# YOUR EMPLOYEE BENEFIT PLAN

# MIAMI-DADE COUNTY PUBLIC SCHOOLS

# STANDARD DENTAL PLAN

Miami-Dade County Public Schools
1500 Biscayne Blvd
Miami, FL 33132

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Benefits are provided through a group policy issued to Miami-Dade County Public Schools by Metropolitan Life Insurance Company.

Miami-Dade County Public Schools

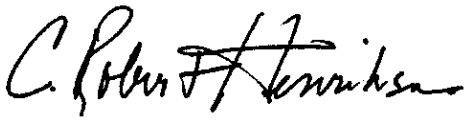
MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that the benefits as described herein are provided under and subject to the terms and conditions of the Group Policy issued to the Employer.

The Employee named below is covered for the Personal Benefits on the effective date set forth below.

The Dependent Benefits apply to the Employee named below only if the Employee is eligible for, has requested and is covered for Dependent Benefits.



C. Robert Henrikson
President and Chief Operating Officer

Employer: **Miami-Dade County Public Schools**

Group Policy No.: **92121-G**

PLEASE AFFIX THE STICKER
SHOWING THE EMPLOYEE'S
NAME AND EFFECTIVE DATE
IN THIS SPACE

**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.

Form G.23000-Cert.

## For Texas Residents:

## IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-638-5433

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

1-800-252-3439

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

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

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:** This notice is for information only and does not become a part or condition of the attached document.

## Para Residentes de Texas:

## AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-638-5433

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

1-800-252-3439

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

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

**UNA ESTE AVISO A SU CERTIFICADO:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

**Arkansas 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 OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:**

**1-800-638-5433**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:**

**ARKANSAS INSURANCE DEPARTMENT**
**CONSUMER SERVICES DIVISION**
**1200 WEST THIRD**
**LITTLE ROCK, ARKANSAS 72201-1904**

**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**
**1 MADISON AVENUE**
**NEW YORK, NY 10010**
**ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT**
**1-800-638-5433**

**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)**

**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.**

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

# NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

## PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

## POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

## EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

### LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

## DISCLAIMER

### *PLEASE READ CAREFULLY:*

- **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**
- **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**
- **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**
- **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**
- **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

**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:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

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

1-800-638-5433

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:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

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.

**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
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

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

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

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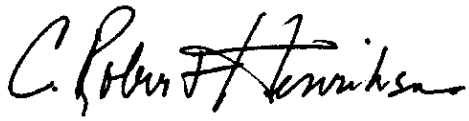
MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Endorsement

This certificate is hereby endorsed as follows:

With respect to Employees who are Texas residents, for Dental Expense Benefits, the term "dependent" includes the Employee's unmarried grandchild who is under age 25, living in the Employee's household and a dependent of the Employee for federal income tax purposes at the time the grandchild is enrolled for coverage.



C. Robert Henrikson
President and Chief Operating Officer

G.23000-LEG-TXDEP

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

The following Benefits are provided subject to the provisions below.

| **BENEFITS (EMPLOYEE AND DEPENDENT)** | | **AMOUNT** |
|---|---|---|
| **DENTAL EXPENSE BENEFITS** | | |
| | **In-Network** | **Out-of-Network Covered Percentage** |
| Type A Expenses | We will pay an amount equal to the Maximum Allowed Charge less the Copay amount | 90% of the Maximum Allowed Charge |
| Type B Expenses | We will pay an amount equal to the Maximum Allowed Charge less the Copay amount | 60% of the Maximum Allowed Charge |
| Type C Expenses | We will pay an amount equal to the Maximum Allowed Charge less the Copay amount | 30% of the Maximum Allowed Charge |
| Type D Expenses | The lesser of the amount charged or $1,500 | 50% of the Maximum Allowed Charge |
| **ANNUAL DEDUCTIBLE AMOUNT** (For Type A, Type B and Type C Expenses Combined) | | |
| Individual | NONE | $50 |
| Family | NONE | $150 |

MAXIMUMS

| | |
|---|---|
| For Orthodontic Treatment<br>Aggregate Maximum Benefit<br>(For All Dental Expense Periods) | $1,500 |
| For Other Covered Dental Expenses<br>Maximum Benefit<br>(For One Dental Expense Period) | $1,500 |

**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.

★ ★ ★ ★

Please call 800-942-0854 for assistance regarding claims and information about coverage.

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. 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.

### C. 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.

**D. 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 a proof must be given to us.

Form G.23000-B1

## 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 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 eligible under This Plan as an Employee;

**3.** a person who lives outside the United States or Canada;

**4.** a child will be covered for benefits until the end of the calendar year in which that dependent attains age 25 if that child meets all of the following:

**a.** the child is dependent upon you for support; and

**b.** the child is living in your household or is a full-time or part-time student.

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.** proof that the child is and remains so unable to work and dependent upon you is given to us when each claim is submitted. The proof must be satisfactory to us.

Subject to the same conditions which apply to a natural child, child also 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 placed in your physical custody for purpose of adoption, but if prior to completion of the legal adoption, the child is removed from your custody, the child's status as an adopted child will end; and

**c.** a child placed in your home due to a court order, including a foster child; and

**d.** a child who is legally adopted by you including a child from the date of placement in the home of the adopting parents until the legal adoption, provided that such child is residing with you and dependent upon you for support and maintenance; a newborn adopted by you if an agreement to adopt is entered into prior to the child's birth and if the child is placed in your home; a child placed in your home pursuant to a court order including a foster child; and

**e.** a stepchild who lives in your home; and

**f.** 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 Employer, who represent themselves publicly as each other's domestic partner and have:

- is of the same or opposite sex;
- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is not related to you by blood in a manner that would bar marriage under applicable state laws;
- is financially interdependent on you and has proven such interdependence by providing documentation of at least two of the following arrangements:
    1. joint mortgage or lease for a residence;
    2. joint bank or investment account, joint credit card or other evidence of joint financial responsibility;
    3. a will and/or life insurance policy which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or health care proxy.

To cover a Domestic Partner an employee must register, under applicable state or municipal laws or provide a duly sworn Afffidavit of Domestic Partnership confirming the eligibility noted above. In addition, the definition of Domestic Partner will be met as long as neither partner:

1. has signed a Domestic Partner affidavit or declaration with any other person within the 12 months before designating each other as Domestic Partner;
2. is not legally married to another person; or
3. does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

**"Employee"** means a person who is employed and paid for services by the Employer on a full-time basis.

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

**"Full Disability"** or **"Fully Disabled"** means that because of a sickness or injury:

**1.** You can not do your job; or

**2.** A Dependent can not do his or her usual activities.

**"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, employment or group coverage 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;

**5.** a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage;

**6.** you previously did not enroll for dental coverage for you or your dependent because you had other group coverage, but that coverage has ceased due to one or more of the following reasons:

   **a.** loss of eligibility for the other group coverage; or

   **b.** COBRA continuation of the other group coverage was exhausted;

**7.** your or your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

**"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 the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

## ELIGIBILITY FOR BENEFITS

**Personal Benefits Eligibility Date**

If you are an Employee on January 1, 2005, that is your Personal Benefits Eligibility Date.

If you become an Employee after January 1, 2005, your Personal Benefits Eligibility Date is the first day of the month after the date you become 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

**A. Making a Request for Benefits**

**1.** Your Employer has established a flexible benefits plan. Under such a plan, you can choose the amount and types of benefits subject to the rules of the plan. Such rules include time frames during which you may make a request to be covered or to change your benefits under This Plan as set forth below. Such rules also establish a time frame for when changes in the amount of your benefits are made as a result of a change in your class or earnings. Your Employer can provide you with more information regarding the flexible benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

**a.** when you are first eligible for Personal Benefits; and

**b.** when you have a Qualifying Event and want to make a change in your coverage for Personal Benefits to be more consistent with your new family status; and

**c.** during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered 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.

If you are already covered for Personal Benefits, requests for changes in Personal 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 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.

**2.** If you make a request to be covered for Personal 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.

**3.** If you make a request to be covered for Personal Benefits or a request for change(s) in Personal Benefits within thirty-one days of a Qualifying Event, your Personal Benefits or the change(s) in 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 that the change in coverage is consistent with your new family status.

**4.** If you make a request to be covered for Personal Benefits during an annual enrollment period, but after your Personal Benefits Eligibility Date, your Personal Benefits will become effective one year following the date of your request.

**5.** If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the calendar year following the annual enrollment period, subject to the Active Work Requirement.

**B. 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.

**C. 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 foregoing provisions.

## EFFECTIVE DATES OF DEPENDENT BENEFITS

### A. Making a Request for Benefits

**1.** In order to become insured for Dependent Benefits under This Plan, you must make a written request to the Employer on the flexible benefits 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.** 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 your Dependent Benefits may only be made:

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

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

**2.** If you make a request to be insured for Dependent 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.

**3.** If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent 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 that the change in coverage is consistent with your new family status.

**4.** If you make a request to be insured for Dependent Benefits during an annual enrollment period, but after your Personal Benefits Eligibility Date; your Dependent Benefits will become effective on the later of:

**a.** one year following the date of your request; and

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

**5.** If you make a request to change your Dependent Benefits during an annual enrollment period in which you can elect coverage, your Dependent Benefits will become effective on the first day of the calendar year following the annual enrollment period.

**B. 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.

**C. New Dependents**

If you are insured for Dependent Benefits and acquire a new Dependent, such event may be considered, subject to the provisions of the flexible benefits plan, as a Qualifying Event. The effective date of Dependent Benefits with respect to such person who becomes your Dependent would be determined in accordance with the foregoing provisions.

Form G.23000-D2

## DENTAL EXPENSE BENEFITS

**A. DEFINITIONS**

**"Covered Dental Expense"** means the charges based on the Preferred Dentist Program Schedule of Maximum Payments for the types of dental services shown in section C.

For In-Network Benefits these services must be:

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

**b.** necessary (see NOTICES) in terms of generally accepted dental standards.

For Out-of-Network Benefits these services must be:

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

**b.** necessary (see NOTICES) 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 Schedule of Maximum Payments.

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.

**"Copay"** means the portion of the Covered Dental Expense for In-Network Dental Expenses which the Covered Person must pay. The Copay amount is shown in the Rider entitled PDP Copay Schedule accompanying this certificate.

The Copay amount that you are responsible to pay is based on the Covered Dental Expense for which we pay benefits, not the service performed. This means that you may be responsible to pay an

amount in excess of the Copay amount if the service performed by the In-Network Dentist is not the Covered Dental Expense for which we pay benefits.

MetLife has the right to increase the amount of your Copay after providing 2 months notice to the Employer by adjusting your Copay schedule in order to maintain a consistent relationship between the Preferred Dentist Program Schedule of Maximum Payments and the Copay amounts.

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

**"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 Schedule of Maximum Payments"** 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 Schedule of Maximum Payments 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 Schedule of Maximum Payments 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:

**In-Network Benefits**

An amount equal to the Preferred Dentist Program Schedule of Maximum Payments less the Copay amount. If under the Alternate Benefits provision we pay benefits based upon a less costly Covered Dental Expense, the Copay amount will be the amount applicable to the less costly service.

**Out-of-Network Benefits**

An amount equal to the Covered Percentage less the Deductible Amount 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.

**b.** **Orthodontic Covered Services** - Orthodontic treatment generally consists of initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist. Orthodontic treatment also includes other services required for the orthodontic treatment such as transseptal fibrotomy and extractions of certain teeth.

Upon the initial placement of the appliance, which may include other services such as the initial workup, we will pay an amount not to exceed 20% of the Covered Expense times the Covered Percentage for Orthodontic Treatment.

After the initial placement of the orthodontic appliance we will pay any remaining benefit during the course of the orthodontic treatment (including periodic follow-up visits) as follows:

**i.** The amount payable during the scheduled course of the orthodontic treatment will be the lower of:

(a) the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia; and

(b) the remaining amount of the Aggregate Maximum Benefit for Orthodontic Treatment (For All Dental Expense Periods).

**ii.** We will divide the benefit payable for the course of the orthodontic treatment by the number of months in the scheduled course of the orthodontic treatment (but no more than 24 months). We will use 3 times the resulting amount as the most we will pay for each 3-month period during the scheduled course of the orthodontic treatment.

Benefits will only be payable during the scheduled course of the orthodontic treatment if:

**i.** Dental Insurance is in effect for the person receiving the orthodontic treatment; and

**ii.** proof is given to Us that the orthodontic treatment is continuing.

For minor orthodontia services that are performed in one visit and do not require follow-up visits, we will pay the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia.

**The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment, will not be more than the applicable Aggregate Maximum Benefit for Orthodontic Treatment as shown in the SCHEDULE OF BENEFITS. This includes any services required for orthodontia received prior or related to the initial placement of an orthodontia appliance.**

**Benefits For Orthodontic Services Begun Prior To This Dental Insurance** - If the initial placement of the appliance was made prior to these Dental Expense Benefits being in effect, no benefits will be payable under these Dental Expense Benefits for the initial placement of the appliance.

If periodic follow-up visits commenced prior to these Dental Expense Benefits being in effect:

**i.** the number of months for which benefits are payable based on the scheduled course of orthodontic treatment will be reduced by the number of months of treatment performed before these Dental Expense Benefits were in effect; and

**ii.** the total amount of the benefit payable that we would have normally provided for treatment which was started while these Dental Expense Benefits were in effect will be reduced proportionately.

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.

When Dental Expense Benefits are determined, the Deductible amount will be applied based on the date the Covered Dental Expenses are incurred. The Deductible Amount will be applied to Covered Dental Expenses which are incurred on an earlier date before Covered Dental Expenses which are incurred on a later date.

For Covered Dental Expenses which are incurred on the same date, but paid on different dates, the Deductible Amount will be applied to the Covered Dental Expenses which are paid earlier.

For Covered Dental Expenses which are incurred on the same date and paid on the same date, the Deductible Amount will be applied to Covered Dental Expenses which belong to a Type of Covered Dental Expenses with a higher Covered Percentage before being applied to Covered Dental Expenses which belong to a Type of Covered Dental Expenses with a lower Covered Percentage.

### 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 twice in a Dental Expense Period.

**b.** Full mouth or panoramic X-rays once every 36 months.

**c.** Bitewing X-rays but not more than twice per Dental Expense Period

**d.** Cleaning of teeth (oral prophylaxis) but not more than twice per Dental Expense Period.

**e.** Topical fluoride treatment once in a Dental Expense Period for a dependent child 19 years of age or younger.

### 2. Type B Expenses

**a.** Intraoral-periapical X-rays and other X-rays not specified above.

**b.** Pulp vitality tests, diagnostic casts, and bacteriological studies for determinations of pathological agents.

**c.** For Dependent child 19 years of age or younger, space maintainers.

**d.** Initial placement of amalgam or composite fillings.

**e.** Replacement of an existing amalgam or composite fillings.

**f.** Sedative fillings

**g.** Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration)

**h.** Periodontal maintenance where periodontal treatment (including scaling, root planing and periodonal surgery such as gingivectomy, gingivoplasty, gingival currettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in a Dentla Expense Period, less the number of teeth cleanings received during such year.

**i.** Emergency palliative treatment to relieve tooth pain.

**j.** For Dependent child 19 years of age or younger, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth every 60 months.

**3. Type C Expenses**

**a.** Prefabricated stainless steel crown or prefabricated resin crown, in either case, only for primary teeth but not more than one per tooth within 5 years.

**b.** Repair or re-cementing of Cast Restorations.

**c.** Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one type of surgical procedure per quadrant in any 36 month period.

**d.** Periodontal scaling and root planing but not more than once per quadrant in any 24 month period.

**e.** Initial installation of Cast Restorations.

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

**f.** Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within 5 years.

**g.** Oral surgery except as mentioned elsewhere.

**h.** Pulp therapy and apexification/recalcification.

**i.** Extractions of unimpacted teeth and removal of exposed roots.

**j.** Extractions of impacted teeth.

**k.** Root canal treatment but not more than once in a 24 month period for the same tooth.

**l.** Initial installation of full or removable Dentures when needed to replace natural teeth that are lost while the Covered Person receiving such benefits was insured for Dental Expense Benefits under this certificate.

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

**m.** Addition of teeth to a partial removable Denture to replace natural teeth removed while Dental Expense Benefits are in effect for the Covered Person receiving such services.

**n.** Replacement of a non-serviceable Denture if such Denture was installed more than 10 years prior to replacement.

**o.** Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture.

**p.** Repair of Dentures.

**q.** Relinings and rebasings of existing removable Dentures:

**i.** if at least 6 months have passed since the installation of the existing removable Denture; and

**ii.** not more than once in any 36 month period.

**r.** Other removable prosthetics services not described elsewhere.

**s.** Other fixed Denture prosthetic services not described elsewhere.

**t.** Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of 5 years.

**u.** Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.

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

**w.** Consultations, but not more than twice in a calendar year.

**x.** Injections of therapeutic drugs.

**y.** Local chemotherapeutic agents.

**z.** Fixed and removable appliances for correction of harmful habits.

**4. Type D Expenses**

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.** Repair or replacement of an orthodontic appliance.

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

**6.** Services or supplies which are covered by any workers' compensation laws or occupational disease laws.

**7.** Services or supplies which are covered by Employers' liability laws.

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

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

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

**15.** Instruction for oral care such as hygiene or diet.

**16.** Periodontal splinting.

**17.** Temporary or provisional restorations.

**18.** Temporary or provisional appliances.

**19.** 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.

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

**21.** Any duplicate appliance or prosthetic device.

**22.** 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.

**23.** Charges made by a Dentist for failure to keep a scheduled visit with such Dentist.

**24.** Sterilization supplies.

**25.** Services rendered by or supplies received from a member of your family or your spouse's family.

**26.** Implantology.

**27.** Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

**28.** Treatment of temporomandibular joint disorders.

## 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. Amalgam and Composite Fillings

When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we will base our benefit determination upon the amalgam filling which is the less costly service.

### 2. 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.

### 3. 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.

### 4. 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. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available to a Covered Person under a Government Plan, as defined below, they will not be considered for Dental Expense Benefits under This Plan. This provision will apply whether or not the Covered Person is enrolled for all Government Plans for which that Covered Person is eligible.

This provision will not apply to a Government Plan if that Government Plan requires that Dental Expense Benefits under This Plan be paid first.

A "Government Plan" is any plan, program or coverage, other than Medicare:

**1.** which is established under the laws or the regulations of any government; or

**2.** in which any government participates other than as an employer.

## H. 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 31 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 31 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 31 days after the date the Dental Expense Benefits end.

In addition, if a Covered Person is Fully Disabled and is receiving Dental Expense Benefits on the date This Plan ends, we will pay the Dental Expense Benefits for dental services on the same basis as if This Plan has continued to be in effect, without change, if the services or the treatment:

**1.** is recommended in writing to the Covered Person by a Doctor or Dentist while the Covered Person is covered under This Plan; and

**2.** began prior to the date This Plan ended and as a result of an injury or sickness which occurred while This Plan was in effect; and

**3.** is for other than: routine exams; prophylaxis; X-rays; sealants; or orthodontics; and

**4.** is performed within 3 months after the Covered Person's Dental Expense Benefits under This Plan end; provided the Dental Expense Benefits do not end as a result of the Employee's voluntary termination.

We will continue to pay such Dental Expense Benefits until the end of the 3 month period specified in 4. above, or the date the Covered Person becomes covered for similar benefits under a plan which replaces This Plan, whichever is earlier; however, if the plan which replaces This Plan does not cover: the dental services or treatment described above or that person because of an elimination period; or, that person is not covered under the replacing plan, we will continue to pay such Dental Expense Benefits for a period of 3 months after the date This Plan ends.

**I. PAYMENT OF BENEFITS**

Dental Expense Benefits will be paid to you. 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

## 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 Benefits will end on the earlier of:

**1.** the last day of the calendar year in which the Dependent ceases to be your Dependent; or

**2.** 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.

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, Your Leave of Absence, Your Lay Off**

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) or a similar state law, the period cannot be longer than the leave required by the law. If a leave qualifies under more than one such law, the period cannot be longer than the longest leave permitted under any of the laws.

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; or

**2.** a group blanket plan, but not including school accident-type coverages covering students in:

**a.** a grammar school;

**b.** a high school; or

**c.** a college;

for accident only (including athletic injuries) either on a 24 hour basis or on a "to and from school basis"; or

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

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

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

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

**7.** 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:

**1.** Government Plans; or

**2.** 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.** expenses for services rendered because of:

**1.** an Occupational Sickness; or

**2.** an Occupational Injury.

**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.

**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.

## 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 One Madison Avenue, New York, New York 10010.**

Form G.23000-E

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MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

CERTIFICATE RIDER

Group Policy No.: 92121-G

Employer: Miami-Dade County Public Schools

Effective Date: February 1, 2004

The certificate is changed by adding the following as the Copay Schedule referred to in the section entitled DENTAL EXPENSE BENEFITS, on the date specified above as follows:

## PDP COPAY SCHEDULE

| Service Category | Description | Area 1 | Area 2 | Area 3 | Area 4 |
|---|---|---|---|---|---|
| Diagnostic | Periodic Exam | $ 0 | $ 0 | $ 0 | $ 0 |
| | Exams | $ 5 | $ 5 | $ 5 | $ 5 |
| | Full Mouth and Bitewing X-Rays | $ 0 | $ 0 | $ 0 | $ 0 |
| | Periapical first film and occlusal | $ 7 | $ 8 | $ 9 | $ 9 |
| | Extraoral X-ray | $ 20 | $ 20 | $ 25 | $ 25 |
| | Additional Periapicals | $ 3 | $ 3 | $ 3 | $ 3 |
| Preventive | Prophylaxis | $ 15 | $ 15 | $ 15 | $ 15 |
| | Fluoride | $ 0 | $ 0 | $ 0 | $ 0 |
| | Sealants | $ 10 | $ 10 | $ 15 | $ 15 |
| | Space Maintainers - unilateral | $ 85 | $ 100 | $ 105 | $ 115 |
| | Space Maintainers - bilateral | $ 140 | $ 155 | $ 170 | $ 190 |
| Restorative | Amalgams - primary | $ 35 | $ 35 | $ 35 | $ 40 |
| | Amalgams - 1 Surface | $ 35 | $ 35 | $ 35 | $ 40 |
| | Amalgams - 2 Surfaces | $ 40 | $ 45 | $ 45 | $ 50 |
| | Amalgams - 3 or More Surfaces | $ 45 | $ 50 | $ 55 | $ 60 |
| | Resin-based composite, anterior, 1 Surface | $ 30 | $ 35 | $ 40 | $ 45 |
| | Resin-based composite, anterior, 2 Surfaces | $ 40 | $ 45 | $ 50 | $ 55 |
| | Resin-based composite, anterior, more than 2 surfaces | $ 55 | $ 60 | $ 70 | $ 75 |
| | Resin-based composite crown | $ 90 | $ 100 | $ 115 | $ 120 |
| | Resin-based posterior composite | $ 35 | $ 40 | $ 45 | $ 50 |
| | Inlays | $ 280 | $ 295 | $ 330 | $ 375 |
| | Crowns / Onlays, Metal/Porcelain | $ 380 | $ 390 | $ 475 | $ 520 |
| | Recementation - Inlays/Crowns | $ 25 | $ 30 | $ 35 | $ 35 |
| | Prefabricated Crowns | $ 80 | $ 85 | $ 95 | $ 105 |
| | Resin Windows | $ 100 | $ 110 | $ 125 | $ 130 |

## PDP COPAY SCHEDULE (Continued)

| Service Category | Description | Area 1 | Area 2 | Area 3 | Area 4 |
|---|---|---|---|---|---|
| Restorative (Continued) | Post and Cores | $ 100 | $ 110 | $ 125 | $ 130 |
| | Prefabricated Crowns / Post and Cores, each additional | $ 10 | $ 10 | $ 10 | $ 10 |
| | Sedative Filling | $ 20 | $ 25 | $ 35 | $ 35 |
| | Core buildup, including any pins | $ 65 | $ 70 | $ 85 | $ 85 |
| | Cast post and core | $ 140 | $ 155 | $ 175 | $ 190 |
| | Crown repairs | $ 70 | $ 70 | $ 90 | $ 90 |
| | Recementation - Bridges | $ 45 | $ 45 | $ 55 | $ 55 |
| Endodontics | Pulpal therapy | $ 25 | $ 25 | $ 30 | $ 35 |
| | Root canal, anterior | $ 240 | $ 265 | $ 300 | $ 335 |
| | Root canal, bicuspid | $ 285 | $ 315 | $ 355 | $ 390 |
| | Root canal, molar | $ 395 | $ 425 | $ 490 | $ 520 |
| | Root canal retreatment, anterior | $ 310 | $ 345 | $ 390 | $ 435 |
| | Root canal retreatment, bicuspid | $ 360 | $ 400 | $ 450 | $ 495 |
| | Root canal retreatment, molar | $ 440 | $ 490 | $ 550 | $ 605 |
| | Apexification, initial | $ 105 | $ 110 | $ 130 | $ 140 |
| | Apexification, interim | $ 60 | $ 60 | $ 70 | $ 75 |
| | Apexification, final | $ 155 | $ 170 | $ 195 | $ 220 |
| | Apicoectomy | $ 250 | $ 250 | $ 300 | $ 335 |
| | Apicoectomy, additional root | $ 120 | $ 120 | $ 150 | $ 165 |
| | Root amputation / hemisection | $ 160 | $ 160 | $ 200 | $ 215 |
| Periodontics | Soft tissue surgery - gingivectomy (per quadrant) | $ 175 | $ 195 | $ 210 | $ 235 |
| | Gingivectomy - per tooth | $ 45 | $ 55 | $ 60 | $ 65 |
| | Gingival Flap Proc: more than 3 teeth/quad | $ 205 | $ 220 | $ 250 | $ 260 |
| | Gingival Flap Proc: less than 3 teeth/quad | $ 120 | $ 130 | $ 150 | $ 155 |
| | Apically Positioned Flap | $ 115 | $ 125 | $ 135 | $ 145 |
| | Clinical crown lengthening | $ 285 | $ 315 | $ 350 | $ 390 |
| | Osseous surgery | $ 370 | $ 415 | $ 460 | $ 515 |
| | Osseous surgery (1-3 teeth) | $ 220 | $ 250 | $ 275 | $ 310 |
| | Bone replacement graft - first site in quadrant | $ 90 | $ 95 | $ 105 | $ 115 |
| | Bone replacement graft - each additional site in quadrant | $ 45 | $ 45 | $ 55 | $ 60 |
| | Guided tissue regeneration | $ 165 | $ 175 | $ 190 | $ 205 |
| | Surgical revision per tooth | $ 45 | $ 55 | $ 60 | $ 65 |
| | Pedicle Soft Tissue Grafts | $ 230 | $ 245 | $ 290 | $ 295 |
| | Other Soft Tissue Grafts | $ 320 | $ 350 | $ 410 | $ 430 |
| | Soft tissue surgery - Distal or Proximal Wedge | $ 120 | $ 125 | $ 135 | $ 145 |
| | Scaling and root planing (per quadrant) | $ 70 | $ 75 | $ 85 | $ 90 |
| | Scaling and root planning (1-3 teeth) | $ 40 | $ 45 | $ 50 | $ 55 |
| | Periodontal maintenance | $ 35 | $ 35 | $ 40 | $ 40 |

## PDP COPAY SCHEDULE (Continued)

| Service Category | Description | Area 1 | Area 2 | Area 3 | Area 4 |
|---|---|---|---|---|---|
| Prosthodontics (Removable) | Complete dentures | $ 430 | $ 485 | $ 535 | $ 595 |
| | Partial dentures - resin base | $ 335 | $ 375 | $ 420 | $ 460 |
| | Partial dentures - cast metal base | $ 650 | $ 650 | $ 820 | $ 865 |
| | Denture adjustments | $ 25 | $ 25 | $ 30 | $ 30 |
| | Denture repairs | $ 65 | $ 70 | $ 80 | $ 85 |
| | Denture rebase | $ 165 | $ 180 | $ 205 | $ 225 |
| | Denture reline - Chairside/Office | $ 90 | $ 100 | $ 105 | $ 115 |
| | Denture reline - Lab | $ 130 | $ 145 | $ 165 | $ 180 |
| | Tissue conditioning | $ 55 | $ 55 | $ 65 | $ 75 |
| Prosthodontics (Fixed) | Fixed partial denture pontics | $ 360 | $ 375 | $ 435 | $ 490 |
| | Retainer | $ 165 | $ 180 | $ 205 | $ 225 |
| | Fixed partial denture repair | $ 60 | $ 65 | $ 70 | $ 80 |
| Oral Surgery | Simple extractions | $ 45 | $ 45 | $ 50 | $ 55 |
| | Surgical removal of erupted tooth | $ 80 | $ 90 | $ 105 | $ 110 |
| | Removal of impacted tooth, soft tissue/partial bony | $ 115 | $ 125 | $ 145 | $ 155 |
| | Removal of impacted tooth, full bony | $ 160 | $ 175 | $ 200 | $ 215 |
| | Surgical exposure of impacted or unerupted tooth to aid eruption | $ 135 | $ 150 | $ 175 | $ 195 |
| | Alveoloplasty with an extraction | $ 75 | $ 80 | $ 95 | $ 100 |
| | Alveoloplasty without an Extraction | $ 115 | $ 125 | $ 145 | $ 165 |
| | Incision and drainage, Intraoral | $ 55 | $ 60 | $ 65 | $ 70 |
| | Incision and drainage, Extraoral | $ 85 | $ 95 | $ 110 | $ 120 |
| | Frenulectomy | $ 105 | $ 110 | $ 125 | $ 135 |
| | Excision of hyperplastic tissue | $ 125 | $ 140 | $ 160 | $ 175 |
| | Excision of pericoronal gingiva | $ 60 | $ 60 | $ 70 | $ 80 |
| Adjunctive General Services | Palliative treatment | $ 20 | $ 20 | $ 25 | $ 25 |
| | General Anesthesia or intravenous sedation, first 30 minutes | $ 120 | $ 120 | $ 155 | $ 165 |
| | General Anesthesia, each additional 15 minutes | $ 50 | $ 50 | $ 60 | $ 60 |
| | Intravenous sedation, each additional 15 minutes | $ 30 | $ 30 | $ 35 | $ 40 |
| | Consultation | $ 35 | $ 35 | $ 40 | $ 45 |
| | Occlusal adjustment - limited | $ 35 | $ 35 | $ 40 | $ 45 |
| | Occlusal adjustment - complete | $ 160 | $ 170 | $ 195 | $ 225 |
| Orthodontics | If your plan covers orthodontics, the Copay amount for a full course of treatment is $3,600 minus your plan's lifetime orthodontic benefit maximum. | | | | |

## PDP COPAY SCHEDULE (Continued)

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

| Area 1 | Area 2 |
|---|---|
| Alabama | Arizona |
| Arkansas | Florida; not including zip codes 330-334, 339-340, nor 349 |
| Illinois; not including zip codes 600-607, 610-611, nor 613 | Georgia; not including zip codes 300-303, 305 nor 311 |
| Indiana; for zip codes 421-424 and 470-472 and 474-478 | Idaho |
| Iowa | Illinois; for zip codes 600-607, 610-611, and 613 |
| Kansas | Indiana; not including zip codes 421-424, nor 470-472 nor 474-478 |
| Kentucky | Louisiana |
| Maryland; for zip code 215 | Maryland; not including zip codes 207-209 nor 215 |
| Minnesota; for zip codes 560-562 and 565-567 | Massachusetts; for zip codes 012-013 and 010 |
| Mississippi | Michigan |
| Missouri | Minnesota; for zip codes 556-559 |
| Nebraska | Montana |
| North Dakota | New Mexico |
| Pennsylvania; for zip codes 154-168, 170, and 172 | New York; not including zip codes 100-119 |
| Puerto Rico | North Carolina |
| South Dakota | Ohio |
| Texas; for zip code 755 | Oklahoma |
| Utah | Pennsylvania; not including zip codes 154-168, 190-191, 170, nor 172 |
| West Virginia | South Carolina |
| Wyoming | Tennessee |
| | Texas for zip codes 750-754, 756-799 |
| | Vermont |
| | Virginia for zip codes 224-246 |
| | Virgin Islands |
| | Wisconsin |

## PDP COPAY SCHEDULE (Continued)

| Area 3 | | Area 4 |
|---|---|---|
| California; for zip codes 922-925, 936-937, 952-953, and 955-961 | | Alaska |
| Colorado | | California; not including zip codes 922-925, 936-937, 952-953, nor 955-961 |
| Connecticut; for zip code 063 | | Connecticut; not including zip code 063 |
| District of Columbia | | Massachusetts; for zip codes 017-022 |
| Delaware | | Nevada; not including zip codes 890-892 |
| Florida; for zip codes 330-334, 339-340, and 349 | | New Jersey; not including zip codes 080-084 |
| Georgia; for zip codes 300-303, 305 and 311 | | New York; for zip codes 100-119 |
| Hawaii | | Washington; not including zip codes 990-992 nor 994 |
| Maine | | |
| Maryland; for zip codes 207-209 | | |
| Massachusetts; not including zip codes 010, 012-013, nor 017-022 | | |
| Minnesota; for zip codes 550-555 and 563-564 | | |
| Nevada; for zip codes 890-892 | | |
| New Hampshire | | |
| New Jersey; for zip codes 080-084 | | |
| Oregon | | |
| Pennsylvania; for zip codes 190-191 | | |
| Rhode Island | | |
| Virginia; for zip codes 201 and 220-223 | | |
| Washington; for zip codes 990-992 and 994 | | |

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

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

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

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 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:

**1.** the end of the 18, 29 or 36 month continuation period, as the case may be;

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

**3.** the date, after a Covered Person elects to continue coverage, that the Covered Person first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to any preexisting condition on the Covered Person;

**4.** the date This Plan is cancelled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the 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.

Any person who elects to continue coverage under the 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.

## PRIVACY OF YOUR MEDICAL INFORMATION

**This Plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined in HIPAA. For purposes of the Plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information, that relates to your or their eligibility for dental benefits under the Plan.**

**Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor**

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

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.

- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.

- Other uses relating to plan administration which are approved in writing by the Plan Administrator.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

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

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

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

**Sharing of PHI With the Plan Sponsor**

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in sections titled "Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor" and "Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes" above;

- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

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

- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

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

  Risk Management

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

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

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this section titled "Sharing of PHI With the Plan Sponsor".

**Participants Rights**

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

**Privacy Complaints/Issues**

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