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

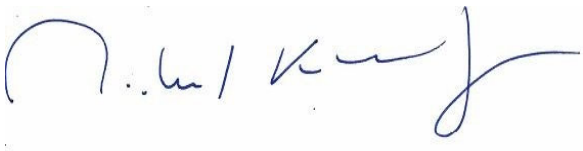
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Michel Khalaf
President

**Group Policy No.:** **TM 05570177-G**

**Employer:** **Coastal Carolina Community College**

**Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.**

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

## For Maryland Residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

**For West Virginia Residents: You have the right to return this certificate within ten days of its receipt and to have your premium refunded if, after examination of the certificate, you are not satisfied for any reason.**

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

**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.

**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.**

Form G.23000-Cert.-1

All Active Full Time Employees hired on the 17th thru the end of the Month

# NOTICE FOR RESIDENTS OF TEXAS

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

**Metropolitan Life Insurance Company**

To get information or file a complaint with your insurance company or HMO:

**Call: Corporate Consumer Relations Department at 1-800-438-6388**

**Toll-free: 1-800-438-6388**

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

**Metropolitan Life Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388**

**Teléfono gratuito: 1-800-438-6388**

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

## NOTICE FOR RESIDENTS OF TEXAS

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

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

**The Definition Of Dependent Is Modified For The Coverages Listed Below:**

**For Louisiana Residents (Dental Expense Benefits):**

The term also includes your grandchildren residing with you. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24.

**For Minnesota Residents (Dental Expense Benefits):**

The term also includes your grandchildren who are financially dependent upon you and reside with you continuously from birth. The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status.

**For Montana Residents (Dental Expense Benefits):**

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status.

**For New Mexico Residents (Dental Expense Benefits):**

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 coverage for Dental Expense Benefits under this certificate because:

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

**For Texas Residents (Dental Expense Benefits):**

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

**For Utah Residents (Dental Expense Benefits):**

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status.

**For Washington Residents (Dental Expense Benefits):**

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.

# 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.

## 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 1-800-275-4638.

### Claim Submission

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

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

### Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will 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.

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 the 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 appear 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.

### 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.

**Arkansas residents please be advised of the following:**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT THE POLICYHOLDER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL THE TOLL FREE TELEPHONE NUMBER SHOWN ON THE CERTIFICATE FACE PAGE.**

**POLICYHOLDERS HAVE THE RIGHT TO FILE A COMPLAINT WITH THE ARKANSAS INSURANCE DEPARTMENT (AID). YOU MAY CALL AID TO REQUEST A COMPLAINT FORM AT (800) 852-5494 OR (501) 371-2640 OR WRITE THE DEPARTMENT AT:**

**ARKANSAS INSURANCE DEPARTMENT**
**CONSUMER SERVICES DIVISION**
**1 COMMERCE WAY, SUITE 102**
**LITTLE ROCK, ARKANSAS 72202**

**California residents please be advised of the following:**

**IMPORTANT NOTICE**

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

**METROPOLITAN LIFE INSURANCE COMPANY**
**200 PARK AVENUE**
**NEW YORK, NY 10166**
**ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT**
**1-800-275-4638**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE**
**300 SOUTH SPRING STREET**
**LOS ANGELES, CA 90013**
**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 Employer, 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.
>
> For purposes of determining who may become a Covered Person, the term does not include any person who:
>
> - is in the military of any country or subdivision of a country;
> - is insured under the Group Policy as an employee."

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

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

## NOTICE FOR RESIDENTS OF COLORADO

### Domestic Partner

Colorado law provides that for dental insurance, domestic partners of Colorado'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 Colorado residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the Colorado government or another government recognized by Colorado 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.

### Definition of Child

The term also includes newborns.

### 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 THE GROUP POLICY'S BENEFITS WITH OTHER BENEFITS

With respect to coordination of benefits, the benefits will never be less than what is shown under the following language.

This coordination of benefits (COB) provision applies when a Covered Person has dental care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

### Definitions

A. A **"Plan"** is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   (1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

**NOTICE FOR RESIDENTS OF COLORADO**

(2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **"This Plan"** means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the Covered Person.

When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.]

D. **"Allowable Expense"** is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the Covered Person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

(1) If a Covered Person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If a Covered Person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the Primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.

(5) If the Primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the Primary Plan because the covered person uses a non-panel provider, except for emergency services that are paid or provided by the primary.

**NOTICE FOR RESIDENTS OF COLORADO**

E. **"Claim Determination Period"** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **"Closed Panel Plan"** is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **"Custodial Parent"** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.]

**Order-Of-Benefit Determination Rules**

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B.

(1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
  (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
  (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

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

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage**. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan

## NOTICE FOR RESIDENTS OF COLORADO

### Effect On The Benefits Of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

### Right To Receive And Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

### Facility Of Payment

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

### Right Of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

**Georgia residents please be advised of the following:**

**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.**

**Idaho residents please be advised of the following:**

**IMPORTANT NOTICE**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:**

**1-800-275-4638**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER 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 or www.DOI.Idaho.gov**

## NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if your Dental Expense Benefits are in danger of lapsing due to a default on your part, such as nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once you have made a designation, you may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at toll-free telephone number 1-800-275-4638 to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, you, any person authorized to act on your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that you suffered from cognitive impairment or functional incapacity at the time of cancellation.

## NOTICE FOR RESIDENTS OF MASSACHUSETTS

**Your Employment Ends**

With respect to all Personal Benefits and all Dependent Benefits , the 31 day period after the date such benefits would have ended because your employment ended.

With respect to all Personal Benefits and all Dependent Benefits , the 90-day period after the date such benefits would have ended because your employment ended due to a plant closing or partial plant closing.

In any event, such benefits will end on the date you would otherwise be entitled to similar benefits.

**NOTICE FOR RESIDENTS OF MINNESOTA**

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

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

“Oral surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ) and craniomandibular disorder. This includes cone beam imaging, but cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period. Such Covered Service is limited to a $500 Lifetime Maximum Benefit Amount.”

## NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

**NOTICE FOR RESIDENTS OF NEW MEXICO**

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

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

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

## NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Benefits will continue if such Dependent 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 Dependent 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 When Benefits End section, this continuation will continue until the earliest of the date:

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

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

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

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

The basic protections provided by the Association are:

- Life Insurance
  - 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 lA, 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.

**Virginia residents please be advised of the following:**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

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

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

To phone in a claim related question, you may call Claims Customer Service at:

1-800-275-4638

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
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 Expense Benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

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

### Appealing the Initial Determination

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

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

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

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

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

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

**Policies and Procedures for Emergency and Urgent Care**

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

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

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

**Urgent Care Submission:**

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

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

**Wisconsin residents please be advised of the following:**

**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.

Metropolitan Life Insurance Company
Customer Service
18210 Crane Nest Drive
Tampa, FL 33647
1-800-275-4638

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.

# TABLE OF CONTENTS

## SCHEDULE OF BENEFITS
## (Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

**BENEFITS (EMPLOYEE AND DEPENDENT)** **AMOUNT**
**For:**
**All Active Full Time Employees hired on the 17th thru the end of the Month**

**DENTAL EXPENSE BENEFITS**

| | In-Network | Out-of-Network |
|---|---|---|
| ANNUAL DEDUCTIBLE AMOUNT | | |
| Individual Type A Expenses…… | $0 | $0 |
| Individual Type B and C Expenses Combined……. | $25 | $25 |
| Type D Expenses…….. | $0 | $0 |
| Family Type A Expenses…… | $0 | $0 |
| Family Type B and C Expenses Combined……. | $75 | $75 |

| | In-Network | Out-of-Network |
|---|---|---|
| COVERED PERCENTAGE | | |
| Type A Expenses…….. | 100% | 100% |
| Type B Expenses…….. | 80% | 80% |
| Type C Expenses…….. | 50% | 50% |
| Type D Expenses…….. | 50% | 50% |

MAXIMUMS

| | |
|---|---|
| For Orthodontic Treatment<br>Aggregate Maximum Benefit<br>(For All Dental Expense Periods)……. | $1,000 |
| For Other Covered Dental Expenses<br>Maximum Benefit<br>(For One Dental Expense Period)……. | $2,000 |

**Waiting Periods for Late Entrants**

| | |
|---|---|
| Type A Expenses…….. | No Waiting Period |
| Type B Expenses | |
| • Fillings…… | 6 Months from Effective Date |
| • All Others …….. | 12 Months from Effective Date |
| Type C Expenses…….. | 24 Months from Effective Date |
| Type D Expenses (Orthodontics)…… | 24 Months from Effective Date |

**NOTE(S)**

Covered Dental Expenses for orthodontia are not included in the Maximum Benefit For One Dental Expense Period.

If a dental bill is expected to be $200 or more, see DENTAL EXPENSE BENEFITS, section F. PRE-DETERMINATION OF BENEFITS.

**COORDINATION OF BENEFITS**

The Dental Expense Benefits are subject to the provisions of the form entitled COORDINATION OF BENEFITS.

**WHEN YOU RETIRE**

No Dental Expense Benefits are provided under This Plan on or after the last day of the month in which you retire.

Form G.23000-B

## SCHEDULE SUPPLEMENT

**A. Statements Made by You Which Relate to Insurability**

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

**1.** in contesting the validity of the benefits with respect to which such statement was made; or

**2.** to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

**a.** The statement must be contained in a written application which has been signed by you.

**b.** A copy of the application has been furnished to you .

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

**B. Time Limit on Certain Defenses**

After This Plan has been in force 2 years from the date of its issue, no statement of the Employer shall be used to void This Plan.

**C. Assignment**

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

For Texas Residents: Upon receipt of services for a Covered Dental Expense, you may assign Dental Expense Benefits to the Dentist providing such care.

**D. Refund to Us for Overpayment of Benefits**

If we pay Dental Expense Benefits to you for expenses incurred on your own account or on account of a Dependent, and it is found that we paid more Dental Expense Benefits to you than we should have paid because:

**1.** all or some of those expenses were not paid for by the Covered Persons in your Family; or

**2.** any Covered Person in your Family was repaid for all or some of those expenses by a source other than from:

**a.** an insurer under a policy of insurance issued to you in your name; and

**b.** an insurer under a policy of insurance issued to a Covered Person in your Family who ordinarily lives in your home; and

**c.** us;

we will have the right to a refund from you. The amount of the refund is the difference between:

**1.** the amount of Dental Expense Benefits paid by us for those expenses; and

**2.** the amount of Dental Expense Benefits which should have been paid by us for those expenses.

However, at our option, we may recover the excess amount by reducing or offsetting any future benefits payable to such person by the amount of the overpayment.

**E. Additional Provisions**

**1.** The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.

**2.** No agent has the authority:

**a.** to accept or to waive the required proof of a claim; nor

**b.** to extend the time within which proof must be given to us.

## DEFINITIONS OF CERTAIN TERMS USED HEREIN

"**Actively at Work**" or "**Active Work**" means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

**1.** on a scheduled non-working day;

**2.** provided you are not disabled.

"**Covered Person**" means an Employee or a Dependent on whose account benefits are in effect under This Plan.

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

For Dental insurance your spouse or your unmarried natural child except for:

**1.** a person who is in the military or like forces of any country or of any subdivision of a country;

**2.** a person who is covered under This Plan as an Employee;

**3**. a child who is 26 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

**a.** that child is and remains unable to work in self-sustaining employment because of:

**i.** physical handicap; or

**ii.** mental retardation; and

**b.** that child is and remains chiefly dependent upon you for support; and

**c.** that child is and remains a Dependent, as defined, except for the age limit; and

**d.** you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and

**e.** you make any payment which is required by the Employer.

Child includes:

**a.** a child who is supported solely by you and permanently living in the home of which you are the head; and

**b.** a child who is legally adopted; and

**c.** a stepchild including the child of a Domestic Partner (wherever the term “stepchild” appears in this certificate it shall be read to include the children of Your Domestic Partner) who lives in your home; and

**d.** a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree).

No person may be covered as a Dependent of more than one Employee.

"**Dependent Benefits**" mean the benefits which are provided on account of a Dependent under This Plan.

**"Doctor"** means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

**1.** there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and

**2.** the service performed by the practitioner is within the scope of his or her license.

**"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; or
- are of the of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

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

A Domestic Partner declaration attesting to the existence of an insurable interest in one another’s lives must be completed and Signed by the Employee.

“**Employee**” means a person who is employed and paid for services by the Employer on a Full-time basis. "Full-time" means an Employee is regularly scheduled to work at least 30 hours per week for the Employer.

"**Employer**" means the individual, firm, or other organization in whose name the Group Policy is issued. Subsidiaries and/or affiliates of the Employer are not covered under This Plan unless they are specified or approved in writing by us.

"**Enrollment Form**" means the form used by you to request Personal and Dependent Benefits.

"**Family**" means you and your Dependents.

"**Occupational Injury**" means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

"**Occupational Sickness**" means a sickness which entitles the Covered Person to benefits under a worker's compensation or occupational disease law.

"**Personal Benefits**" mean the benefits which are provided on account of an Employee under This Plan.

**"Qualifying Events"** means a change in your family status which would affect your Benefits under This Plan due to one or more of the following:

**1.** marriage;

**2.** birth, adoption or placement for adoption of a dependent child;

**3.** divorce, legal separation or annulment;

**4.** death of a dependent spouse*;*

**5.** termination of spouse's employment; or

**6**. a change in a spouse's class of employment or status or a change in the group policy which applies to a spouse's class of Employees and which results in a change in dental benefits under the spouse's insurance.

"**Spouse**" means your lawful spouse. The term also includes your Domestic Partner.

"**This Plan**" means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

"**We**", "**us**" and "**our**" mean Metropolitan.

"**You**" and "**your**" mean an Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of an Employee.

Form G.23000-A

## ELIGIBILITY FOR BENEFITS

**For All Active Full Time Employees hired on the 17th thru the end of the Month**

**Personal Benefits Eligibility Date**

Your Personal Benefits Eligibility Date is the later of:

1. March 1, 2024; and

2. the first day of the calendar month coincident with or next following the date you complete 30 days of continuous service as an Employee of the Employer.

If you become an Employee after March 1, 2024, your Personal Benefits Eligibility Date is the first day of the calendar month coincident with or next following the date you complete 30 days of continuous service as an Employee of the Employer.

**Dependent Benefits Eligibility Date**

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

## EFFECTIVE DATES OF PERSONAL BENEFITS

### APPLICABLE TO CONTRIBUTORY BENEFITS

### (Dental Expense Benefits)

**A. Making a Request for Dental Expense Benefits**

In order to become insured for Personal Dental Expense Benefits under This Plan, you must make a written request to the Employer on the enrollment form furnished by the Employer.

Requests to be insured for Personal Benefits may only be made:

**a.** during the thirty-one day period following your Personal Benefits Eligibility Date; or

**b.** during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or

**c.** within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Personal Benefits, requests for changes in Personal Benefits may only be made:

**a.** at the annual enrollment period which occurs after the enrollment period in which you enrolled for coverage. Subsequent requests may be made only at each subsequent annual enrollment period provided you have been continuously enrolled for Personal Benefits; or

**b.** within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you make a request to enroll for, or change, Personal Benefits at any other time, your request is a late request.

## B. Effective Dates of Dental Expense Benefits

**1.** If you make a request to be insured for Personal Dental Expense Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Active Work Requirement, and

**2.** If you make a request to be insured for Personal Benefits during the first annual enrollment period in which you can elect coverage, your Personal Benefits will become effective on the first day of the calendar month following the annual enrollment period, subject to the Active Work Requirement, and

**3.** If you make a request to change your Personal Benefits during the second annual enrollment period or any subsequent annual enrollment period, your Personal Benefits will become effective on the first day of the calendar month following the annual enrollment period, subject to the Active Work Requirement, and

**4.** If you make a request to be insured for Personal Dental Expense Benefits or a request for change(s) in Personal Dental Expense Benefits within thirty-one days of a Qualifying Event, your Personal Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement and provided the change in coverage is consistent with your new family status.

**5.** If you make a late request for Personal Dental Expense Benefits, your Personal Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

| | |
|---|---|
| Preventive Services | No waiting period |
| Basic Restorative Services (Fillings) | 6 month waiting period |
| Basic – All Other Services | 12 month waiting period |
| Major Services | 24 month waiting period |
| Orthodontic Services | 24 month waiting period |

## C. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

## D. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the forgoing provisions.

## EFFECTIVE DATES OF DEPENDENT BENEFITS

### APPLICABLE TO CONTRIBUTORY BENEFITS

**A. Making a Request for Dental Expense Benefits**

In order to become insured for Dependent Dental Expense Benefits under This Plan, you must make a written request to the Employer on the enrollment form furnished by the Employer.

Requests to be insured for Dependent Benefits may only be made:

**a.** during the thirty-one day period following your Dependent Benefits Eligibility Date; or

**b.** during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; or

**c.** within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Dependent Benefits, requests for changes in Dependent Benefits may only be made:

**a.** at the first annual enrollment period which occurs after the enrollment period in which you enrolled for coverage. Subsequent requests may be made only at each subsequent annual enrollment period provided you have been continuously enrolled for Dependent Benefits; or

**b.** within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you make a request to enroll for, or change, Dependent Benefits at any other time, your request is a late request.

**B. Effective Dates of Dental Expense Benefits**

**1.** If you make a request to be insured for Dependent Dental Expense Benefits within thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective on the latest of:

**a.** your Dependent Benefits Eligibility Date; and

**b.** the effective date of your Personal Benefits.

**2.** If you make a request to be insured for Dependent Dental Expense Benefits during the first annual enrollment period in which you can elect coverage, your Dependent Benefits will become effective the first day of the calendar month following the annual enrollment period, subject to the Active Work Requirement.

**3.** If you make a request to change your Dependent Dental Expense Benefits during the second annual enrollment period or any subsequent annual enrollment period, your Dependent Benefits will become effective on the first day of the calendar month following the annual enrollment period, subject to the Active Work Requirement, and

**4.** If you make a request to be insured for Dependent Dental Expense Benefits or a request for change(s) in Dependent Dental Expense Benefits within thirty-one days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective on the latest of :

**a.** The date of the Qualifying Event;

**b.** The effective date of your Personal Benefits; and

**c.** The date of your request

provided the change in coverage is consistent with your new family status.

If you make a late request for Dependent Benefits, your Dependent Benefits will become effective on the later of:

**1.** the date after the waiting period(s) shown below following the date of your request:

| | |
|---|---|
| Preventive Services | No waiting period |
| Basic Restorative Services (Fillings) | 6 month waiting period |
| Basic – All Other Services | 12 month waiting period |
| Major Services | 24 month waiting period |
| Orthodontic Services | 24 month waiting period |

**2.** the effective date of your Personal Benefits.

**C. Reinstatement of Benefits**

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

**D. New Dependents**

Dependent Benefits with respect to a person who becomes your Dependent while you are insured for Dependent Benefits will be effective on the date such person becomes your Dependent, subject to all provisions herein.

Form G.23000-D2

## DENTAL EXPENSE BENEFITS

### A. DEFINITIONS

**"Covered Dental Expense"** means:

**1. For In-Network Benefits**

The charges based on the Preferred Dentist Program Table of Maximum Allowed Charges for the types of dental services shown in section C. These services must be:

**a.** performed or prescribed by a Dentist who is a Participating Provider; and

**b.** necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

No more than the Maximum Allowed Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Maximum Allowed Charge is the lower of:

**a.** the amount charged by the Participating Provider for the service or supply; and

**b.** the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

**2. For Out-of-Network Benefits**

The charges for the types of dental services shown in section C. These services must be:

**a.** performed or prescribed by a Dentist who is not a Participating Provider; and

**b.** necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

No more than the Reasonable and Customary Charge for dental services or supplies will be covered by the Dental Expense Benefits. The Reasonable and Customary Charge is the lower of:

a**.** 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

**b.** the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the ‘Usual Charge’); or

**c.** the usual charge of other Dentists or other providers in the same geographic area equal to the 90th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife’s Reasonable and Customary Charge records (the ‘Customary Charge’). Where MetLife determines that there is inadequate charge information maintained in MetLife’s Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

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

There may be more than one way to treat a dental problem. If, in our view, an adequate method or material which costs less could have been used, the Dental Expense Benefits will be based on the method or material which costs less. The rest of the cost will not be a Covered Dental Expense. See section E for examples that show how this works.

**"Deductible Amount"** means the amount shown in the SCHEDULE OF BENEFITS. The Deductible Amount is an annual amount.

The In-Network Deductibles during any one Dental Expense Period will not apply to In-Network Covered Dental Expenses for your Family after Covered Dental Expenses have been incurred for Covered Persons in your Family and the sum of In-Network Covered Dental Expenses and Out-of-Network Covered Dental Expenses equal the In-Network Family Deductible Amount.

The Out-of-Network Deductibles during any one Dental Expense Period will not apply to Out-of-Network Covered Dental Expenses for your Family after Covered Dental Expenses have been incurred for Covered Persons in your Family and the sum of In-Network Covered Dental Expenses and Out-of-Network Covered Dental Expenses equal the Out-of-Network Family Deductible Amount.

**"Dental Expense Period"** means a period which starts on any January 1 and ends on the next December 31.

**"Dentist"** means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a Doctor will be considered for Dental Expense Benefits as if it were performed or prescribed by a Dentist.

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

**1.** placing the health of the person afflicted with such condition in serious jeopardy;

**2.** serious impairment to such person's bodily functions;

**3.** serious impairment or dysfunction of any bodily organ or part of such person; or

**1.** serious disfigurement of such person.

**"Covered Percentage"** means the percentage or percentages shown in the SCHEDULE OF BENEFITS.

**"In-Network Benefits"** means the Dental Expense Benefits provided under This Plan for covered dental services that are provided by a Dentist who is a Participating Provider.

**"Out-of-Network Benefits"** means the Dental Expense Benefits provided under This Plan for covered dental services that are not provided by a Dentist who is a Participating Provider.

**"Preferred Dentist Program Table of Maximum Allowed Charges"** means our fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

**"Preferred Dentist Program"** means our program to offer a Covered Person the opportunity to receive dental care from Dentists who are designated by us as Participating Providers. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for the services rendered.

**"Participating Provider"** means a Dentist who has been selected by us for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

**"Non-Participating Provider"** means a Dentist who is not a Participating Provider.

**"Preferred Dentist Program Directory"** means the list which consists of selected Dentists who:

**1.** are located in the Covered Person's area; and

**2.** have been selected by us to be Participating Providers and part of the Preferred Dentist Program.

These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

The list will be periodically updated.

## B. COVERAGE

### 1. When Benefits May Be Payable

We will pay Dental Expense Benefits if you incur Covered Dental Expenses:

**a.** for a Covered Person during a Dental Expense Period; and

**b.** while you are covered for the Dental Expense Benefits for that Covered Person; and

**c.** the Covered Dental Expenses are more than the Deductible Amount.

An expense is "incurred" on the date the type of dental service for which the charge is made is completed.

### 2. How Benefits Are Determined

Benefits will be equal to the Covered Percentage of those Covered Dental Expenses which are more than the Deductible Amount. However:

**a.** The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person during any one Dental Expense Period will not be more than the Maximum Benefit For One Dental Expense Period shown in the SCHEDULE OF BENEFITS; and

**b.** The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment during all Dental Expense Periods will not be more than the applicable Aggregate Maximum Benefit For All Dental Expense Periods as shown in the SCHEDULE OF BENEFITS.

In order to determine what are the amounts of Covered Dental Expenses, we may ask for X-rays and other diagnostic and evaluative materials. If they are not given to us, we will determine Covered Dental Expenses on the basis of the information which is available to us. This may reduce the amount of benefits which otherwise would have been payable.

### 3. How the Preferred Dentist Program Works

Free Choice Of A Dentist:

A Covered Person is always free to choose the services of a Dentist who is either:

**a.** a Participating Provider; or

**b.** a Provider.

Benefits under This Plan will be determined and paid in either case, except that the Covered Person will generally incur less out-of-pocket cost if a Participating Provider is chosen.

## C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

### 1. Type A Expenses

**a.** Oral exams but not more than once every 6 months.

**b.** Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, once every 6 months.

**c.** 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), once every 6 months.

**d.** Bitewing X-rays but not more than once every 6 months for all Covered Persons.

**e.** Full mouth X-rays but not more than once every 5 years.

**f.** Preventive treatment:

**i.** 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) but not more than once every 6 months; and

**ii.** topical fluoride treatment for a Dependent child under 19 years of age but not more than once every 12 months.

**iii.** Periodontal maintenance where periodontal treatment (such as osseous surgery, gingivectomy or gingivoplasty) has been previously performed, but the total of:

**1.** the number of covered periodontal maintenance treatments; and

**2.** the number of covered oral prophylaxes;

will not exceed four treatments in a Dental Expense Period.

**g.** Sealants (materials other than fluorides, painted on the grooves of the teeth in order to prevent future decay) which are applied to molars only, for Dependents up to age 14, but not more than once per tooth per lifetime.

**h.** Space maintainers for a Dependent under 19 years of age.

### 2. Type B Expenses

**If you are a late entrant, certain waiting periods must be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the late entrant waiting period that applies.**

**a.** Fillings but not more than once every 24 months.

**b.** Extractions.

**c.** Oral surgery (other than as described elsewhere in this certificate).

**d.** Administration of general anesthesia, when dentally necessary (see NOTICES)as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.

**e.** Root canal treatment.

**f.** Periodontal surgery.

**g.** Repair or relining of dentures.

**h.** Repair or re-cementing of

**i.** crowns; or

**ii.** inlays or onlays; or

**iii.** dentures or bridgework.

**3. Type C Expenses**

**If you are a late entrant, certain waiting periods must be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the late entrant waiting period that applies.**

**a.** Inlays, onlays, crowns, laminates, and gold foils but no more than once in a 5 year period for the same tooth surface.

**b.** Replacement of crowns, but not more than once for the same tooth in a 5 year period.

**c.** Replacement of inlays or onlays, but not more than once for the same tooth surface in a 5 year period.

**d.** Those services needed to replace one or more natural teeth which are lost while Dental Expense Benefits for the Covered Person are in effect for:

**i.** installation of fixed bridgework done for the first time.

**ii.** installation for the first time of:

**1.** a partial removable denture; or

**2.** a full removable denture.

**e.** Replacing an existing removable denture or fixed bridgework if:

**i.** it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or

**ii.** it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 years prior to its replacement.

**f.** Replacing an existing immediate temporary full denture by a new permanent full denture when:

**i.** the existing denture cannot be made permanent; and

**ii.** the permanent denture is installed within 12 months after the existing denture was installed.

**g.** Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

**h.** With respect to residents of Minnesota, Oral surgical and non-surgical treatment of Temporomandibular joint disorders (TMJ) and craniomandibular disorder. This includes cone beam imaging and TMJ non-invasive physical therapies. However, cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period and TMJ non-invasive physical therapies will not be covered more than once in a 12 month period.

**4. Type D Expenses**

**If you are a late entrant, certain waiting periods must be satisfied before expenses for these services are payable. Refer to the Schedule of Benefits for the late entrant waiting period that applies.**

Orthodontia, including appliance therapy.

The Aggregate Maximum Benefit for orthodontia is shown in the SCHEDULE OF BENEFITS.

## D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

**1.** Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person**.**

**2.** Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for**:**

**a.** scaling and polishing of teeth; or

**b.** fluoride treatments.

**3.** Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:

**a.** it otherwise is a Covered Dental Expense; and

**b.** it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or

**c.** it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.

**4.** Replacement of a lost, missing or stolen crown, bridge or denture**.**

**5.** Services paid under any workers' compensation, occupational disease or employer liability law as follows:

**a.** for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the Employee, Employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

**b.** or for persons who are not covered in North Carolina, services paid or payable under any workers' compensation or occupational disease law.

**6.** Services:

**a.** for which the Employer of the person receiving such services is not required to pay; or

**b.**. received at a facility maintained by the Employee, labor union, mutual benefit association, or VA hospital.

7. Services or supplies which any employer is required by law to furnish in whole or in part.

8. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.

9. Repair or replacement of an orthodontic appliance.

10. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.

11. Services or supplies for which a Covered Person is not required to pay.

12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.

13. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.

14. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.

15. Any duplicate appliance or prosthetic device.

16. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.

17. Instruction for oral care such as hygiene or diet.

18. Periodontal splinting.

19. Temporary or provisional restorations.

20. Temporary or provisional appliances.

21. Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.

22. Myofunctional therapy or correction of harmful habits.

23. Implantology.

24. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.

25. Charges for broken appointments.

26. Charges by the Dentist for completing dental forms.

27. Sterilization supplies.

28. Services or supplies furnished by a family member.

## E. EXAMPLES OF ALTERNATE BENEFITS

Dental Expense Benefits will be based on the materials and method of treatment which cost the least and which, in our view, meet generally accepted dental standards.

### 1. Inlays, Onlays, Crowns and Gold Foil

If a tooth can be repaired to our satisfaction according to generally accepted dental standards by a less costly method than an inlay, onlay, crown or gold foil, Dental Expense Benefits will be based on the adequate method of repair which costs the least.

### 2. Crowns, Pontics, and Abutments

Veneer materials may be used for front teeth or bicuspids. However, Dental Expense Benefits will be based on the adequate veneer materials which cost the least.

### 3. Bridgework and Dentures

Dental Expense Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the Dental Expense Benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your Dental Expense Benefits will be, see section F.

## F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be $200 or more, before the Dentist starts the treatment, a Covered Person can find out what Dental Expense Benefits will be paid under This Plan. To do this, the Covered Person should send a claim form to us in which the Dentist tells us:

**1.** the work to be done; and

**2.** what the cost will be.

We will then tell the Covered Person what Dental Expense Benefits This Plan will pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan will pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan will pay.

This method should not be used for:

**1.** emergency treatment; or

**2.** routine oral exams; or

**3.** X-rays, scaling and polishing, and fluoride treatments; or

**4.** dental services which cost less than $200.

## G. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person end. This will apply even if we have pre-determined benefits for dental services. However, benefits for Covered Dental Expenses incurred for a Covered Person for the following services will be paid after Dental Expense Benefits end:

**1.** For a prosthetic device if:

**a.** the Dentist prepared the abutment teeth and made impressions while Dental Expense Benefits for the Covered Person were in effect; and

**b.** the device is installed within 60 days after the date the Dental Expense Benefits end; or

**2.** For a crown if:

**a.** the Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; and

**b.** the crown is installed within 60 days after the date the Dental Expense Benefits end; or

**3.** For root canal therapy if:

**a.** the Dentist opened the tooth while the Dental Expense Benefits for the Covered Person were in effect; and

**b.** the treatment is finished within 60 days after the date the Dental Expense Benefits end.

**H. PAYMENT OF BENEFITS**

Dental Expense Benefits will be paid to:

**1.** the Dentist, if you have assigned benefits directly to the Dentist; or

**2.** you, in all other cases.

We will pay benefits when we receive satisfactory written proof of your claim. Proof must be given to us 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 proof is given as soon as possible.

Form G.23000-13A

## NOTICE FOR RESIDENTS OF CALIFORNIA

**NOTICE OF YOU AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL COVERAGE UNDER SECTION 10128.50 et seq. OF THE CALIFORNIA INSURANCE CODE (Known as Cal-Cobra)**

If Dental Insurance for You and Your Dependent ends, You and Your Dependent may qualify for continuation of such insurance under Cal-Cobra, section 10128.50 et seq. of the California Insurance Code.

**Events that Allow Continuation, and Length of Continuation**

You and Your Dependent may continue dental insurance under This Plan for a period of up to 36 months, if your dental insurance would otherwise end because:

1. Your employment ends for any reason other than Your gross misconduct, or
2. Your hours worked are reduced.

The Employer must notify us of Your termination or reduction of hours within 31 days after Your termination or reduction of hours.

Your Dependent may continue coverage under this plan for up to 36 months if Your Dependent's dental insurance would otherwise end because of:

1. Your divorce,
2. Your legal separation,
3. Your death or
4. Your becoming eligible for Medicare.

Also, Your Dependent Child may continue coverage under this plan for up to 36 months if such Child's insurance would otherwise end because that Child no longer qualifies as a Dependent under the terms of this plan.

**New Dependents**

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 Dependent at the time insurance was lost due to an event described above. To obtain insurance for the Child You must enroll the Child for coverage within 30 days of birth, adoption or placement for adoption.

**Termination of Coverage**

With respect to each person who continues insurance, the continued insurance will end on the earliest of:

1. the end of the 36 month continuation period;

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

3. the date this plan or coverage for Your class is cancelled;

4. the date the person becomes entitled to Medicare;

5. the date a person becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;

6. the date a person becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);

7. the date a person becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;

8. The first day of the first month that begins more than 31 days after the date of final determination under Title I or Title XVI of the Social Security Act that the person is no longer disabled.

**Notice and Election of Coverage**

When You or Your Dependent become entitled to continue insurance under the plan because of:

1. Your termination or
2. Your reduction of hours worked,

We will send You, at Your last known address, the necessary premium information and enrollment forms and disclosures within 14 days. You or Your Dependent, will then have 60 days to elect to continue insurance from the latest of:

1. the date of the event that gives a right to continue coverage;

2. the date You are given notice of a right to continue coverage; and

3. the date coverage under this plan ends.

When You or Your Dependent become entitled to continue insurance under the plan because of:

1. You or Your Dependent receipt of determination of disability under the terms of the Social Security Act,

2. Your Dependent Child's ceasing to qualify as a Dependent under this plan,
3. Your divorce,
4. Your legal separation,
5. Your death, or
6. Your becoming eligible for Medicare.

You or Your Dependent must notify us within 60 days. If We do not receive notice within 60 days, the person or persons who would otherwise have been entitled to continue insurance will be disqualified from having dental insurance continued. Your or Your Dependent's notice and request for continued insurance must be in writing and delivered to Us by first class mail or other reliable means of delivery including personal delivery, express mail, or private courier company.

**Cost of Continued Coverage**

Any person who elects to continue coverage under the plan must pay not more than 110% of the full cost of that insurance (including both the share you now pay and the share the Employer now pays).

**Premium Payment**

The first premium payment must be made within 45 days of your election to continue insurance. Your first premium payment must be sufficient to pay all required premiums and all premiums due. The premium payment must be delivered to the Employer by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company. After the first premium payment Your payments for continued coverage must be made on the first day of each month in advance. Failure to submit the correct premium amount within the 45-day period will disqualify the person(s) to whom the premium relates from receiving continuation coverage.

**Exceptions**

This right to continue coverage under This Plan does not apply:

1. to a person who is covered by or eligible to be covered by Medicare;

2. to a person who is covered or who becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;

3. to a person who is covered, or becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);

4. to a person who is covered, or becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;

5. to a person who fails to meet any one or more of the time limits set forth above for notice and election of coverage;

6. to a person who fails to submit the correct premium when or before it is due;

7. if at the time coverage under this plan ends the Employer has 20 or more employees; or

8. if the Employer fails to notify us of your termination or reduction in hours within 31 days.

**Continuation under a New Plan**

The Employer must notify each person who has continued insurance under this plan if this plan ends for any reason and is replaced by the Employer with a new group plan. The notice must be given 30 days before this plan ends. The notice will be sent to the last known address of the person who has continued coverage under this plan. If this plan ends, continued insurance under this plan will end. A person who has continued insurance under this plan may then elect similar coverage under the Employer's new group plan, if any, for the balance of the period that the person would have remained covered under This Plan. Continued insurance will end for that person if the person does not, within 30 days of receiving notice that this plan has ended, enroll in the new plan and pay premiums to the new plan. The Employer will provide benefit and premium information, enrollment forms and instructions for enrolling in the new plan. This information will be sent to the last known address of the person who has a right to continue insurance. If the Employer or any successor Employer or purchaser of the Employer ceases to provide a similar group benefit plan to active employees, the right to continue insurance ends.

**Other Notifications**

The Employer is required, within 30 days, to notify us in writing:

1. of any Employee who has a qualifying event; or

2. when the Employer becomes subject to Federal COBRA (Section 4980B of the U.S. Internal Revenue Code).

The Employer is required to notify any new plan that replaces this plan of persons who are entitled to elect continuing insurance under the new plan.

The Employer will also notify each person, who is entitled to continue insurance for 36 months of the date the insurance is to end. The written notice will be sent in writing to the person's last known address 180 days before the insurance is to end.

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## WHEN BENEFITS END

**A**. All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

**B**. If This Plan ends in whole or in part, your benefits which are affected will end.

**C**. Your Dependent Dental Benefits will end on the earlier of:

1. the date that the Dependent ceases to be your Dependent except in the case of a Dependent Child who has reached the maximum age as defined in the DEFINITIONS OF CERTAIN TERMS USED HEREIN section, Insurance will end on the last day of the calendar month; or

2. for Utah residents, the last day of the calendar month the person ceases to be a Dependent; or

3. the date of your death.

**D.** If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

The Dental Expense Benefits for a Covered Person may be continued in accordance with the Federal law called COBRA. See the pages entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS.

Form G.23000-F

## CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or

2. the end of the last period for which the Employer has paid premiums to us for your benefits.

**Your Sickness or Injury**

The period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than nine months.

**Your Leave of Absence or Lay Off**

The period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than two months following the date the leave of absence or lay off begins.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

## COORDINATION OF BENEFITS

### A. Definitions

**"Plan"** means a plan which provides benefits or services for, or by reason of, dental care and which is:

**1.** a group insurance plan but not including a group blanket plan; or

**2.** a group practice plan; or

**3.** a group service plan; or

**4.** a group prepayment plan; or

5. any other plan which covers people as a group; or

6. a governmental program or coverage required or provided by any law, except Medicaid, but including any motor vehicle No Fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

"**This Plan**" means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under Plans which the Employer (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

**"Primary Plan/Secondary Plan"** When This Plan is a Primary Plan, it means that This Plan's benefits are determined:

1. before those of the other Plan; and

2. without considering the other Plan's benefits.

When This Plan is a Secondary Plan, it means that This Plan's benefits:

1. are determined after those of the other Plan; and

2. may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more of those other Plans and may be a Secondary Plan as to a different Plan or Plans.

**"Allowable Expense"** means any reasonable and customary charge which meets all of the following tests:

1. it is a charge for an item of necessary dental expense; and

2. it is an expense which a Covered Person must pay; and

3. it is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expenses do not include:

a. services paid under any workers' compensation, occupational disease or Employer liability law as follows:

    1. for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the Employee, or Employer, or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act; or

**2**. for persons who are not covered in North Carolina, for which you are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation.

**b.** any amount of benefits reduced under a Primary Plan because the Covered Person does not comply with the Plan provisions. Examples of such provisions are those related to:

**1.** second surgical opinions;

**2.** precertification of admissions or services; and

**3.** preferred provider arrangements.

Only benefit reductions based upon provisions similar in purpose to those described in the prior sentence and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision will not be used by a Secondary Plan to refuse to pay benefits because a Health Maintenance Organization member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obliged to pay for providing those services.

**"Claim Determination Period"** means a period which starts on any January 1 and ends on the next December 31. However, 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 by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

**B. Effect on Benefits**

**1.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

**a.** the other Plan has rules coordinating its benefits with those of This Plan; and

**b.** both those rules and This Plan's rules in subsection 3 of this Section B require that This Plan's benefits be determined before those of the other Plan.

**2.** If This Plan is a Secondary Plan, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:

**a.** the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and

**b.** the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

the benefits described in item 2(a) of this section B will be reduced. 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 given on time.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

**3.** Rules for Determining the Order in which Plans Determine Benefits. When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

**a.** Non-dependent/Dependent. The Plan which covers that person other than as a dependent (for example, as an employee, member, subscriber or retiree) determines its benefits before the Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary,

and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

**i.** Secondary to the Plan covering the person as a dependent; and

**ii.** Primary to the Plan covering the person as other than a dependent (e.g., a retired person);

then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

**b.** Child Covered under More than One Plan. When This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

**i.** the Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

**1.** the parents are married;

**2.** the parents are not separated (whether or not they ever have been married); or

**3.** a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

For example, if one parent's birthday were January 8 and the other parent's birthday were March 3, then the Plan covering the parent with the January 8 birthday would determine its benefits before the Plan covering the parent with the March 3 birthday.

**ii.** if both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.

**iii.** if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that Plan has that actual knowledge of the terms of the court decree. If the parent with responsibility has no health care coverage for the child's health care expenses, but that parent's spouse does, that parent's spouse's plan is Primary. This paragraph applies to Claim Determination Periods during which the Plan is given notice of the court decree or that start after the Plan is given notice of the court decree.

**iv.** if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

**1.** the Plan of the Custodial Parent;

**2.** the Plan of the spouse of the Custodial Parent;

**3.** the Plan of the Non-Custodial Parent;

**4.** the Plan of the spouse of the Non-Custodial Parent.

**c.** Active/Laid-off or Retired Employee. The Plan which covers that person as an active Employee (or as that Employee's dependent) is Primary to a Plan which covers that person as a laid-off or retired Employee (or as that Employee's dependent). If the Plan which covers that 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.

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

**e.** Longer/Shorter Time Covered. If none of the above rules determines the order of benefits, the Plan which has covered the Employee, for the longer time determines its benefits before the Plan which covered that person for the shorter time.

### C. Right to Receive and Release Needed Information

Certain facts are needed to apply these 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 need not tell, nor get the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

### D. Facility of Payment

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

### E. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this Coordination of Benefits provision, we may recover the excess from one or more of:

**1.** the persons we have paid or for whom we have paid;

**2.** insurance companies; or

**3.** other organizations.

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

Form G.23000-N7

## NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

If you or your Dependents had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

The fact that a Dentist may recommend that a Covered Person receive a dental service does not mean:

**1**. that the dental service will be deemed to be necessary; or

**2.** that benefits under This Plan will be paid for the expenses of the dental service.

Metropolitan will make the decision as to whether the dental service:

**1.** is necessary in terms of generally accepted dental standards; and

**2.** is qualified for benefits under This Plan.

**Our Home Office is located at 200 Park Avenue, New York, New York 10166.**

Form G.23000-E

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

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

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

- the covered person is a Child under the age of 13 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition; or

- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or

- We determine such anesthesia is necessary in accordance with generally accepted dental standards.

## NOTICE FOR RESIDENTS OF NEW MEXICO

### Consumer Complaint Notice

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

## NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS

**The following applies to employers with 20 or more employees that are not church or government plans:**

When 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 certain of your covered dependents may continue coverage under This Plan for a period of up to 18 months. However, if it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within 60 days after your termination of employment or reduction of hours, you and your covered dependents may continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. 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. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may continue coverage under This Plan for up to 36 months. Also, your covered children may continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan.

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 (as the case may be) 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 This Plan is cancelled;

e. the date it would be legally permissible for This Plan to otherwise terminate your coverage during the continuation period.

Notice will be given when you or your covered dependents become entitled to continue coverage under This Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within 60 days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan. If you do not notify the Employer within the 60-day 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 dependent children. 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.

When the Plan Administrator is notified that a qualifying event has occurred, the Plan Administrator will notify you that you have the right to choose COBRA coverage. Under the law, you have 60 days from the date you would lose coverage because of a qualifying event to inform the Plan Administrator that you want COBRA coverage. If you do not choose COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day time 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.

**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) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of the COBRA coverage period, 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 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.**

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(s) (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 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.

MetLife

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

## Our Privacy Notice

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

### SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

### SECTION 2: Protecting Your Information

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

### SECTION 3: Collecting Your Information

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

### SECTION 4: How We Get Your Information

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

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

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

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

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

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

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

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

**SECTION 5: Using Your Information**

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

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

**SECTION 6: Sharing Your Information With Others**

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

Other reasons we may share your information include:

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

**SECTION 7: HIPAA**

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

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

**SECTION 8: Accessing and Correcting Your Information**

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

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

**SECTION 9: Questions**

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

**Send privacy questions to**:

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

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

## CONTINUITY OF DENTAL EXPENSE COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

**(not applicable to self-insured plans)**

**Coverage Under This Plan**

In order to prevent loss of coverage due to a transfer of insurance carriers, This Plan will provide dental coverage for those who:

1. are eligible for Personal Benefits and/or for Dependent Benefits under This Plan; and
2. have made written request, if required, to the Employer for Personal Benefits and/or for Dependent Benefits under This Plan; and
3. were covered for similar Personal Benefits and/or Dependent Benefits under the prior plan of the Employer on the day before This Plan is effective.

However:

1. Employees who are not Actively at Work will receive full coverage under This Plan when they return to Active Work; and
2. Eligible Dependents who are confined in a Hospital or other treatment facility or at home will receive full coverage under This Plan when they are no longer confined.

Coverage provided as a result of the transfer of insurance carriers is subject to all of This Plan's provisions, except as set forth in the following sections.

**Dental Expense Benefits**

The dental coverage provided under This Plan will be subject to the following special rules:

A. Service Requirements: We will give credit for service requirements and late enrollment waiting periods which were met in part or in full under the prior carrier's plan at the time of transfer.

B. Deductibles: We will credit This Plan's Deductible requirements with amounts applied to similar requirements of the prior plan at the time of transfer. The credit given will not exceed This Plan's requirements.

C. Maximum Benefits: We will provide This Plan's Dental Expense Benefit at the time of transfer. However, we will reduce the maximum benefits available under This Plan by the amount of benefits that were:

   1. provided for similar covered dental expenses under the prior carrier's plan; and

   2. applied against a prior carrier's maximum; and

   3. received during a period of time that corresponds to This Plan's maximum benefit period.

D. Interim Coverage During Disability: We will waive This Plan's Actively at Work and non-confinement rules in order to provide interim coverage for Employees and their eligible Dependents who are disabled at the time of transfer. Coverage so provided is subject to the provision of This Plan as set forth in WHEN BENEFITS END.

**Coverage Continued Under Prior Plan**

Persons who were covered under government-mandated continuance provisions of the prior plan at the time of transfer may continue coverage under This Plan. Benefits available under This Plan will be payable until the earlier of:

A. the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or

B. the date This Plan ends;

provided required payment is made for the cost of benefits so continued.

**MetLife®**

# HIPAA Notice of Privacy Practices for Personal Health Information

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

### PLEASE REVIEW IT CAREFULLY.

Dear MetLife Dental Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company ("**MetLife**"). **Please read it carefully**. You have received this notice because of your Dental Insurance coverage with us. MetLife and each member of the MetLife family of companies (an "Affiliate") strongly believe in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

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

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898, Bridgewater, NJ 08807-6896.

We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our

employees, and those of companies that help us service your MetLife Dental Insurance, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Dental Insurance coverage.

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

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

- **For Health Care Operations:** We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Dental Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

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

may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

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

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

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

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

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

## Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

- **Right to Inspect and Copy your Personal Health Information:** In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

    - is accurate and complete;

    - was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;

    - is not part of the Personal Health Information kept by or for us; or

    - is not part of the Personal Health Information which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. We may charge you for responding to

any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282* and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to file a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896, Bridgewater, NJ 08807-6896. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as how to file a complaint please contact us at (908) 253-2706 or at HIPAAprivacyInst@MetLife.com.

**ADDITIONAL INFORMATION**

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

**Further Information:** You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact us at HIPAAprivacyInst@MetLife.com, (908) 253-2706 or write to us at MetLife, Institutional Business HIPAA Privacy Office, P.O.

Box 6898, Bridgewater, NJ  08807-6896.

 Effective- {01012003}

## 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 USERAA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

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

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

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

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

**The following addenda apply to residents of New Hampshire.**

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

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

**Patient's Bill of Rights**

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

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

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

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

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

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

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

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

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

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

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

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

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

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

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

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

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

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

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

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

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

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

## CONTINUATION OF DENTAL INSURANCE ON YOU

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

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

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

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

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.

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

To continue Your Dental Insurance, You must, within 45 days after the date of the notice:
- send a written request to MetLife to continue Your Dental Insurance; and
- pay the first premium.

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

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

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the 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 You cease to be a member of an eligible class; or

- 18 months in all other cases.

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

- the end of the maximum continuation period;

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

- if You are eligible for Medicare, the date of the first Medicare open enrollment period following the date You become ineligible for continued coverage under the Employer's plan;

- the date You become eligible for coverage under any other group dental coverage; or

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

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

## CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS

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

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

**Notices**

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

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

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

**Premium Contributions**

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

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

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

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

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

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

- fails to provide any required notification; or
- fails to request to continue Dental Insurance on Your Dependents and pay the first premium within the time limits stated in this section.

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

## CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

**Divorce Decree or Legal Separation Decree**

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

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

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

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

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

(3) The date of Your remarriage;

(4) Your death; or

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

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

**Maximum Continuation Period**

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

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

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

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

## NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

## CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

**Maximum Continuation Period (Continued)**

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

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

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

- 18 months in all other cases.

**Cessation of Dental Insurance on Your Dependents**

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

- the end of the maximum continuation period;

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

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

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

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

**The State of New Hampshire**
**Insurance Department**
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

# CONSUMER GUIDE TO EXTERNAL APPEAL

## What is an External Appeal?

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

## What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

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

## What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

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

## Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

## Submitting the External Appeal:

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

Please submit the following documentation:

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

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

**Mailing Address:**

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

**Expedited External Review Applications**

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department's mailing address.

**What is the Standard External Appeal Process and Time Frame for receiving a Decision?**
It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

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

## What is an Expedited External Appeal?

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

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

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

**What happens when the Independent Review Organization makes its decision?**

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

**Have a question or need assistance?**

**Staff at the Insurance Department is available to help.**
**Call 800-852-3416 to speak with a consumer services officer.**

**The State of New Hampshire**
**Insurance Department**
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

# INDEPENDENT EXTERNAL REVIEW
## Appealing a Denied Medical or Dental Claim

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

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

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

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

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

**Have a question or need assistance?**

**Staff at the Insurance Department is available to help.**
**Call 800-852-3416 to speak with a consumer services officer.**

## SUBMITTING A REQUEST FOR EXTERNAL REVIEW

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

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

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

**Mailing Address:**

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

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

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# EXTERNAL REVIEW APPLICATION FORM

**Request for Independent External Appeal of a Denied Medical or Dental Claim**

## Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____State:_____Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

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## Section II – Appointment of Authorized Representative

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

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

I hereby authorize_____to pursue my appeal on my behalf.

_____ _____

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

Representative's Mailing Address: _____

City:_____State:_____Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

## Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: (_____) _____
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

### New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes_____No _____

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

Medicaid ID Number: _____

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

## Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

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## Section V – Health Care Decision in Dispute

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

**Please attach the following:**

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

_____

_____

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_____

*Continued on next page*

## Section VI – Expedited Review

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

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

Do you request an expedited review? Yes ____ No ____

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

## Section VII – Request for a Telephone Conference

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

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

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

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

_____

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## VIII – Authorization and Release of Medical Records

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

Sign Here

_____ _____

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

**Before submitting this application, please verify that you have …**

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

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

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

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# PROVIDER'S CERTIFICATION FORM

**For Expedited Consideration of a Patient's External Review**

## NOTE TO THE TREATING HEALTH CARE PROVIDER

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

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

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

## GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

# PROVIDER CERTIFICATION

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

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

During non-business hours I may be reached at: (_____) _____.

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

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date