YOUR BENEFIT PLAN

Florida Health Sciences Center, Inc. dba Tampa General Hospital

All Full-Time Employees of Florida Health Sciences Center, Inc.
dba Tampa General Hospital

Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2019

Certificate Number 9A

Florida Health Sciences Center, Inc. dba Tampa General Hospital
1 Tampa General Dr.
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

MetLife

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.

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.

NOTICE FOR RESIDENTS OF ALASKA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

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

For Alaska Residents (Dental Insurance):

The term also includes newborns.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

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

For New Hampshire Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

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

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

For Utah Residents (Dental Insurance):

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

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

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

For Washington Residents (Dental Insurance):

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

NOTICE 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 ALASKA

Reasonable and Customary Charges

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

Reasonable Access to an In-Network Dentist

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

Exclusions

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

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

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

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

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

Initial Determination

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

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

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

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

Appealing the Initial Determination

If MetLife denies Your claim, You may appeal the denial. 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, or as soon as reasonably possible for situations in which You cannot reasonably meet the deadline. Appeals must be in writing and must include at least the following information:

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

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

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

After MetLife receives Your written request, 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. Your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. 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. MetLife will notify You in writing of its final decision within 18 days after MetLife's receipt of Your written request for review.

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.

Second Level Appeal

If You disagree with the response to the initial appeal of the denied claim, You have the right to a second level appeal. We shall communicate Our final determination to You within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to You shall include the specific reasons for the determination.

External Appeal

If You disagree with the response to the second appeal of the denied claim, You have the right to an external appeal. We will communicate the decision of the external appeal agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer's decision. Decisions made by an external appeal agency are binding on Us and You unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by You or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

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

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Insurance benefits is more than the total of the benefits due to You under this certificate; or

- payment We made should have been made by another group plan.

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

NOTICE FOR RESIDENTS OF ALASKA

Overpayments (Continued)

How We Recover Overpayments

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

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

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

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

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 MASSACHUSETTS RESIDENTS

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 RESIDENTS OF MISSISSIPPI

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

If Your claim is a Clean Claim and it is approved by MetLife, benefits will be paid within 25 days after MetLife receives due written proof in electronic form of a covered loss, or within 35 days after receipt of due written proof in paper form of a covered loss. Due written proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by You or the provider of the services in order for MetLife to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on Your behalf, a claim submitted more than 30 days after the date the provider bills You.

If MetLife is unable to pay a claim for Dental Insurance benefits because MetLife needs additional information or documentation, or there is a particular circumstance requiring special treatment, within 25 days after the date MetLife receives the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, MetLife will send You notice of what supporting documentation or information MetLife needs. Any claim or portion of a claim for Dental Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to You within 20 days after MetLife receives it.

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Clean Claim (Continued)

If MetLife does not deny payment of such benefits to You by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for clean claims submitted in paper form, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of 1½ percent per month until such benefits are finally settled. If MetLife does not pay benefits to You when due and payable, You may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. MetLife will pay benefits when MetLife receives satisfactory Written proof of Your claim.

Proof must be given to MetLife not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the proof is given as soon as possible.

Appealing the Initial Determination

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all employees;
- this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Dental Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

- send a written request to continue Your Dental Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

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

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all Dependents;
- this Dental Insurance is changed, for the class of employees to which You belong, to end Dental Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Dental Insurance for Your Dependents ends because You fail to pay a required premium.

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

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

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

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

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

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

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

NOTICE FOR 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 6 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;

- 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 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
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Appealing the Initial Determination

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

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

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.
MetLife will notify You in writing of its final 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 are required to have 24-hour emergency coverage or have alternate arrangements for emergency care for their patients. Since the MetLife Preferred Dentist Program is a freedom-of-choice PPO program, there is no primary care physician. No authorization of a service is necessary by a Primary Care Physician, nor is it necessary to obtain a pre-authorization of services. The patient is free to use the dentist of their choice.

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

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	In-Network	Out-of-Network Covered Percentage of the Reasonable and Customary Charge
Preventive and Diagnostic Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	85%
Basic Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	50%
Major Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	30%
Deductibles for:		
Yearly Individual Deductible	None	$50 for the following Covered Services Combined: Basic Restorative; Major Restorative
Yearly Family Deductible	None	$150 for the following Covered Services Combined: Basic Restorative; Major Restorative
Maximum Benefit:		
Yearly Individual Maximum	$1,500 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative	$1,500 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative

DEFINITIONS

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

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

- the 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 who is under age 26, supported by and living with You. The term also includes Your natural, adopted or stepchild under age 26 who is:
  - supported by You; and
  - a full-time or part-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

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

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

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

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

Co-Payment means the dollar amount that You pay to Your Dentist for Covered Services performed by an In-Network Dentist. The Co-Payment amount is shown in the Rider entitled PDP Co-Payment Schedule accompanying this certificate.

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

Contributory Insurance includes: Dental Insurance.

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

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

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

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services performed by an Out-of-Network Dentist.

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 16 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. He must also be certified and/or registered if required by such jurisdiction.

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

- the nature and extent of the loss or condition;

DEFINITIONS (continued)

- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lower of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) (the 'Actual Charge'); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 80th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife's Reasonable and Customary Charge records (the 'Customary Charge'). Where MetLife determines that there is inadequate charge information maintained in MetLife's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

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

Further information on how We determine the Reasonable and Customary Charge for a particular claim is available upon request.

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

Spouse means Your lawful spouse.

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

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

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

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder excluding residents of Louisiana, Mississippi, Montana and Texas.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

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

1. January 1, 2019; 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 30 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 30 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.

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

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

Qualifying Event includes:

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

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time employees of the Policyholder excluding residents of Louisiana, Mississippi, Montana and Texas.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

1. January 1, 2019;
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.

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

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

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

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

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

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 30 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.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 30 days of becoming eligible, You will not be able to enroll for Dependent Insurance until the next annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During an Annual Enrollment Period

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

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

Qualifying Event includes:

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

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 date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the end of the period for which the last premium has been paid;
9. the last day of the calendar month the person ceases to be a Dependent; or
10. 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;

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 <u>NOT</u> 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. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 12 months;
2. for the period You cease Active Work in an eligible class due to injury or sickness, up to 12 months.

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

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

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

DENTAL INSURANCE

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

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

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

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

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

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

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

BENEFIT AMOUNTS

We will pay benefit amounts for charges incurred by You or a Dependent for a Covered Service, subject to the conditions set forth in this certificate.

In-Network

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

If a Covered Service is performed by an In-Network Dentist, You will be responsible for paying the Co-Payment Amount shown in the MetLife Preferred Dentist Program Copay Schedule. If under the Alternate Benefits provision We pay benefits based upon a less costly Covered Service, the Co-Payment amount will be the amount applicable to the less costly service.

MetLife has the right to increase the amount of Your Co-Payment at the time of Your re-enrollment by adjusting Your Co-Payment schedule in order to maintain a consistent relationship between the Maximum Allowed Charges and the Co-Payment amounts.

Out-of-Network

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

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

- the Deductible
- any other part of the Reasonable and Customary Charge for which We do not pay benefits; and

- any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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 and each Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

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

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, 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

Preventive and Diagnostic 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 16, once in 12 months.

Basic 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. Space maintainers for a Child under age 16 once per lifetime per tooth area.
14. Sealants or sealant repairs for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
15. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
16. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Major 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. Injections of therapeutic drugs.
7. 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.
8. 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.
9. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 Years prior to replacement.
10. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 Years prior to replacement.
11. 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.
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, but not more than once in a 12 month period.
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. Oral surgery, except as mentioned elsewhere in this certificate.
21. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
22. Other consultations, but not more than twice in a 12 month period.
23. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24 month period for the same tooth.
24. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
25. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
26. Full mouth debridements.

27. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
28. Simple extractions.
29. Surgical extractions.
30. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 5 Year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
31. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5 Year period**:**
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
32. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5 Year period**:**
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
33. Implant supported removable Dentures, but no more than once for the same tooth position in a 5 Year period**:**
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
34. Tissue conditioning, but not more than once in a 36 month period.
35. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
36. Occlusal adjustments, but not more than once in a 12 month period.
37. Cleaning and inspection of a removable appliance once every 6 months.
38. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

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. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
19. 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;
20. 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;
21. caries susceptibility tests;
22. appliances or treatment for bruxism (grinding teeth);
23. initial installation of a Denture or implant or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;

DENTAL INSURANCE: EXCLUSIONS (continued)

24. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
25. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
26. duplicate prosthetic devices or appliances;
27. replacement of a lost or stolen appliance, Cast Restoration or Denture;
28. orthodontic services or appliances;
29. repair or replacement of an orthodontic device;
30. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
31. intra and extraoral photographic images
32. modification of removable prosthodontic and other removable prosthetic services.

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.

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.

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent).

If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-438-6388. 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.

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

Step 1
A claimant can request a claim form by calling Us at 1-800-438-6388.

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

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

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond 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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

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

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.

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MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10010-3690

CERTIFICATE RIDER

Group Policy No.: 143078-1-G

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

Effective Date: January 1, 2019

As of the above effective date, the certificate for all employees is changed by adding the following MetLife Preferred Dentist Program Copay Schedule.

Service Category	Description	Area 1	Area 2	Area 3	Area 4
Diagnostic	Periodic Oral Evaluation	$0	$0	$0	$0
	Limited Oral Evaluation	$5	$5	$5	$10
	Oral Evaluation Under Age of 3	$5	$5	$5	$5
	Comprehensive Oral Evaluation	$5	$5	$5	$10
	Extensive Oral Evaluation	$10	$10	$10	$15
	Limited Oral Re-Evaluation	$5	$5	$5	$10
	Comprehensive Perio Evaluation	$5	$5	$10	$10
	Screening of a Patient	$0	$0	$0	$0
	Assessment of a Patient	$0	$0	$0	$0
	Complete Set Radiographic Images	$10	$10	$15	$15
	Periapical Radiographic Image	$5	$10	$10	$10
	Additional Periapical Images	$5	$5	$5	$5
	Occlusal Radiographic Image	$15	$15	$15	$20
	Extraoral 2D Radiographic Image	$25	$25	$30	$30
	Extraoral Posterior Image	$25	$25	$30	$30
	Bitewing - Single Image	$0	$0	$5	$5
	Bitewings - Two Images	$5	$5	$5	$5
	Bitewings - Three Images	$5	$5	$5	$5
	Bitewings - Four Images	$5	$5	$5	$5
	Vertical Bitewings 7-8 Images	$5	$5	$5	$10
	Skull/Facial Bone Image	$30	$35	$40	$40
	Panoramic Radiographic Image	$10	$10	$10	$15
	2D Cephalometric Image	$35	$40	$45	$45
	Cone Beam Less Than Whole Jaw	$225	$260	$295	$320
	Cone Beam Full Arch Mandible	$225	$260	$295	$320
	Cone Beam Full Arch Maxilla	$225	$260	$295	$320
	Cone Beam Both Jaws	$225	$260	$295	$320
	Cone Beam - TMJ	$225	$260	$295	$320
	Cone Beam Capture Less Than One Jaw	$225	$260	$295	$320
	Cone Beam Capture - Mandible	$225	$260	$295	$320

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	Cone Beam Capture - Maxilla	$225	$260	$295	$320
	Cone Beam Capture - Both Jaws	$225	$260	$295	$320
	Cone Beam Capture - TMJ Series	$225	$260	$295	$320
	Interpretation-Diagnostic Image	$15	$15	$15	$20
	Lab Test	$20	$20	$25	$35
	Saliva Sample Collection	$15	$15	$20	$25
	Pulp Vitality Test	$15	$15	$20	$20
	Diagnostic Casts	$30	$35	$40	$45
Preventive	Cleaning - Adult	$15	$15	$15	$15
	Cleaning - Child	$15	$15	$15	$15
	Topical Fluoride-Varnish	$5	$5	$5	$10
	Topical Application-Fluoride	$5	$5	$5	$5
	Sealant - Per Tooth	$15	$15	$15	$20
	Preventive Resin Restoration	$15	$15	$20	$20
	Sealant Repair-Per Tooth	$0	$0	$0	$0
	Interim Caries Medicament	$5	$10	$10	$10
	Space Maintainer Fixed-Unilateral	$115	$135	$150	$160
	Space Maintainer Fixed-Bilateral	$160	$185	$205	$225
	Space Maintainer Rem-Unilateral	$115	$135	$150	$160
	Space Maintainer Rem-Bilateral	$205	$235	$265	$280
	Recement Space Maintainer	$15	$20	$25	$25
	Distal Space Maintainer Fixed	$115	$135	$150	$160
Restorative	One Surface Amalgam	$35	$40	$45	$55
	Two Surface Amalgam	$40	$50	$55	$65
	Three Surface Amalgam	$55	$60	$70	$85
	Four or More Surface Amalgam	$60	$70	$80	$100
	One Surface Composite Anterior	$40	$45	$50	$60
	Two Surface Composite Anterior	$50	$55	$65	$75
	Three Surface Composite Anterior	$60	$70	$75	$95
	4 or More Surface Composite Anterior	$70	$80	$90	$110
	Resin Crown	$105	$125	$140	$175
	One Surface Composite Posterior	$40	$45	$55	$65
	Two Surface Composite Posterior	$55	$65	$70	$85
	3 Surface Composite Posterior	$65	$75	$90	$105
	4 or More Surface Composite Posterior	$70	$85	$95	$120
	1 Surface Gold Foil	$130	$150	$165	$180
	2 Surface Gold Foil	$185	$210	$235	$255
	3 Surface Gold Foil	$220	$250	$285	$300
	One Surface Metallic Inlay	$270	$305	$345	$400
	Two Surface Metallic Inlay	$335	$380	$425	$485
	Three Surface Metallic Inlay	$360	$405	$455	$510
	Two Surface Metallic Onlay	$410	$465	$530	$590
	Three Surface Metallic Onlay	$420	$480	$545	$600
	4 or More Surface. Metallic Onlay	$435	$500	$565	$640
	One Surface Porcelain Inlay	$320	$360	$405	$470
	2 Surface Porcelain Inlay	$355	$400	$455	$505

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	3 or More Surface Porcelain Inlay	$410	$465	$530	$575
	2 Surface - Porcelain Onlay	$475	$545	$615	$675
	3 Surface - Porcelain Onlay	$490	$560	$635	$690
	4 or More Surface - Porcelain Onlay	$500	$570	$645	$700
	1 Surface Composite/Resin Inlay	$245	$275	$310	$320
	2 Surface Composite/Resin Inlay	$285	$320	$365	$410
	3 or More Surface Composite/Resin Inlay	$315	$360	$405	$430
	2 Surface Composite/Resin Onlay	$390	$445	$505	$565
	3 Surface Composite/Resin Onlay	$395	$445	$505	$555
	4 or More Surface Composite/Resin Onlay	$405	$460	$515	$575
	Resin Crown (Indirect)	$180	$210	$230	$255
	Crown 3/4 Resin Based Indirect	$175	$195	$220	$245
	Crown Resin with High Noble Metal	$445	$505	$575	$640
	Crown Resin with Base Metal	$350	$395	$445	$475
	Crown Resin with Noble Metal	$390	$440	$500	$545
	Crown Porcelain/Ceramic	$470	$540	$610	$680
	Crown Porcelain-High Noble Metal	$465	$535	$605	$670
	Crown Porcelain-Base Metal	$425	$485	$550	$595
	Crown Porcelain-Noble Metal	$445	$505	$575	$625
	Crown 3/4 High Noble	$460	$525	$595	$655
	Crown 3/4 Base Metal	$425	$480	$540	$610
	Crown 3/4 Cast Noble Metal	$425	$485	$550	$595
	Crown 3/4 Porcelain/Ceramic	$470	$540	$610	$665
	Crown High Noble	$430	$495	$565	$640
	Crown Full Cast/Base Metal	$385	$440	$505	$560
	Crown Full Cast Noble Metal	$395	$455	$515	$590
	Titanium Crown	$420	$480	$540	$590
	Recement Inlay, Onlay	$30	$35	$40	$50
	Recement Cast - Post Core	$30	$35	$40	$50
	Recement Crown	$30	$35	$40	$55
	Prefab Porcelain/Ceramic Crown-Primary	$75	$85	$95	$110
	Stainless Steel Crown - Child	$90	$100	$115	$140
	Stainless Steel Crown - Adult	$95	$110	$120	$160
	Resin Crown	$100	$115	$130	$150
	Stainless Steel Crown/Resin	$125	$140	$165	$180
	Stainless Steel Crown Primary Tooth	$95	$105	$120	$140
	Sedative Filling	$20	$25	$25	$40
	Core Buildup	$80	$90	$100	$135
	Pin Retention Per Tooth	$15	$15	$20	$20
	Post And Core	$165	$185	$210	$225
	Cast Post - Each Additional Same Tooth	$20	$20	$25	$30
	Prefab Post And Core	$115	$130	$145	$170
	Steel Post - Each Additional Same Tooth	$10	$15	$15	$30
	Resin Labial Veneer-Chairside	$195	$220	$245	$295
	Resin Labial Veneer-Laboratory	$310	$345	$390	$435
	Porcelain Labial Veneer	$395	$450	$500	$590

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	Additional Crown Procedure	$75	$85	$100	$110
	Crown Repair	$80	$90	$100	$125
	Inlay Repair	$80	$90	$100	$125
	Onlay Repair	$80	$90	$100	$125
	Veneer Repair	$80	$90	$100	$125
	Resin Infiltration/Smooth Surface	$15	$15	$20	$20
Endodontics	Pulp Cap-Direct	$20	$20	$25	$30
	Pulp Cap-Indirect	$15	$20	$25	$25
	Therapeutic Pulpotomy	$40	$45	$50	$60
	Pulpal Debridement	$25	$25	$30	$60
	Partial Pulpotomy - Apexogenesis	$40	$45	$50	$60
	Pulpal Therapy Anterior/Primary Tooth	$115	$130	$150	$155
	Pulpal Therapy Post/Primary Tooth	$140	$160	$180	$185
	Endodontic Therapy - Anterior	$285	$320	$365	$420
	Endodontic Therapy - Bicuspid	$335	$380	$435	$495
	Endodontic Therapy - Molar	$450	$510	$580	$625
	Treatment of Root Canal Obstruct	$90	$100	$110	$120
	Incomplete Root Canal Therapy	$130	$150	$165	$205
	Root Perforation Repair	$75	$85	$95	$110
	Root Canal Retreat/Anterior	$350	$395	$450	$510
	Root Canal Retreat/Bicuspid	$395	$450	$510	$585
	Root Canal Retreatment - Molar	$515	$580	$665	$725
	Apexification - Initial Visit	$120	$135	$155	$175
	Apexification/Recalcification	$70	$75	$85	$95
	Apexification - Final Visit	$175	$200	$225	$275
	Pulpal Regeneration - Initial Visit	$70	$75	$85	$95
	Pulpal Regeneration - Interim Medication Replacement	$35	$40	$45	$50
	Pulpal Regeneration - Completion Of Treatment	$70	$75	$85	$95
	Apicoectomy – Anterior	$265	$295	$335	$395
	Apicoectomy – Bicuspid	$300	$335	$380	$440
	Apicoectomy – Molar	$335	$375	$430	$485
	Apicoectomy - Additional Root	$130	$145	$160	$190
	Periradicular Surgery without Apioectomy	$250	$280	$320	$365
	Bone Graft In Conjunction with Periradicular Surgery	$185	$200	$225	$255
	Bone Graft In Conjunction with Periradicular Surgery	$115	$135	$150	$135
	Retrograde Filling - Per Root	$85	$90	$105	$130
	Biologic Materials to Aid in Soft And Osseous Tissue Regeneration	$115	$130	$145	$190
	Guided Tissue Regeneration, Resorbable Barrier	$170	$195	$220	$280
	Root Amputation - Per Root	$190	$215	$245	$270
	Hemisection	$160	$180	$205	$220
Periodontics	Gingivectomy/Plasty Full Quadrant	$215	$245	$280	$305
	Gingivectomy/Plasty - 1-3 Teeth	$40	$45	$50	$65
	Gingivectomy/Plasty with Rest-Tooth	$35	$40	$45	$50
	Gingival Flap Procedure Full Quadrant	$235	$265	$300	$335

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	Gingival Flap 1 - 3 Teeth	$150	$165	$190	$210
	Apically Positioned Flap	$130	$140	$160	$180
	Crown Lengthening	$345	$390	$450	$465
	Osseous Surgery - 4 or More Teeth	$480	$540	$620	$675
	Osseous Surgery 1 - 3 Teeth	$300	$345	$395	$445
	Bone Graft - First Site	$185	$205	$225	$255
	Bone Graft - Additional Site	$115	$135	$150	$135
	Biologic Materials	$115	$130	$150	$190
	Guided Tissue Regeneration - Resorbable Barrier	$175	$200	$225	$280
	Guided Tissue Regeneration - Nonresorbable Barrier	$215	$245	$275	$325
	Surgical Revision Procedure	$60	$65	$75	$100
	Pedicle Soft Tissue Graft	$270	$300	$335	$415
	Autogenous Tissue Graft	$420	$480	$545	$620
	Distal/Proximal Wedge	$155	$170	$190	$240
	Non Autogenous Tissue Graft	$400	$455	$515	$565
	Combined Tissue Grafting/Tooth	$430	$490	$550	$630
	Free Soft Tissue Graft 1st Tooth	$345	$390	$445	$505
	Free Soft Tissue Graft-Additional Tooth	$175	$200	$225	$255
	Subepithelial Tissue Graft/Additional	$210	$240	$275	$310
	Soft Tissue Allograft Additional	$200	$230	$260	$285
	Scaling/Root Planing - Per Quadrant	$85	$100	$110	$130
	Scaling & Root Planing 1-3 Teeth	$55	$65	$70	$85
	Scaling Gingival Inflammation	$15	$15	$15	$15
	Full Mouth Debridement	$45	$50	$55	$75
	Delivery of Antimicrobial Agents	$40	$45	$50	$60
	Periodontal Maintenance	$35	$40	$50	$55
	Dressing Change	$25	$25	$30	$35
Prosthodontics – Removable	Complete Upper Denture	$575	$650	$740	$825
	Complete Lower Denture	$575	$650	$740	$825
	Immediate Denture Maxillary	$615	$700	$795	$925
	Immediate Denture Mandibular	$615	$700	$795	$925
	Upper Partial Denture - Resin	$425	$485	$550	$615
	Lower Partial Denture - Resin	$425	$485	$550	$615
	Upper Partial Denture - Cast	$700	$780	$885	$950
	Lower Partial Denture - Cast	$700	$780	$885	$950
	Immediate Maxillary Partial Resin	$425	$485	$550	$615
	Immediate Mandibular Partial Resin	$425	$485	$550	$615
	Immediate Maxillary Partial Metal	$700	$780	$885	$950
	Immediate Mandibular Partial Metal	$700	$780	$885	$950
	Upper Partial Denture - Flexible	$510	$580	$655	$725
	Lower Partial Denture - Flexible	$510	$580	$655	$725
	Unilateral Partial Denture	$265	$295	$340	$435
	Adjust Upper Complete Denture	$25	$30	$35	$40
	Adjust Lower Complete Denture	$25	$30	$35	$40
	Adjust Upper Partial Denture	$25	$30	$35	$45

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	Adjust Lower Partial Denture	$25	$30	$35	$45
	Repair Denture Base - Mandibular	$80	$85	$85	$105
	Repair Denture Base - Maxillary	$80	$85	$85	$105
	Replace Tooth on Denture-Per Tooth	$70	$80	$90	$100
	Repair Resin Partial – Mandibular	$60	$65	$65	$80
	Repair Resin Partial - Maxillary	$60	$65	$65	$80
	Repair Cast Partial – Mandibular	$75	$75	$75	$95
	Repair Cast Partial - Maxillary	$75	$75	$75	$95
	Repair/Replace Broken Clasp	$70	$75	$85	$105
	Replace Tooth on Denture	$70	$80	$90	$100
	Add Tooth to Denture	$75	$85	$95	$110
	Add Clasp Partial Denture	$95	$110	$125	$135
	Replace Maxillary Teeth & Framework	$185	$210	$240	$265
	Replace Mandibular Teeth & Framework	$190	$215	$245	$270
	Rebase Complete Upper Denture	$210	$240	$275	$310
	Rebase Complete Lower Denture	$205	$235	$265	$295
	Rebase Upper Partial Denture	$185	$210	$245	$270
	Rebase Lower Partial Denture	$185	$215	$245	$270
	Reline Upper Denture - Chairside	$120	$135	$155	$175
	Reline Lower Denture - Chairside	$120	$135	$155	$175
	Reline Upper Denture - Chairside	$100	$110	$125	$160
	Reline Lower Denture - Chairside	$100	$110	$125	$160
	Reline Upper Denture - Lab	$180	$200	$230	$250
	Reline Lower Denture - Lab	$180	$200	$230	$250
	Reline Upper Denture - Lab	$155	$175	$205	$225
	Reline Lower Denture - Lab	$155	$175	$200	$230
	Tissue Conditioning - Upper	$55	$65	$75	$85
	Tissue Conditioning - Lower	$55	$65	$75	$85
	Overdenture - Complete Maxillary	$755	$845	$955	$1,040
	Overdenture - Partial Maxillary	$680	$770	$875	$965
	Overdenture - Complete Mandibular	$755	$845	$960	$1,045
	Overdenture - Partial Mandibular	$680	$770	$875	$965
Implant Services	Endosteal Implant	$890	$1,010	$1,160	$1,215
	Placement of Internal Implant	$865	$980	$1,125	$1,180
	Surgical Placement of Mini Implant	$880	$1,000	$1,145	$1,200
	Eposteal Implant	$1,635	$1,855	$2,110	$2,290
	Transosteal Implant	$1,995	$2,265	$2,575	$2,750
	Interim Abutment	$150	$170	$195	$185
	Semi-Precision Attachment Abutment	$400	$450	$510	$495
	Implant Connecting Bar	$390	$440	$505	$560
	Prefab Implant Abutment	$305	$345	$390	$375
	Custom Implant Abutment	$400	$450	$510	$495
	Implant Crown - Porcelain	$585	$665	$755	$780
	Implant Crown- Porcelain-High Noble	$555	$630	$715	$765
	Implant Crown- Porcelain Base Metal	$500	$570	$650	$680
	Implant Crown-Porcelain Noble Metal	$535	$605	$695	$705

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	Implant Crown - Cast High Noble	$535	$605	$690	$750
	Implant Crown - Cast Base Metal	$465	$525	$595	$615
	Implant Crown - Cast Noble Metal	$495	$565	$640	$665
	Implant Crown - Porcelain	$570	$650	$740	$810
	Implant Crown - Porcelain-Metal	$555	$630	$720	$780
	Implant Crown - Metal	$540	$610	$695	$750
	Implant Retainer - Porcelain	$570	$645	$730	$735
	Implant Retainer - Porcelain-Metal	$545	$620	$705	$725
	Implant Retainer - Base Metal	$500	$565	$640	$645
	Implant Retainer - Noble Metal	$530	$600	$680	$680
	Implant Retainer - High Noble	$520	$590	$670	$685
	Implant Retainer - Base Metal	$430	$485	$555	$575
	Implant Retainer - Noble Metal	$475	$535	$610	$640
	Implant Retainer - Ceramic	$545	$615	$700	$700
	Implant Retainer - High Noble	$540	$615	$700	$745
	Implant Retainer-Cast-High Noble	$505	$575	$655	$685
	Implant Maintenance Procedures	$45	$50	$55	$70
	Scaling and Debridement Implant	$20	$25	$30	$30
	Repair Implant Prosthesis	$105	$120	$135	$150
	Precision Attachment Replacement	$180	$205	$230	$260
	Recement Implant Crown	$30	$35	$40	$55
	Recement Implant Fixed Denture	$50	$55	$65	$80
	Implant Crown - Titanium	$505	$570	$650	$660
	Repair Implant Abutment By Report	$120	$135	$155	$170
	Remove Broken Implant Screw	$15	$15	$15	$20
	Implant Removal By Report	$150	$170	$190	$290
	Debridement Peri-implant Defect	$45	$50	$55	$65
	Debride/Oss Peri-implant Defect	$90	$105	$120	$125
	Bone Graft/Peri-implant Defect	$195	$230	$255	$330
	Bone Graft Implant Placement	$195	$230	$255	$335
	Implant Overdenture-Maxillary	$1,145	$1,320	$1,475	$1,720
	Implant Overdenture-Mandibular	$1,145	$1,320	$1,475	$1,720
	Implant Overdenture Partial-Maxillary	$1,030	$1,200	$1,355	$1,555
	Implant Overdenture Partial-Mandibular	$1,030	$1,200	$1,355	$1,555
	Implant Supported Fixed Denture Maxillary	$1,865	$2,110	$2,380	$2,320
	Implant Supported Fixed Denture Mandibular	$1,865	$2,110	$2,380	$2,320
	Implant Supported Fixed Partial Maxillary	$1,930	$2,165	$2,475	$2,480
	Implant Supported Fixed Partial Mandibular	$1,930	$2,165	$2,475	$2,480
	Implant Index	$105	$120	$135	$145
	Implant Retainer - Titanium	$485	$550	$625	$635
Prosthodontics – Fixed	Pontic - Indirect Composite	$325	$365	$415	$455
	Pontic - Cast High Noble	$420	$480	$550	$615
	Pontic - Cast Base Metal	$380	$430	$490	$550
	Pontic - Cast Noble Metal	$395	$450	$510	$575
	Pontic – Titanium	$400	$450	$515	$570
	Pontic - Porcelain - High Noble	$440	$505	$575	$630

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	Pontic - Porcelain - Base Metal	$410	$470	$535	$565
	Pontic - Porcelain Noble Metal	$430	$490	$555	$600
	Pontic – Porcelain	$465	$525	$600	$665
	Pontic-Resin with High Noble Metal	$445	$505	$575	$630
	Pontic - Resin with Base Metal	$340	$380	$430	$475
	Pontic - Resin with Noble Metal	$365	$415	$470	$520
	Cast Metal Retainer	$180	$205	$240	$265
	Retainer - Porcelain/Ceramic	$205	$230	$270	$395
	Resin Retainer-Fixed Prosthesis	$155	$175	$200	$295
	Retainer Inlay Ceramic 2 Surface	$420	$475	$540	$575
	Retainer Inlay Ceramic 3 or More Surface	$430	$485	$555	$595
	Retainer Inlay High Noble 2 Surface	$310	$350	$400	$440
	Retainer Inlay High Noble 3-More Surface	$340	$385	$435	$485
	Retainer Inlay Metal 2 Surfaces	$300	$340	$390	$415
	Retainer Inlay Metal 3-More Surface	$320	$360	$410	$445
	Retainer Inlay Cast Metal 2 Surface	$300	$340	$390	$425
	Retainer Inlay Cast Metal 3-More Surface	$335	$380	$435	$465
	Retainer Onlay Ceramic 2 Surface	$425	$485	$550	$590
	Retainer Onlay Ceramic 3 or More Surface	$440	$500	$570	$605
	Retainer Onlay High Noble 2 Surface	$360	$400	$455	$485
	Retainer Onlay High Noble 3 or More Surface	$405	$455	$520	$565
	Retainer Onlay Base Metal 2 Surfaces	$345	$385	$435	$460
	Retainer Onlay Base Metal 3 or More Surface	$390	$445	$505	$550
	Retainer Onlay Cast Noble 2 Surface	$350	$390	$440	$470
	Retainer Onlay Cast Noble 3 or More Surface	$400	$450	$510	$550
	Retainer Inlay – Titanium	$290	$330	$375	$405
	Retainer Onlay – Titanium	$345	$385	$440	$460
	Retainer Crown Indirect Resin	$330	$370	$420	$440
	Retainer Crown-Resin High Noble	$445	$505	$575	$630
	Retainer Crown-Resin Base Metal	$355	$400	$450	$475
	Retainer Crown-Resin Noble Metal	$380	$430	$490	$535
	Retainer Crown-Porcelain/Ceramic	$480	$550	$625	$695
	Retainer Crown-Porcelain-High Noble	$465	$535	$605	$670
	Retainer Crown-Porcelain-Base Metal	$425	$485	$550	$600
	Retainer Crown-Porcelain-Noble Metal	$440	$505	$570	$625
	Retainer Crown 3/4 Cast High Noble	$440	$505	$570	$635
	Retainer Crown 3/4 Base Metal	$390	$440	$500	$545
	Retainer Crown-3/4 Noble Metal	$405	$465	$525	$580
	Retainer Crown-3/4 Porcelain	$465	$525	$600	$645
	Retainer Crown Full Cast High	$430	$495	$560	$625
	Retainer Crown-Full Cast Base	$380	$435	$495	$555
	Retainer Crown-Full Cast Noble	$400	$460	$520	$595
	Retainer Crown – Titanium	$410	$470	$535	$585
	Connector Bar	$290	$330	$375	$400
	Recement Bridge	$50	$55	$65	$80
	Bridge Repair, By Report	$75	$85	$95	$120

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Oral and Maxillofacial Surgery	Extract Coronal Remnants	$45	$50	$60	$70
	Extract Erupted Tooth/Exposed Root	$50	$60	$65	$85
	Extract Erupted Tooth - Surgical	$90	$105	$120	$145
	Extract Impacted Tooth Soft Tissue	$115	$135	$150	$175
	Extract Impacted Tooth Partial Bony	$145	$165	$190	$215
	Extract Impacted Tooth Completely Bony	$185	$210	$240	$260
	Extract Impacted Tooth Bony with Complications	$210	$235	$275	$290
	Remove Residual Root	$95	$110	$125	$155
	Coronectomy	$185	$210	$240	$260
	Oroantral Fistula Surgery	$310	$355	$400	$430
	Primary Sinus Perforation Closure	$330	$370	$420	$445
	Tooth Replantation	$165	$190	$215	$265
	Tooth Transplantation	$160	$185	$210	$230
	Unerupted Tooth Access	$185	$210	$240	$285
	Mobilize to Aid Eruption	$165	$185	$210	$240
	Cytology Sample	$35	$40	$45	$65
	Brush Biopsy	$35	$40	$45	$70
	Reposition Teeth - Surgical	$175	$200	$225	$255
	Alveoplasty - with Extractions	$85	$100	$110	$130
	Alveoplasty With Extractions	$50	$60	$70	$75
	Alveoplasty without Extraction	$135	$150	$170	$215
	Alveoplasty without Extraction	$80	$90	$105	$130
	Vestibuloplasty	$435	$490	$555	$590
	Vestibuloplasty	$1,150	$1,300	$1,480	$1,590
	Remove Odontogenic Cyst/Tumor	$165	$185	$215	$255
	Remove Odontogenic Cyst/Tumor	$395	$445	$500	$510
	Removal Of Exostosis	$240	$270	$315	$330
	Remove Torus Palatinus	$240	$270	$310	$325
	Remove Torus Mandibularis	$245	$280	$320	$335
	Reduce Osseous Tuberosity	$130	$150	$170	$210
	Abscess - Intraoral Incision	$70	$75	$85	$110
	Abscess - Intraoral Incision	$70	$75	$85	$100
	Abscess - Extraoral Incision	$110	$125	$145	$175
	Abscess - Extraoral Incision	$105	$120	$135	$165
	Collect - Apply Autologous Product	$115	$130	$145	$190
	Bone Grafts- Mandible or Maxilla	$840	$840	$840	$850
	Sinus Augmentation-Lateral	$1,190	$1,190	$1,190	$1,195
	Sinus Augmentation - Vertical	$1,190	$1,190	$1,190	$1,195
	Bone Graft	$195	$230	$255	$330
	Frenulectomy – Separate	$135	$150	$175	$220
	Frenuloplasty	$130	$145	$170	$195
	Excision Hyperplastic Tissue	$155	$175	$195	$220
	Excise Pericoronal Gingiva	$70	$75	$85	$110
	Reduce Fibrous Tuberosity	$145	$165	$185	$220

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Adjunctive General Services	Emergency Relief of Pain	$25	$25	$30	$40
	Bridge Sectioning	$55	$60	$70	$70
	Deep Sedation/Gen Anesthesia 1st 15 Minutes	$75	$80	$80	$95
	Deep Sedation/General Anesthesia	$75	$85	$100	$105
	Intravenous Sedation 1st 15 Minutes	$65	$70	$70	$80
	Intravenous Sedation	$65	$75	$85	$95
	Consultation with Medical Professional	$25	$30	$30	$35
	Consultation	$50	$55	$65	$70
	Inject Drug - Therapeutic	$25	$30	$30	$35
	Multiple Therapeutic Drugs	$40	$45	$55	$60
	Apply Desensitizing Medicine	$20	$25	$25	$30
	Desensitizing Resin	$20	$25	$25	$30
	Post-Surgical Complications	$35	$40	$45	$60
	Clean Inspect Complete Upper	$45	$50	$55	$70
	Clean Inspect Complete Lower	$45	$50	$55	$70
	Clean Inspect Partial Upper	$45	$50	$55	$70
	Clean Inspect Partial Lower	$45	$50	$55	$70
	Occlusal Guards	$235	$270	$305	$330
	Repair / Reline Occlusal Guard	$75	$85	$95	$105
	Occlusal Guard Adjustment	$20	$20	$25	$25
	Adjust Occlusion - Limited	$35	$45	$50	$55
	Adjust Occlusion - Complete	$170	$200	$225	$270

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The Copay amounts vary depending on the geographic location of where the Covered Dental Expense is performed. In order to determine what Copay amount will apply, the following is a listing of the geographic locations that are included within each area.

State	Zip	Area	State	Zip	Area	State	Zip	Area	State	Zip	Area
Alabama	350	1	Alabama	351	1	Alabama	352	1	Alabama	354	1
Alabama	355	1	Alabama	356	1	Alabama	357	1	Alabama	358	1
Alabama	359	1	Alabama	360	1	Alabama	361	1	Alabama	362	1
Alabama	363	1	Alabama	364	1	Alabama	365	1	Alabama	366	1
Alabama	367	1	Alabama	368	1	Alabama	369	1	Alaska	995	4
Alaska	996	4	Alaska	997	4	Alaska	998	4	Alaska	999	4
Arizona	850	2	Arizona	851	2	Arizona	852	2	Arizona	853	2
Arizona	855	2	Arizona	856	2	Arizona	857	1	Arizona	859	2
Arizona	860	2	Arizona	863	2	Arizona	864	2	Arizona	865	2
Arkansas	716	1	Arkansas	717	1	Arkansas	718	2	Arkansas	719	1
Arkansas	720	1	Arkansas	721	2	Arkansas	722	1	Arkansas	723	1
Arkansas	724	1	Arkansas	725	1	Arkansas	726	1	Arkansas	727	2
Arkansas	728	1	Arkansas	729	1	California	900	2	California	901	2
California	902	2	California	903	3	California	904	3	California	905	2
California	906	2	California	907	2	California	908	2	California	910	3
California	911	3	California	912	2	California	913	2	California	914	2
California	915	2	California	916	2	California	917	2	California	918	2
California	919	2	California	920	2	California	921	2	California	922	2
California	923	2	California	924	2	California	925	2	California	926	2
California	927	2	California	928	2	California	930	3	California	931	4
California	932	3	California	933	3	California	934	3	California	935	3
California	936	2	California	937	2	California	938	2	California	939	3
California	940	4	California	941	4	California	942	4	California	943	4
California	944	4	California	945	3	California	946	3	California	947	4
California	948	3	California	949	4	California	950	3	California	951	4
California	952	3	California	953	2	California	954	3	California	955	4
California	956	3	California	957	3	California	958	3	California	959	3
California	960	3	California	961	3	Colorado	800	2	Colorado	801	2
Colorado	802	2	Colorado	803	2	Colorado	804	2	Colorado	805	2
Colorado	806	2	Colorado	807	2	Colorado	808	2	Colorado	809	2
Colorado	810	2	Colorado	811	2	Colorado	812	2	Colorado	813	2
Colorado	814	2	Colorado	815	2	Colorado	816	4	Connecticut	060	3
Connecticut	061	3	Connecticut	062	4	Connecticut	063	3	Connecticut	064	3
Connecticut	065	4	Connecticut	066	3	Connecticut	067	3	Connecticut	068	3
Connecticut	069	4	D.C.	200	3	D.C.	202	2	D.C.	203	2
D.C.	204	2	D.C.	205	2	Delaware	197	4	Delaware	198	4
Delaware	199	4	Florida	320	1	Florida	321	1	Florida	322	1
Florida	323	1	Florida	324	1	Florida	325	1	Florida	326	1
Florida	327	1	Florida	328	1	Florida	329	1	Florida	330	2
Florida	331	2	Florida	332	2	Florida	333	1	Florida	334	1
Florida	335	1	Florida	336	1	Florida	337	1	Florida	338	2
Florida	339	2	Florida	341	2	Florida	342	2	Florida	344	1
Florida	346	1	Florida	347	1	Florida	349	2	Georgia	300	2
Georgia	301	2	Georgia	302	2	Georgia	303	2	Georgia	304	2
Georgia	305	2	Georgia	306	2	Georgia	307	1	Georgia	308	1
Georgia	309	1	Georgia	310	2	Georgia	311	2	Georgia	312	1
Georgia	313	2	Georgia	314	2	Georgia	315	2	Georgia	316	2

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State	Zip	Area	State	Zip	Area	State	Zip	Area	State	Zip	Area
Georgia	317	2	Georgia	318	2	Georgia	319	2	Georgia	398	2
Guam	969	4	Hawaii	967	2	Hawaii	968	2	Idaho	832	2
Idaho	833	2	Idaho	834	2	Idaho	835	2	Idaho	836	2
Idaho	837	2	Idaho	838	2	Illinois	600	1	Illinois	601	2
Illinois	602	2	Illinois	603	2	Illinois	604	2	Illinois	605	2
Illinois	606	2	Illinois	607	2	Illinois	608	2	Illinois	609	1
Illinois	610	1	Illinois	611	1	Illinois	612	1	Illinois	613	1
Illinois	614	1	Illinois	615	1	Illinois	616	1	Illinois	617	1
Illinois	618	1	Illinois	619	1	Illinois	620	1	Illinois	622	1
Illinois	623	2	Illinois	624	1	Illinois	625	1	Illinois	626	1
Illinois	627	1	Illinois	628	1	Illinois	629	1	Indiana	460	1
Indiana	461	1	Indiana	462	1	Indiana	463	1	Indiana	464	1
Indiana	465	1	Indiana	466	2	Indiana	467	2	Indiana	468	2
Indiana	469	1	Indiana	470	2	Indiana	471	1	Indiana	472	1
Indiana	473	1	Indiana	474	1	Indiana	475	1	Indiana	476	1
Indiana	477	1	Indiana	478	1	Indiana	479	2	Iowa	500	1
Iowa	501	1	Iowa	502	2	Iowa	503	2	Iowa	504	2
Iowa	505	2	Iowa	506	1	Iowa	507	1	Iowa	508	1
Iowa	509	1	Iowa	510	3	Iowa	511	3	Iowa	512	1
Iowa	513	1	Iowa	514	1	Iowa	515	1	Iowa	516	2
Iowa	520	1	Iowa	521	1	Iowa	522	1	Iowa	523	1
Iowa	524	1	Iowa	525	1	Iowa	526	1	Iowa	527	1
Iowa	528	1	Kansas	660	2	Kansas	661	1	Kansas	662	2
Kansas	664	2	Kansas	665	2	Kansas	666	2	Kansas	667	1
Kansas	668	1	Kansas	669	1	Kansas	670	2	Kansas	671	1
Kansas	672	2	Kansas	673	1	Kansas	674	1	Kansas	675	1
Kansas	676	1	Kansas	677	1	Kansas	678	2	Kansas	679	1
Kentucky	400	1	Kentucky	401	1	Kentucky	402	1	Kentucky	403	1
Kentucky	404	1	Kentucky	405	1	Kentucky	406	1	Kentucky	407	1
Kentucky	408	1	Kentucky	409	1	Kentucky	410	1	Kentucky	411	1
Kentucky	412	1	Kentucky	413	1	Kentucky	414	1	Kentucky	415	2
Kentucky	416	1	Kentucky	417	1	Kentucky	418	1	Kentucky	420	2
Kentucky	421	1	Kentucky	422	1	Kentucky	423	1	Kentucky	424	1
Kentucky	425	1	Kentucky	426	1	Kentucky	427	1	Louisiana	700	1
Louisiana	701	1	Louisiana	703	1	Louisiana	704	1	Louisiana	705	1
Louisiana	706	1	Louisiana	707	1	Louisiana	708	1	Louisiana	710	1
Louisiana	711	1	Louisiana	712	1	Louisiana	713	1	Louisiana	714	1
Maine	039	4	Maine	040	4	Maine	041	4	Maine	042	4
Maine	043	4	Maine	044	3	Maine	045	4	Maine	046	3
Maine	047	3	Maine	048	4	Maine	049	4	Maryland	206	1
Maryland	207	2	Maryland	208	2	Maryland	209	2	Maryland	210	2
Maryland	211	2	Maryland	212	1	Maryland	214	2	Maryland	215	1
Maryland	216	1	Maryland	217	1	Maryland	218	1	Maryland	219	2
Massachusetts	010	2	Massachusetts	011	3	Massachusetts	012	2	Massachusetts	013	2
Massachusetts	014	3	Massachusetts	015	3	Massachusetts	016	3	Massachusetts	017	3
Massachusetts	018	3	Massachusetts	019	3	Massachusetts	020	3	Massachusetts	021	3
Massachusetts	022	3	Massachusetts	023	3	Massachusetts	024	3	Massachusetts	025	3
Massachusetts	026	2	Massachusetts	027	2	Michigan	480	2	Michigan	481	2
Michigan	482	2	Michigan	483	2	Michigan	484	2	Michigan	485	2
Michigan	486	1	Michigan	487	1	Michigan	488	2	Michigan	489	2
Michigan	490	2	Michigan	491	2	Michigan	492	2	Michigan	493	2
Michigan	494	2	Michigan	495	2	Michigan	496	2	Michigan	497	2

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State	Zip	Area	State	Zip	Area	State	Zip	Area	State	Zip	Area
Michigan	498	3	Michigan	499	2	Minnesota	550	3	Minnesota	551	3
Minnesota	553	3	Minnesota	554	3	Minnesota	555	2	Minnesota	556	2
Minnesota	557	2	Minnesota	558	2	Minnesota	559	2	Minnesota	560	2
Minnesota	561	1	Minnesota	562	1	Minnesota	563	2	Minnesota	564	2
Minnesota	565	2	Minnesota	566	1	Minnesota	567	1	Mississippi	386	1
Mississippi	387	1	Mississippi	388	1	Mississippi	389	1	Mississippi	390	1
Mississippi	391	2	Mississippi	392	1	Mississippi	393	1	Mississippi	394	1
Mississippi	395	1	Mississippi	396	2	Mississippi	397	2	Missouri	630	2
Missouri	631	2	Missouri	632	1	Missouri	633	1	Missouri	634	2
Missouri	635	1	Missouri	636	1	Missouri	637	1	Missouri	638	1
Missouri	639	1	Missouri	640	1	Missouri	641	1	Missouri	644	1
Missouri	645	1	Missouri	646	1	Missouri	647	1	Missouri	648	1
Missouri	649	1	Missouri	650	1	Missouri	651	1	Missouri	652	2
Missouri	653	1	Missouri	654	1	Missouri	655	1	Missouri	656	1
Missouri	657	1	Missouri	658	2	Montana	590	2	Montana	591	2
Montana	592	2	Montana	593	2	Montana	594	2	Montana	595	3
Montana	596	3	Montana	597	3	Montana	598	3	Montana	599	2
Nebraska	680	1	Nebraska	681	1	Nebraska	683	1	Nebraska	684	1
Nebraska	685	1	Nebraska	686	1	Nebraska	687	1	Nebraska	688	1
Nebraska	689	1	Nebraska	690	1	Nebraska	691	1	Nebraska	692	1
Nebraska	693	1	Nevada	889	2	Nevada	890	2	Nevada	891	2
Nevada	893	3	Nevada	894	4	Nevada	895	4	Nevada	897	4
Nevada	898	4	New Hampshire	030	4	New Hampshire	031	4	New Hampshire	032	4
New Hampshire	033	4	New Hampshire	034	4	New Hampshire	035	4	New Hampshire	036	4
New Hampshire	037	4	New Hampshire	038	4	New Jersey	070	2	New Jersey	071	2
New Jersey	072	2	New Jersey	073	2	New Jersey	074	3	New Jersey	075	3
New Jersey	076	3	New Jersey	077	2	New Jersey	078	3	New Jersey	079	3
New Jersey	080	2	New Jersey	081	2	New Jersey	082	2	New Jersey	083	2
New Jersey	084	2	New Jersey	085	2	New Jersey	086	2	New Jersey	087	2
New Jersey	088	3	New Jersey	089	3	New Mexico	870	3	New Mexico	871	2
New Mexico	872	2	New Mexico	873	3	New Mexico	874	3	New Mexico	875	2
New Mexico	877	2	New Mexico	878	3	New Mexico	879	2	New Mexico	880	2
New Mexico	881	2	New Mexico	882	2	New Mexico	883	2	New Mexico	884	2
New York	100	3	New York	101	3	New York	102	3	New York	103	2
New York	104	1	New York	105	3	New York	106	3	New York	107	3
New York	108	3	New York	109	2	New York	110	2	New York	111	2
New York	112	2	New York	113	2	New York	114	2	New York	115	2
New York	116	2	New York	117	2	New York	118	2	New York	119	2
New York	120	1	New York	121	1	New York	122	1	New York	123	1
New York	124	1	New York	125	1	New York	126	1	New York	127	2
New York	128	2	New York	129	2	New York	130	2	New York	131	2
New York	132	2	New York	133	2	New York	134	2	New York	135	2
New York	136	2	New York	137	2	New York	138	2	New York	139	2
New York	140	1	New York	141	1	New York	142	1	New York	143	1
New York	144	2	New York	145	2	New York	146	2	New York	147	1
New York	148	1	New York	149	1	North Carolina	270	2	North Carolina	271	3
North Carolina	272	3	North Carolina	273	3	North Carolina	274	3	North Carolina	275	3
North Carolina	276	3	North Carolina	277	3	North Carolina	278	3	North Carolina	279	3
North Carolina	280	3	North Carolina	281	3	North Carolina	282	3	North Carolina	283	2

$15 PDP COPAY SCHEDULE

State	Zip	Area	State	Zip	Area	State	Zip	Area	State	Zip	Area
North Carolina	284	3	North Carolina	285	2	North Carolina	286	2	North Carolina	287	3
North Carolina	288	3	North Carolina	289	3	North Dakota	580	3	North Dakota	581	3
North Dakota	582	2	North Dakota	583	2	North Dakota	584	3	North Dakota	585	2
North Dakota	586	2	North Dakota	587	2	North Dakota	588	2	Ohio	430	1
Ohio	431	1	Ohio	432	1	Ohio	433	1	Ohio	434	1
Ohio	435	1	Ohio	436	1	Ohio	437	1	Ohio	438	1
Ohio	439	1	Ohio	440	1	Ohio	441	1	Ohio	442	1
Ohio	443	1	Ohio	444	1	Ohio	445	1	Ohio	446	1
Ohio	447	1	Ohio	448	1	Ohio	449	1	Ohio	450	1
Ohio	451	2	Ohio	452	1	Ohio	453	1	Ohio	454	1
Ohio	455	1	Ohio	456	1	Ohio	457	2	Ohio	458	2
Ohio	459	1	Oklahoma	730	1	Oklahoma	731	1	Oklahoma	733	1
Oklahoma	734	1	Oklahoma	735	2	Oklahoma	736	1	Oklahoma	737	1
Oklahoma	738	1	Oklahoma	739	1	Oklahoma	740	1	Oklahoma	741	1
Oklahoma	743	1	Oklahoma	744	1	Oklahoma	745	1	Oklahoma	746	1
Oklahoma	747	1	Oklahoma	748	1	Oklahoma	749	1	Oregon	970	3
Oregon	971	3	Oregon	972	3	Oregon	973	3	Oregon	974	3
Oregon	975	3	Oregon	976	3	Oregon	977	3	Oregon	978	3
Oregon	979	3	Pennsylvania	150	1	Pennsylvania	151	1	Pennsylvania	152	1
Pennsylvania	153	1	Pennsylvania	154	1	Pennsylvania	155	1	Pennsylvania	156	1
Pennsylvania	157	1	Pennsylvania	158	1	Pennsylvania	159	1	Pennsylvania	160	1
Pennsylvania	161	1	Pennsylvania	162	1	Pennsylvania	163	1	Pennsylvania	164	1
Pennsylvania	165	1	Pennsylvania	166	1	Pennsylvania	167	1	Pennsylvania	168	1
Pennsylvania	169	2	Pennsylvania	170	1	Pennsylvania	171	1	Pennsylvania	172	1
Pennsylvania	173	1	Pennsylvania	174	1	Pennsylvania	175	2	Pennsylvania	176	2
Pennsylvania	177	2	Pennsylvania	178	2	Pennsylvania	179	2	Pennsylvania	180	1
Pennsylvania	181	2	Pennsylvania	182	1	Pennsylvania	183	1	Pennsylvania	184	1
Pennsylvania	185	1	Pennsylvania	186	1	Pennsylvania	187	1	Pennsylvania	188	1
Pennsylvania	189	2	Pennsylvania	190	1	Pennsylvania	191	1	Pennsylvania	192	1
Pennsylvania	193	2	Pennsylvania	194	2	Pennsylvania	195	2	Pennsylvania	196	2
Puerto Rico	006	1	Puerto Rico	007	1	Puerto Rico	009	1	Rhode Island	028	3
Rhode Island	029	3	South Carolina	290	2	South Carolina	291	2	South Carolina	292	2
South Carolina	293	2	South Carolina	294	2	South Carolina	295	2	South Carolina	296	2
South Carolina	297	2	South Carolina	298	2	South Carolina	299	2	South Dakota	570	2
South Dakota	571	3	South Dakota	572	3	South Dakota	573	2	South Dakota	574	2
South Dakota	575	2	South Dakota	576	2	South Dakota	577	2	Tennessee	370	1
Tennessee	371	1	Tennessee	372	1	Tennessee	373	2	Tennessee	374	1
Tennessee	375	1	Tennessee	376	2	Tennessee	377	2	Tennessee	378	1
Tennessee	379	1	Tennessee	380	1	Tennessee	381	1	Tennessee	382	1
Tennessee	383	1	Tennessee	384	1	Tennessee	385	1	Texas	750	1
Texas	751	1	Texas	752	1	Texas	753	1	Texas	754	2
Texas	755	1	Texas	756	1	Texas	757	1	Texas	758	1
Texas	759	1	Texas	760	1	Texas	761	1	Texas	762	1
Texas	763	1	Texas	764	1	Texas	765	1	Texas	766	1
Texas	767	1	Texas	768	1	Texas	769	1	Texas	770	1
Texas	771	1	Texas	772	1	Texas	773	1	Texas	774	1
Texas	775	1	Texas	776	1	Texas	777	1	Texas	778	1
Texas	779	1	Texas	780	1	Texas	781	1	Texas	782	1
Texas	783	2	Texas	784	2	Texas	785	1	Texas	786	1
Texas	787	1	Texas	788	1	Texas	789	1	Texas	790	1
Texas	791	1	Texas	792	1	Texas	793	1	Texas	794	1
Texas	795	1	Texas	796	1	Texas	797	1	Texas	798	1

$15 PDP COPAY SCHEDULE

State	Zip	Area	State	Zip	Area	State	Zip	Area	State	Zip	Area
Texas	799	1	Texas	885	2	Utah	840	1	Utah	841	1
Utah	842	1	Utah	843	1	Utah	844	1	Utah	845	1
Utah	846	1	Utah	847	1	Vermont	050	4	Vermont	051	4
Vermont	052	3	Vermont	053	3	Vermont	054	3	Vermont	056	3
Vermont	057	3	Vermont	058	3	Vermont	059	3	Virgin Islands	008	2
Virginia	201	2	Virginia	220	2	Virginia	221	2	Virginia	222	2
Virginia	223	2	Virginia	224	1	Virginia	225	1	Virginia	226	2
Virginia	227	1	Virginia	228	2	Virginia	229	2	Virginia	230	1
Virginia	231	1	Virginia	232	1	Virginia	233	1	Virginia	234	2
Virginia	235	2	Virginia	236	2	Virginia	237	2	Virginia	238	1
Virginia	239	1	Virginia	240	2	Virginia	241	1	Virginia	242	1
Virginia	243	1	Virginia	244	1	Virginia	245	2	Virginia	246	1
Washington	980	4	Washington	981	4	Washington	982	4	Washington	983	3
Washington	984	3	Washington	985	3	Washington	986	3	Washington	988	3
Washington	989	3	Washington	990	3	Washington	991	3	Washington	992	3
Washington	993	4	Washington	994	3	West Virginia	247	1	West Virginia	248	1
West Virginia	249	2	West Virginia	250	1	West Virginia	251	1	West Virginia	252	1
West Virginia	253	1	West Virginia	254	3	West Virginia	255	1	West Virginia	256	1
West Virginia	257	1	West Virginia	258	2	West Virginia	259	2	West Virginia	260	1
West Virginia	261	2	West Virginia	262	1	West Virginia	263	1	West Virginia	264	1
West Virginia	265	1	West Virginia	266	1	West Virginia	267	1	West Virginia	268	1
Wisconsin	530	2	Wisconsin	531	2	Wisconsin	532	2	Wisconsin	534	2
Wisconsin	535	2	Wisconsin	537	4	Wisconsin	538	1	Wisconsin	539	1
Wisconsin	540	1	Wisconsin	541	2	Wisconsin	542	2	Wisconsin	543	3
Wisconsin	544	2	Wisconsin	545	2	Wisconsin	546	2	Wisconsin	547	2
Wisconsin	548	1	Wisconsin	549	2	Wyoming	820	2	Wyoming	821	1
Wyoming	822	1	Wyoming	823	1	Wyoming	824	1	Wyoming	825	2
Wyoming	826	2	Wyoming	827	1	Wyoming	828	1	Wyoming	829	2
Wyoming	830	1	Wyoming	831	1						

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

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

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 Dr.

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 January 1st and ending on the following December 31st.

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.

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 Plan 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:

  Benefits Manager, Benefits Specialist and Benefits Analyst

  (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.