

✂ Cut along dotted line

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[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

- Locate a participating dentist.
- Verify eligibility and plan design information.
- Review claim status and claim history for your entire family.
- View and print processed claims with one click.
- Obtain claims forms\* and educational information (including interactive risk assessment).
- Get instant answers to Frequently Asked Questions.
- Access trained customer service representatives.

**1-800-ASK-4MET (800-275-4638)**

- Virtually 24 hours a day, 7 days a week to confirm eligibility, order claim forms or request dentist directories
- Monday-Friday, 8 a.m. to 11 p.m., Eastern Time, to speak with a live customer service representative
- MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
- For International Dental Travel Assistance call 1-312-356-5970 (collect)

**MetLife**



**Dental Reference Card**

Member Name

**The Florida Bar**

Association Name

Member ID

**05336959**

Group Number

This card is not a guarantee of coverage or eligibility.  
See Reverse side for important information.  
1115-2010

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Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166-0188

## 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 contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

This certificate describes insurance provided by a certificate previously issued to You by MetLife and replaces such previous certificate.

Policyholder: The Florida Bar  
Group Policy Number: TS 05336959-G  
Type of Insurance: Dental Insurance  
MetLife Toll Free Number(s):  
For General Information 1-800-275-4638

### **THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.**

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

**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.**

**Dental Insurance benefits for Covered Services are subject to a Deductible.**

**IN ACCORDANCE WITH THE TERMS OF THE POLICY, THE PREMIUM MAY CHANGE.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICES SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

**For Texas Residents:**

**IMPORTANT NOTICE**

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-275-4638

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**PREMIUM OR CLAIM DISPUTES:** Should You have a dispute concerning Your premium or about a claim You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:**

This notice is for information only and does not become a part or condition of the attached document.

**Para Residentes de Texas:**

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-275-4638

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU CERTIFICADO:**

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

# NOTICE FOR RESIDENTS OF TEXAS

## DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

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

### Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Policyholder 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](http://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 1-800-275-4638.

### Claim Submission

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

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

### Initial Determination

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

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

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

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

### Appealing the Initial Determination

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

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

## **NOTICE FOR RESIDENTS OF TEXAS**

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

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

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

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

## **NOTICE FOR RESIDENTS OF TEXAS**

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

## **NOTICE FOR RESIDENTS OF ARKANSAS**

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

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

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

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

### **IMPORTANT NOTICE**

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

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

**DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1 (800) 927-4357**



## NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

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

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

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

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

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

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

## **NOTICE FOR RESIDENTS OF ALL STATES**

If You have questions about your insurance coverage you may contact MetLife at 1-800-275-4638.

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

MetLife  
Attn: Corporate Consumer Relations Department  
200 Park Avenue  
New York, New York 10166-0188

Or call MetLife at 1-800-638-5433

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

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

## **NOTICE FOR RESIDENTS OF IDAHO**

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

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

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043  
1-800-721-3272 or [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

## **NOTICE FOR RESIDENTS OF ILLINOIS**

### **IMPORTANT NOTICE**

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

MetLife  
200 Park Avenue  
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

**Questions regarding your policy or coverage should be directed to:**

**Metropolitan Life Insurance Company  
1-800-275-4638**

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

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

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

Complaint can be filed electronically at *[www.in.gov/doi](http://www.in.gov/doi)*

## **NOTICE FOR RESIDENTS OF MAINE**

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

# NOTICE FOR MASSACHUSETTS RESIDENTS

The following provisions are required by Massachusetts law.

## Translation Services

Translation services are available by calling 1-800-638-3368. We shall make available upon request interpreter and translation services related to administrative procedures by calling member services.

منقوم عند الطلب بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية وذلك بالاتصال بخدمات العملاء.

យើងនឹងមានផ្តល់អ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង វិធីចាត់ចែងការ តាមការស្នើ ដោយទូរស័ព្ទទៅកន្លែងបំរើសមាជិក ។

我們提供協助辦理行政手續的翻譯服務，若您需要翻譯人員，請電洽會員服務處。

Nous assurerons sur demande, les services d'interprétariat et de traduction en connexion avec les procédures administratives, en appelant les services aux membres.

Θα διαθέσουμε μετά από αίτηση υπηρεσίες διερμηνεία και μεταφραστική σχετικά με διοικητικές διαδικασίες ερχόμενοι σε επαφή με τις υπηρεσίες μελών.

Si w rele depatman sèvis kliyan an, epi w mande sèvis entèprèt ak tradiksyon pou pwosede administratif, sèvis la ap disponib pou w.

A richiesta metteremo a disposizione servizi di interpretariato e traduzione riguardo le procedure amministrative. Telefonare all'ufficio di Assistenza soci.

ຖ້າທ່ານຮ້ອງຂໍ, ພວກເຮົາຈະຈັດຮຽນບາງບາງສາຂາຂອງບໍລິການແປພາສາໃຫ້ກັບທ່ານ ຈຳນວນຮ້ອງຂໍທີ່ຮຽວຂ້ອງກັບຂັ້ນຕອນການບໍລິຫານ ໂດຍທ່ານສາມາດໂທຕິດຕໍ່ກັບພະແນກບໍລິການສະມາຊິກ.

Disponibilizaremos, a seu pedido, os serviços de um(a) tradutor(a)/intérprete para os procedimentos administrativos, contactando os serviços para membros.

По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами, если Вы позвоните в отдел по обслуживанию членов.

Si usted lo solicita, pondremos a su disposición servicios de interpretación y traducción para asistirle en los procedimientos administrativos. Si necesita estos servicios, comuníquese con servicios a los miembros.



## **NOTICE FOR MASSACHUSETTS RESIDENTS (Continued)**

**The following provisions are required by Massachusetts law.**

### **Summary of Utilization Review Procedures**

MetLife reviews claims for evidence of need for certain dental procedures. These reviews are conducted by licensed dentists. If there is no evidence of need MetLife will deny benefits for a claim. MetLife also reviews claims to determine whether there exists a less costly treatment for a dental condition that is generally considered effective to treat the condition. If a less costly alternative treatment exists, MetLife will determine benefits based on the alternative treatment. If you want to determine the status of any such claim review, you can call MetLife at 1-800-275-4638.

### **Summary of Quality Assurance Programs**

MetLife performs a check on certain credentials of any dentist applying to participate in MetLife's Participating Dentist Program (PDP). If the credentials do not meet MetLife's standards, for example if a dentist does not have a valid license, the dentist will not be permitted to participate in the PDP. MetLife does not interfere with the traditional relationship between PDP dentists and their patients, or any determination between the patient and dentist as to what the appropriate dental treatment may be. MetLife dental plans also allow you to choose between any dentist, whether they participate in the PDP or not. Therefore you should choose your dentist carefully, and you are responsible to be sure that your dentist delivers quality dental care.

### **Involuntary Disenrollment Rate**

The involuntary disenrollment rate among insureds of MetLife is 0.

## NOTICE FOR RESIDENTS OF MASSACHUSETTS

### CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Dental Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

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

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

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

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS**

### **CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE**

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

- this Dental Insurance ends for all Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Dental Insurance for Your Dependents ends because You fail to pay a required premium.

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

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

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

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

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

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

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

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.

## NOTICE FOR NEW HAMPSHIRE RESIDENTS

### CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

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

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Dental Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

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

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of Members to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Dental Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group dental coverage.

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

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

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

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

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

## NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

## NOTICE FOR RESIDENTS OF UTAH

### Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

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

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

The basic protections provided by the Association are:

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

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

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

## NOTICE FOR RESIDENTS OF VIRGINIA

### IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23209  
1-877-310-6560 - toll-free  
1-804-371-9032 - locally  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

Or:

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

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



## **NOTICE FOR RESIDENTS OF VIRGINIA**

### **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

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

You may contact the Virginia Office of the Managed Care Ombudsman either by dialing toll free at (877) 310-6560, or locally at (804) 371-9032, via the internet at Web address [www.scc.virginia.gov](http://www.scc.virginia.gov), email at [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov), or mail to:

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

## NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

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

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

## **NOTICE FOR RESIDENTS OF WEST VIRGINIA**

### **FREE LOOK PERIOD:**

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

## NOTICE FOR RESIDENTS OF WISCONSIN

### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

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

MetLife  
Attn: Corporate Consumer Relations Department  
200 Park Avenue  
New York, NY 10166-0188  
1-800-638-5433

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

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

## **NOTICE FOR RESIDENTS OF FLORIDA**

### **FRAUD WARNING**

#### **For Residents of Florida**

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

## **NOTICE FOR RESIDENTS OF LOUISIANA, MINNESOTA, MONTANA, NEW MEXICO, TEXAS, UTAH AND WASHINGTON**

**The Definition of Child In The Definitions Section Of This Certificate Is Modified For The Coverage Listed Below:**

### **For Louisiana Residents (Dental Insurance):**

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 26, regardless of the child's or grandchild's marital status, student status or full-time employment status. Your natural child, adopted child, stepchild or grandchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. In addition, marital status will not prevent or cease the continuation of insurance for a mentally or physically handicapped child or grandchild past the age limit.

### **For Minnesota Residents (Dental Insurance):**

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

### **For Montana Residents (Dental Insurance):**

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

### **For New Mexico Residents (Dental Insurance):**

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

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

### **For Texas Residents (Dental Insurance):**

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

### **For Utah Residents (Dental Insurance):**

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

### **For Washington Residents Dental Insurance:**

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

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

## **Notice Regarding Your Rights and Responsibilities**

### Rights:

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

### Responsibilities:

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

## **NOTICE FOR RESIDENTS OF ALL STATES**

If you have questions about your insurance coverage you may contact MetLife at 1-800-275-4638.

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

MetLife  
Attn: Corporate Consumer Relations Department  
200 Park Avenue  
New York, New York 10166-0188

Or call MetLife at 1-800-638-5433



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## SCHEDULE OF BENEFITS

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

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

### BENEFIT

### BENEFIT AMOUNT AND HIGHLIGHTS

#### Dental Insurance For You and Your Dependents

##### For All Members Who Elect the Freedom Choice 5K Plan

<b>Covered Percentage for:</b>	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	90%
Type B Services	80%	70%
Type C Services	50%	40%
Type D Services (Orthodontic)	50%	50%
<b>Deductibles for:</b>	In-Network	Out-of-Network
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
<b>Maximum Benefit:</b>	In-Network	Out-of-Network
Yearly Individual Maximum	\$5,000 for the following Covered Services: Type A, Type B & Type C	\$5,000 for the following Covered Services: Type A, Type B & Type C
Lifetime Individual Maximum for Type D Covered Services (Orthodontic)	\$1,000	\$1,000

#### Benefit Waiting Periods for Timely Entrants

Type A Services.....	No waiting period
Type B Services.....	No waiting period
Type C Services .....	12 month waiting period
Type D Services (Orthodontic) .....	12 month waiting period

**SCHEDULE OF BENEFITS (CONTINUED)**

**Benefit Waiting Periods for Late Entrants**

Type A Services.....	No waiting period
Type B (Fillings).....	6 month waiting period
All Other Type B Services .....	12 month waiting period
Type C Services .....	24 month waiting period
Type D Services (Orthodontic) .....	24 month waiting period

## DEFINITIONS

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

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

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

- Your natural, adopted, or stepchild (including the child of a Domestic Partner) who is under age 30, supported by and living with You. The term also includes Your natural, adopted or stepchild (including the child of a Domestic Partner) under age 30 who is:
  - supported by You; and
  - a full-time or part-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

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

**The term does not include** any person who:

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

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

Contributory Insurance includes: Personal and Dependent 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 the amount You or Your Dependents must pay before We will pay for Covered Services.

**Dental Hygienist** means a person trained to:

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

**The term does not include:**

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);

## DEFINITIONS

- siblings;
- grandparents; or
- grandchildren.

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

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

**Dentist** means:

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

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

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

**Domestic Partner** means each of two people, one of whom is a Member of the Policyholder, who have submitted an affidavit to the Policyholder certifying that:

- each person is 18 years of age or older;
- neither person is married;
- neither person has had another domestic partner within 6 months prior to the date they enroll for insurance for the Domestic Partner under the Group Policy;
- they have shared the same residence for at least 6 months prior to the date they enroll for insurance for the Domestic Partner under the Group Policy;
- they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside;
- they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations which commitment existed for at least 6 months prior to the date they enroll for insurance for the Domestic Partner under the Group Policy, and such commitment is expected to last indefinitely; and
- 2 or more of the following exist as evidence of joint responsibility for basic financial obligations:
  - a joint mortgage or lease;
  - designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
  - joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;
  - designation of the Domestic Partner as durable power of attorney or health care proxy;
  - ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility;
  - or
  - other evidence of economic interdependence.

The Policyholder will review the affidavit and determine whether to accept the request to insure the Domestic Partner.

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

**Maximum Allowed Charge** means the lesser of:

- the amount charged by the Dentist; or

## DEFINITIONS

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

**Member** means a member in good standing with the Florida Bar.

**Noncontributory Insurance** means insurance for which the Policyholder does not require You to pay any part of the premium.

**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.

**The term does not include:**

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

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

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

Proof must be provided at the claimant's expense.

**Reasonable and Customary Charge** is the lowest of:

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

## DEFINITIONS

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

**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. The term also includes Your Domestic Partner.

**The term does not include** any person who:

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

**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** means the 12 month period that begins January 1.

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

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**All Members Who Elect the Freedom Choice 5k PPO Plan**

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

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

**For All Members Who Elect the Freedom Choice 5k PPO Plan**

You will be eligible for insurance on the later of:

1. January 01, 2015; and
2. the date You enter that class.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

### **ENROLLMENT PROCESS FOR DENTAL INSURANCE**

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. You will be notified by the Policyholder how much You will be required to contribute.

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Rules for Contributory Insurance**

If You complete the enrollment process for Contributory Dental Insurance within 31 days of the date You become eligible for such insurance, such insurance will take effect on the later of:

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

If You complete the enrollment process for Contributory Insurance after 31 days from the date You become eligible for such insurance, such insurance will take effect at the next calendar quarter.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the last day of the calendar month in which You cease to be a Member.

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 Members Who Elect the Freedom Choice 5k PPO Plan**

### **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.

#### **For All Members Who Elect the Freedom Choice 5k PPO Plan**

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

1. January 01, 2015; and
2. the date You enter that class.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

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

### **ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE**

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. You will be notified by the Member how much You will be required to contribute.

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

### **DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS**

#### **Rules for Contributory Insurance**

If You complete the enrollment process for Contributory Dependent Dental Insurance within 31 days of the date You become eligible for such insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance and benefits will become effective after the dependent satisfies the timely entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS; and
- the date You enroll and benefits will become effective after the dependent satisfies the timely entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS.

If You complete the enrollment process for Contributory Dependent Dental Insurance after 31 days from the date You become eligible for such insurance, such insurance will take effect at the next calendar quarter.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (CONTINUED)**

### **DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS**

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

1. the date Your Dental Insurance ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the last day of the calendar month in which You cease to be a Member;
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent;
9. for Utah residents, the last day of the calendar month the person ceases to be a Dependent.

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

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

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

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

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

## **EVIDENCE OF INSURABILITY**

No evidence of insurability is required for the insurance described in this certificate.

## 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 1-800-275-4638 or by visiting Our website at [www.metlife.com/dental](http://www.metlife.com/dental).

## BENEFIT AMOUNTS

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

### In-Network

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

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

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

### Out-of-Network

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

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

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

## **DENTAL INSURANCE (CONTINUED)**

### **Maximum Benefit Amounts**

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

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

### **Deductibles**

The Deductible amounts are shown in the Schedule of Benefits.

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

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.

## **DENTAL INSURANCE (CONTINUED)**

### **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 Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be based on the lower of:

- the amount charged by the Dentist; and
- the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment if:

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

### **Benefits for Orthodontic Services Begun Prior to this Dental Insurance**

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

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

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

### **Pretreatment Estimate of Benefits**

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

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

### **Benefits We Will Pay After Insurance Ends**

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

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

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

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

### Type A Covered Services

1. Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, are limited to once every 6 months.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), are limited to once every 6 months.
4. Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months.
5. Bitewing x-rays but not more than 1 set every 12 months.
6. Cleaning of teeth (oral prophylaxis) once every 6 months.
7. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.
8. Genetic test for susceptibility to oral diseases.
9. Diagnostic casts.
10. Topical fluoride treatment for a Child under age 13, but not more than once in 12 months.

### Type B Covered Services

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

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical x-rays.
3. Dental x-rays except as mentioned elsewhere in this certificate.
4. Sealants for a Child under age 13, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 3 calendar years.
5. Protective (sedative) fillings.
6. Initial placement of amalgam fillings.
7. 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.
8. Initial placement of resin fillings.
9. Replacement of an existing resin 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.



## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

10. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
11. Other consultations, but not more than once in a 12 month period.
12. Emergency palliative treatment to relieve tooth pain.
13. Simple extractions.
14. Pulp capping (excluding final restoration).
15. Pulp therapy.
16. Therapeutic pulpotomy (excluding final restoration).
17. 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 two times in any calendar year less the number of teeth cleanings received during such calendar year.
18. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period.
19. Prefabricated crown, but no more than one replacement for the same tooth surface within 24 months.
20. Simple Repairs of Cast Restorations but not more than once in a 12 month period.
21. Repair of Dentures but not more than once in a 12 month period.
22. Addition of teeth to fixed and permanent Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
23. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
24. Re-cementing of Cast Restorations or Dentures but not more than once in a 12 month period.
25. Repair of implant supported prosthetics but not more than once in a 12 month period.
26. Local chemotherapeutic agents.
27. Injections of therapeutic drugs.
28. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.
29. Occlusal adjustments, but not more than once in a 12 month period.

### Type C Covered Services

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

1. Space maintainers for a Child under age 13, once per lifetime per tooth area.

## **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)**

2. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
3. Surgical extractions.
4. Oral surgery except as mentioned elsewhere in this certificate.
5. Apexification/recalcification.
6. Root canal treatment, but not more than once for the same tooth.
7. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
8. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 36 month period.
9. Tissue Conditioning, but not more than once in a 36 month period.
10. Initial installation of Cast Restorations.
11. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 10 calendar years of a prior replacement.
12. Core buildup, but no more than once per tooth in a period of 10 calendar years.
13. Labial veneers, but no more than once per tooth in a period of 10 calendar years.
14. Post and cores, but no more than once per tooth in a period of 10 calendar years.
15. Initial installation of fixed and permanent Denture:
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance under this certificate.
16. Replacement of a non-serviceable fixed and permanent Denture if such Denture was installed more than 10 calendar years prior to replacement.
17. Initial installation of full or removable Dentures:
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance under this certificate.
18. 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.
19. Replacement of a non-serviceable full or removable Denture if such Denture was installed more than 10 calendar years prior to replacement.
20. Adjustments of Dentures:
  - if at least 6 months have passed since the installation of the existing removable Denture; and
  - not more than once in any 12 month period.

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

21. 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.

22. 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 10 calendar year period:

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

23. Repair of implants, but not more than once in a 10 calendar year period.

24. Implant supported prosthetics, but no more than once for the same tooth position in a 10 calendar year period:

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

25. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging but cone beam imaging for this treatment will not be covered more than once for the same tooth position in a 60 month period.

### Type D Covered Services

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

Orthodontia, up to age 19, if the orthodontic appliance is initially installed while Dental Insurance is in effect for such Child.

The Lifetime Individual Maximum Benefit Amount for orthodontia is shown in the SCHEDULE OF BENEFITS.

## DENTAL INSURANCE: EXCLUSIONS

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

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are 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,

For residents of Texas see notice page section.

5. 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.
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, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
  - paid under any workers' compensation or occupational disease law;
  - paid under any employer liability law;
  - for which You are not required to pay; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.

## DENTAL INSURANCE: EXCLUSIONS (CONTINUED)

17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.

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

**The term does not include:**

- any plan, program or coverage provided by a government as an employer; or
  - Medicare.
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. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  24. Other fixed Denture prosthetic services not described elsewhere in this certificate.
  25. Precision attachments, except when the precision attachment is related to implant prosthetics.
  26. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  27. Addition of teeth to a partial removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  28. Addition of teeth to a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  29. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
  30. Implants to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  31. Implants supported prosthetics to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
  32. Fixed and removable appliances for correction of harmful habits.

## **DENTAL INSURANCE: EXCLUSIONS (CONTINUED)**

33. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
34. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota.
35. Repair or replacement of an orthodontic device.
36. Duplicate prosthetic devices or appliances.
37. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
38. Intra and extraoral photographic images.

## DENTAL INSURANCE: COORDINATION OF BENEFITS

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

### DEFINITIONS

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

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

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

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

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

#### **The term does not include:**

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

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

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

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

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

## **DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)**

**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.

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

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

**The term does not include any of the following:**

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

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

- Government Plans; or
- Plans which the employer , 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.



## DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

**This Plan** means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the employer (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.

### 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.

## DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

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.

## **DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)**

### **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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-275-4638. Dental claim forms can also be downloaded from [www.metlife.com/dental](http://www.metlife.com/dental). The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

### CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

**Step 1**

A claimant can request a claim form by calling Us at 1-800-275-4638.

**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 for Dental Insurance benefits may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 5 years after the date such Proof is required.

## DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

### Claim Submission

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

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

### Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

### Initial Determination

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

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

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

### Appealing the Initial Determination

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

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

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In

## **DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)**

addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

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

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

## **GENERAL PROVISIONS**

### **Assignment**

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

Upon receipt of a Covered Service, You may assign Dental Insurance benefits to the Dentist providing such service.

### **Dental Insurance: Who We Will Pay**

If You assign payment of Dental Insurance benefits to Your or Your Dependent's Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay Dental Insurance benefits to You.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

### **Misstatement of Age**

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

### **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.

### **Autopsy**

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

### **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

## **GENERAL PROVISIONS (CONTINUED)**

- 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.

We may recover such overpayment in accordance with that agreement.

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

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





**"THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION"**



## 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.

### Plan Sponsors and Group Insurance Contract Holders

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

### Protecting Your Information

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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.

### Collecting Your Information

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

### How We Get Your Information

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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.

### Using Your Information

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

### Sharing Your Information With Others

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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

## HIPAA

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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](http://www.MetLife.com). Select “Privacy Policy” at the bottom of the home page. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

## Accessing and Correcting Your Information

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You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. 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.

## Questions/More Information

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

### Send privacy questions to:

MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto: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 these MetLife companies:

**Metropolitan Life Insurance Company**  
**MetLife Insurance Company USA**  
**SafeGuard Health Plans, Inc.**

**MetLife Health Plans, Inc.**  
**General American Life Insurance Company**  
**SafeHealth Life Insurance Company**