grievance under Our internal Grievance process.

Grievance Review for Adverse Decision (Non-Emergency) (Prospective)

We will render a final Written decision within 30 working days after the date You, Your Representative, or Your Dentist on Your behalf filed the Grievance. We may have an extension not to exceed 30 working days with the Written approval of the person who filed the Grievance. If We communicate Our decision to You, Your Representative, or Your Dentist on Your behalf, orally, We will document Our decision in Writing. We will send Our final Written decision to You, Your Representative, or Your Dentist on Your behalf within 5 working days after We render Our decision.

Our Written decision shall include the following:

1. the specific factual basis for Our decision, stated in detail in clear, understandable language;
2. references to the specific criteria and standards, including interpretive guidelines, on which the decision was based, and does not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not medically necessary”;
3. the name, business address, and business telephone number of Ours internal grievance process representative;
4. Written details of Our internal grievance process and procedures, including the following information:
   (a) that You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner within 4 months after receipt of Our Grievance decision;
   (b) that a complaint may be filed without first filing a grievance if You, Your Representative, or Your Dentist filing a Grievance on Your behalf can demonstrate a compelling reason to do so as determined by the Commissioner;
   (c) the Commissioner’s address, telephone number, and facsimile number; and
   (d) a statement that the Health Advocacy Unit is available to assist You or Your Representative in both mediating and filing a grievance under Our internal Grievance process.

Grievance Review for Coverage Decision (and Retrospective Adverse Decision)

For a Retrospective Adverse Decision, You, Your Representative, or Your Dentist on Your behalf have at least 180 days to file the Grievance after such person receives an Adverse Decision. We will render a final Written decision within 45 working days after the date You, Your Representative, or Your Dentist on Your behalf filed the Grievance. We may have an extension not to exceed 30 working days with the Written approval of the person who filed the Grievance. If We communicate Our decision to You, Your Representative, or Your Dentist on Your behalf, orally, We will document Our decision in Writing. We will send Our final Written decision to You, Your Representative, or Your Dentist on Your behalf within 5 working days after We render Our decision.

Our Written decision shall include the following:

1. the specific factual basis for Our decision, stated in detail in clear, understandable language;
2. references to the specific criteria and standards, including interpretive guidelines, on which the decision was based, and does not solely use generalized terms such as “experimental procedure not covered”, “cosmetic procedure not covered”, “service included under another procedure”, or “not medically necessary”;
3. the name, business address, and business telephone number of Our internal grievance process representative;
4. Written details of Our internal Grievance process and procedures, including the following information:
   (a) that You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner within 4 months after receipt of Our Grievance decision;
   (b) that a complaint may be filed without first filing a Grievance if You, Your Representative, or a Dentist filing a Grievance on Your behalf can demonstrate a compelling reason to do so as determined by the Commissioner;
   (c) the Commissioner’s address, telephone number, and facsimile number; and
   (d) a statement that the Health Advocacy Unit is available to assist You or Your Representative in both mediating and filing a Grievance under Our internal Grievance process.

INVOLVING THE MARYLAND INSURANCE COMMISSIONER

Complaint for Emergency Cases

You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner of Insurance if We do not render Our Grievance Decision within 24 hours after the date You, Your Representative, or Your Dentist on Your behalf file a complaint through Our internal Grievance process.

COMPLAINT FOR ADVERSE DECISION (PROSPECTIVE)
You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner of Insurance if We do not render Our Grievance Decision on or before the 30th working day after You, Your Representative, or Your Dentist on Your behalf file a complaint through Our internal Grievance process.

COMPLAINT FOR COVERAGE DECISION (AND RETROSPECTIVE ADVERSE DECISION)
You, Your Representative, or Your Dentist on Your behalf have a right to file a complaint with the Commissioner of Insurance if we do not render Our Grievance Decision on or before the 45th working day after You, Your Representative, or Your Dentist on Your behalf file a complaint through Our internal Grievance process.

COMPLAINT WITHOUT USE OF OUR INTERNAL GRIEVANCE PROCESS
In the case of an Adverse Decision, You, Your Representative, or Your Dentist on Your behalf, may file a complaint without going through Our internal Grievance process if:

- We waive the requirement that Our internal Grievance process be exhausted before filing a complaint with the Commissioner;
- We have failed to comply with any of the requirements of the internal Grievance process as described in this policy; or
- You, Your Representative, or Your Dentist on Your behalf, can demonstrate a Compelling Reason. Compelling Reason means showing that the potential delay in receipt of a dental service until after You, Your Representative or Your Dentist exhausts the internal Grievance process and obtains a final decision under the Grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or You (or Your Dependent) remaining seriously mentally ill with symptoms that cause You (or Your Dependent) to be in danger to self or others.

COMPLAINT AFTER GRIEVANCE DECISION

You, Your Representative, or Your Dentist on Your behalf, also have the right to file a complaint with the Commissioner of Insurance within 4 months after You receive Our Grievance Decision.

In any case, when filing a complaint with the Commissioner, You or Your Representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

CONTACT INFORMATION FOR THE INSURANCE COMMISSIONER
Appeal and Grievance Unit
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
(410) 468-2000 or (800) 492-6116 (toll free)
fax (410) 468-2270

CONTACT INFORMATION FOR THE HEALTH ADVOCACY UNIT
The Health Advocacy Unit is available to assist You or Your Representative in both mediating and filing a Grievance under Our internal Grievance process.

Consumer Protection Division
Offices of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(410) 528-1840 or (877) 261-8807 (toll free)
e-mail: heau@oag.state.md.us
fax (410) 576-6571

ADDITIONAL DEFINITIONS FOR THIS SECTION:

“Adverse decision” means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

1. a proposed or delivered health care service covered under an insured’s contract is or was not medically necessary, appropriate, or efficient; and
2. may result in noncoverage of the health care service.

“Adverse decision” does not include a decision concerning Your status as an insured.

“Complaint” means a protest filed with the Commissioner involving an adverse decision or Grievance decision concerning the insured.

“Grievance” means a protest filed by the insured, Your Representative, or a Dentist on the insured’s behalf with a carrier through the carrier’s internal Grievance process regarding an adverse decision concerning the insured.

“Grievance decision” means a final determination by a carrier that arises from a Grievance filed with the carrier under its internal Grievance process regarding an adverse decision concerning an insured.

“Your Representative” means an individual who has been authorized by You to file a Grievance or a complaint on Your behalf.

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.

If Dental Insurance benefits are paid on behalf of a Dependent Child who is covered by a Child Health Insurance Enforcement Order for which We have received Proof, We will pay such benefits according to the following order:

1. the Dentist, if the person or state agency which incurred the expenses for the Covered Service for the Child assigned the benefits to the Dentist;

2. the Maryland Department of Health and Mental Hygiene if it incurred the expenses or if it previously notified us that it is administering the coverage for the benefit of the Child and that the dental insurance benefits should be paid to the Maryland Department of Health and Mental Hygiene;

3. the non-insuring parent, if the non-insuring parent incurred the expenses for Covered Services for the Child;

4. You, in all other cases.

If the person on whose behalf dental insurance benefits are paid is not a Dependent Child who is covered by a Child Health Insurance Enforcement Order for which We have received Proof, We will pay benefits for Covered Services to:

- the Dentist, if You have assigned benefits to the Dentist, or
- You, in all other cases.

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.

A change in the policy will not be valid:

1. until approved by an executive officer of MetLife; and
2. unless the approval is endorsed on the policy or attached to the policy.

Contestability: 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.

Contestability: Statements Made by the Policyholder

In the absence of fraud, any statement made by the Policyholder will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim, except for non-payment of premium, unless:

1. it is contained in a Written application signed by the Policyholder; and
2. a copy of the application is given to the Policyholder.

We will not contest insurance after it has been in force for 2 years from its effective date, except for non-payment of premium.

Conformity with Law

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

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

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.

MetLife

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

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

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

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

SECTION 5: Using Your Information

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

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

SECTION 6: Sharing Your Information With Others

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

Other reasons we may share your information include:

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

SECTION 7: HIPAA

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

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

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

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

Send privacy questions to:

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

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

HIPAA Notice of Privacy Practices for Protected Health Information

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

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

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

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

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

NOTICE SUMMARY

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

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

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

In addition, we may use or disclose PHI:

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

You have the right to:

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

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

We are required by law to:

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

NOTICE DETAILS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Protected Health Information That We Maintain About You

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

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

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

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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.