

YOUR BENEFIT PLAN

Florida Health Sciences Center, Inc. dba Tampa General Hospital

All Full-Time and Part-Time employees of the Policyholder

High Plan

Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2023

Florida Health Sciences Center, Inc. dba Tampa General Hospital
1 Tampa General Circle
Tampa, FL 33606

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Florida Health Sciences Center, Inc. dba Tampa General Hospital



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

To present inquiries, obtain information about coverage, or for assistance in resolving complaints, please call MetLife at 1-800-942-0854.

CERTIFICATE RIDER

Group Policy No.: 143078-1-G
Policyholder: Florida Health Sciences Center, Inc. dba Tampa General Hospital
Effective Date: January 1, 2023

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

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

"Maximum Allowed Charge" means:

1. with respect to In-Network Dentists, the lesser of:
 - a. the amount charged by the In-Network Dentist; or
 - b. the maximum amount which the In-Network Dentist has agreed to accept as payment in full for the dental service;
2. with respect to Out-of-Network Dentists, the lesser of:
 - a. the amount charged by the Out-of-Network Dentist; or
 - b. the Out-of-Network scheduled amount for the state where the dental service is performed."

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

Michel Khalaf
President and Chief Executive Officer



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Florida Health Sciences Center, Inc. dba Tampa General Hospital

Group Policy Number: 143078-1-G

Type of Insurance: Dental Insurance

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

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE: You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

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

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

For New Hampshire Residents: 30 Day Right to Examine Certificate.

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

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

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

NOTICE FOR RESIDENTS ALL STATES

If you have questions about your insurance coverage you may contact MetLife at 1-800-438-6388.

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 CONNECTICUT, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

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

For Connecticut 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.

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

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

For New Hampshire Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

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

For Utah Residents (Dental Insurance):

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

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

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

NOTICE FOR RESIDENTS OF CONNECTICUT, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON (continued)

For Washington Residents (Dental Insurance):

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

**METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904**

1-800-438-6388

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

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

WEBSITE: <http://www.insurance.ca.gov/>

**1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

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

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

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

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

NOTICE FOR RESIDENTS OF 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 GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF IDAHO

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

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

1-800-438-6388

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/idoi

NOTICE FOR RESIDENTS OF MAINE

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

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

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

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

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

To continue Dental insurance under this provision:

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

The request form will be furnished by the Employer.

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

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

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

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

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

NOTICE FOR RESIDENTS OF NEW MEXICO

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

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

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

NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

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

NOTICE 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 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 THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

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

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

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

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

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

Or:

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

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

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

Appealing the Initial Determination

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

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

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

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

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

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

Policies and Procedures for Emergency and Urgent Care

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

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

The benefit amount will be consistent with the terms contained in the insured's contract.

Urgent Care Submission:

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

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

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

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

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-438-6388

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

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	70%
Type B Services	80%	50%
Type C Services	50%	30%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type A; Type B; Type C
Yearly Family Deductible	\$150 for the following Covered Services Combined: Type B; Type C	\$150 for the following Covered Services Combined: Type A; Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$1,500 for the following Covered Services: Type A; Type B; Type C	\$1,500 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$1,000	\$1,000

DEFINITIONS

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

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

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

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

Cast Restoration means an inlay, onlay, or crown.

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

Your natural; adopted; or stepchild, an unmarried foster child who resides with and is fully supported by You; and who, in each case, is under age 26.

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

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

The term includes an Employee's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

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

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

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

Contributory Insurance includes: Dental Insurance.

Covered Percentage means the percentage of the Maximum Allowed Charge that We will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

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

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

DEFINITIONS (continued)

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

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

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

Full-Time means Active Work of at least 40 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

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

Maximum Allowed Charge means the lesser of:

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

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

Part-Time means Active Work of at least 20 hours per week but less than 40 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Physician means:

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

DEFINITIONS

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

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

Proof must be provided at the claimant's expense.

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

Spouse means Your lawful spouse.

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

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

We, Us and **Our** mean MetLife.

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time and Part-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

You will be eligible for insurance described in this certificate on the later of:

1. January 1, 2023; and
2. the first day of the calendar month following the date You complete the Waiting Period of 60 days.

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

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

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment Due to a Qualifying Event

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

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

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

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 last day of the calendar month in which You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. the last day of the calendar month in which You retire in accordance with the Policyholder's retirement plan.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time and Part-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. January 1, 2023;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the first day of the calendar month following the date You complete the Waiting Period of 60 days.

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 DEPENDENT DENTAL INSURANCE

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

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

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

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

Enrollment Due to a Qualifying Event

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

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

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

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

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

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;
2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
 - the loss of a tooth; and
 - the accumulation of amounts toward:
 - a) Annual Deductibles;
 - b) Annual Maximum Benefits;
 - c) Lifetime Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
 - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
 - the date this Dental Insurance ends.

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

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

AT THE POLICYHOLDER'S OPTION

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

Insurance will continue for the following periods:

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

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

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

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

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

DENTAL INSURANCE

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

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

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

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

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

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

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

BENEFIT AMOUNTS

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

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

In-Network

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

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

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

Out-of-Network

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

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

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

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 must pay for Covered Services to which such Deductible applies each Year before We will pay benefits for such Covered Services.

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

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

Alternate Benefit

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

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

For example:

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

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

DENTAL INSURANCE (continued)

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

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins.

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

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

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

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

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

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

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 and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than 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), but no more than once every 6 months.
4. Full mouth or panoramic x-rays once every 60 months.
5. Bitewing x-rays:
 - 1 set every 6 months for a Child; and
 - 1 set every Year for everyone else.
6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) once every 6 months.
7. Topical fluoride treatment for a Child under age 19 once in a Year.

Type B Covered Services

1. Intraoral-periapical x-rays.
2. X-rays, except as mentioned elsewhere.
3. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
4. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
5. Diagnostic casts.
6. Emergency palliative treatment to relieve tooth pain.
7. Amalgam fillings.
8. Resin-based composite fillings.
9. Protective (sedative) fillings.
10. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
11. Pulp capping (excluding final restoration).
12. Therapeutic pulpotomy (excluding final restoration).
13. Injections of therapeutic drugs.
14. Space maintainers for a Child under age 19.
15. Sealants or sealant repairs for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
16. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
17. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
18. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type C Covered Services

1. Pulp therapy.
2. Apexification/recalcification.
3. Pulpal regeneration, but not more than once per lifetime.
4. 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.
5. Local chemotherapeutic agents.
6. Initial installation of full or partial Dentures (other than implant supported prosthetics):
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
7. Addition of teeth to a partial removable Denture to replace teeth removed while this Dental Insurance was in effect for the person receiving such services.
8. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
9. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
10. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
11. Other removable prosthetic services not described elsewhere.
12. 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.
13. Re-cementing of Cast Restorations or Dentures.
14. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
15. Initial installation of Cast Restorations (except implant supported Cast Restorations).
16. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least a 5 Year period have passed since the most recent time that:
 - a Cast Restoration was installed for the same tooth; or
 - a Cast Restoration for the same tooth was replaced.
17. Prefabricated crown, but no more than one replacement for the same tooth within 5 Years.
18. Core buildup, but no more than once per tooth in a period of 5 Years.
19. Posts and cores, but no more than once per tooth in a period of 5 Years.
20. Labial veneers, but no more than once per tooth in a period of 5 Years.
21. Oral surgery, except as mentioned elsewhere in this certificate.
22. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image but not more than twice in a Year.
23. Other consultations but not more than twice in a Year.
24. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24 month period for the same tooth.
25. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
26. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

27. Full mouth debridements, but not more than once per lifetime.
28. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
29. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
30. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
31. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
32. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
33. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
34. Tissue conditioning, but not more than once in a 36 month period.
35. Simple repair of Cast Restorations or Dentures other than recementing.
36. Occlusal adjustments.

Orthodontic Covered Services

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

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic unless such service is:
 - required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part; or
 - required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
 - paid under any workers' compensation or occupational disease law;
 - paid under any employer liability law;
 - for which You are not required to pay; or
 - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control, such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. implants including, but not limited to any related surgery, placement, maintenance, and removal;
24. repair of implants;

DENTAL INSURANCE: EXCLUSIONS (continued)

25. fixed and removable appliances for correction of harmful habits;
26. appliances or treatment for bruxism (grinding teeth);
27. initial installation of a Denture or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
28. precision attachments associated with fixed and removable prostheses;
29. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
30. duplicate prosthetic devices or appliances;
31. replacement of a lost or stolen appliance, Cast Restoration or Denture;
32. replacement of an orthodontic device;
33. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
34. intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

The term does not include any of the following:

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

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

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both insured under This Plan as employees, each person's insurance will be treated as a separate Plan.

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

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.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

CLAIMS FOR DENTAL INSURANCE BENEFITS

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-438-6388. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

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

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

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.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 5 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

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 1-800-438-6388.

Initial Determination

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

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

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

Appealing the Initial Determination

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

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

GENERAL PROVISIONS (continued)

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

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



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

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

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

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

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

SECTION 5: Using Your Information

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

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

SECTION 6: Sharing Your Information With Others

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

Other reasons we may share your information include:

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

SECTION 7: HIPAA

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

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

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

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

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

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

HIPAA Notice of Privacy Practices for Protected Health Information

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

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

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

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

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

NOTICE SUMMARY

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

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

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

In addition, we may use or disclose PHI:

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

You have the right to:

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

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

We are required by law to:

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

NOTICE DETAILS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights Regarding Protected Health Information That We Maintain About You

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

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

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

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

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

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

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

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

- **Right to Request Confidential**

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

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

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

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE FLORIDA HEALTH SCIENCES CENTER, INC. DBA TAMPA GENERAL HOSPITAL DENTAL INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Florida Health Sciences Center, Inc. dba Tampa General Hospital
1 Tampa General Circle
Tampa, FL 33606

EMPLOYER IDENTIFICATION NUMBER: 59-3458145

PLAN NUMBER	COVERAGE	PLAN NAME
503	All Coverages	Florida Health Sciences Center, Inc. Dental Plan

TYPE OF ADMINISTRATION

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

AGENT FOR SERVICE OF LEGAL PROCESS

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

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

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

PLAN TERMINATION OR CHANGES

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

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

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

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

CONTRIBUTIONS TO PREMIUM

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

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each Y and ending on the following Y.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

CLAIMS INFORMATION

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

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

Routine Questions

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

Claim Submission

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

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

Initial Determination

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

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

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

Appealing the Initial Determination

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

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

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

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

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

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

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

Urgent Care Claim Submission

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

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

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

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

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

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

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

This continuation will terminate on the earliest of:

- a. the end of the 18, 29 or 36 month continuation period, as the case may be;
- b. the date of expiration of the last period for which the required payment was made;
- c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent's preexisting condition;
- d. the date your employer ceases to provide any group health plan for its employees.

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

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

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

Qualifying Event Due To Bankruptcy Of Employer

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

If You Elect COBRA

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

Duration Of COBRA Coverage

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

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

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

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

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

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

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

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

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

Premiums For COBRA Coverage

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

Initial Premium Payment

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

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

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Dental Plan Insurance

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

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

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

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

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

Assistance with Your Questions

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

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means Florida Health Sciences Center, Inc. dba Tampa General Hospital.

The term "Plan Administrator" means Florida Health Sciences Center, Inc. dba Tampa General Hospital.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

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

HR Manager, Sr. HR Generalists, Benefits Manager, HR Specialist

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Florida Health Sciences Center, Inc. dba Tampa General Hospital reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Florida Health Sciences Center, Inc. dba Tampa General Hospital shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

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