

YOUR BENEFIT PLAN

UNC Hospitals Office of Graduate Medical Education

All Full-Time Employees

LOW PLAN

Dental Insurance for You and Your Dependents

Certificate Date: July 1, 2009

UNC Hospitals Office of Graduate Medical Education
101 Manning Drive, RM 1107G
Chapel Hill, NC 27514

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.

UNC Hospitals Office of Graduate Medical Education



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: UNC Hospitals Office of Graduate Medical Education

Group Policy Number: 141644-1-G

Type of Insurance: Dental Insurance

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

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

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

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

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

For Texas Residents:

Para Residentes de Texas:

IMPORTANT NOTICE

AVISO IMPORTANTE

To obtain information or make a complaint:

Para obtener informacion o para someter una queja:

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

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

1-800-438-6388

1-800-438-6388

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

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

1-800-252-3439

1-800-252-3439

You may write the Texas Department of Insurance

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

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

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

Email: ConsumerProtection@tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

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

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).

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

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

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

NOTICE FOR RESIDENTS OF TEXAS

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

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

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

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

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

Appealing the Initial Determination

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third
Little Rock, Arkansas 72204-1904
1-800-852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

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

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (Continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

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

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

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

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

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (Continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

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

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

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

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

NOTICE FOR RESIDENTS OF NORTH CAROLINA

Read your Certificate Carefully.

This Certificate Contains a Pre-existing Condition Limitation.

NOTICE FOR RESIDENTS OF NORTH CAROLINA

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

- (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
- (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

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

NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

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

NOTICE FOR RESIDENTS OF TEXAS

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

NOTICE FOR RESIDENTS OF UTAH

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.

NOTICE FOR RESIDENTS OF UTAH (continued)

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

FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

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

Or:

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

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

TABLE OF CONTENTS

Section	Page
CERTIFICATE FACE PAGE	1
NOTICES	2
SCHEDULE OF BENEFITS	24
DEFINITIONS	25
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.....	31
Eligible Classes	31
Date You Are Eligible for Insurance	31
Enrollment Process For Dental Insurance.....	31
Date Your Insurance Takes Effect	31
Date Your Insurance Ends	32
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS	33
Eligible Classes For Dependent Insurance	33
Date You Are Eligible For Dependent Insurance	33
Enrollment Process For Dependent Dental Insurance.....	33
Date Dental Insurance Takes Effect For Your Dependents.....	33
DENTAL INSURANCE: SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE	35
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT	36
For Mentally or Physically Handicapped Children.....	36
For Family And Medical Leave	36
COBRA Continuation For Dental Insurance.....	36
At The Policyholder's Option	36
DENTAL INSURANCE.....	37
DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES.....	40
Type A Covered Services.....	40
Type B Covered Services.....	40
Type C Covered Services.....	41

TABLE OF CONTENTS (continued)

Section	Page
DENTAL INSURANCE: EXCLUSIONS	42
DENTAL INSURANCE: COORDINATION OF BENEFITS	44
FILING A CLAIM	49
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS.....	50
GENERAL PROVISIONS.....	52
Assignment.....	52
Dental Insurance: Who We Will Pay	52
Entire Contract.....	52
Incontestability: Statements Made by You	52
Conformity with Law	52
Overpayments	52

SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	50%	50%
Type C Services	25%	25%

Deductibles for:

Yearly Individual Deductible	\$75 for the following Covered Services Combined: Type B; Type C	\$75 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	3 Individual Deductibles	3 Individual Deductibles

Maximum Benefit:

Yearly Individual Maximum	\$1,000 for the following Covered Services: Type A; Type B; Type C	\$1,000 for the following Covered Services: Type A; Type B; Type C
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Benefits for Covered Services performed by an Out-of-Network Dentist for Emergency Dental Conditions will be paid as if the Covered Service had been performed by an In-Network Dentist. How the benefit is reimbursed is described in the form GCERT2000 den/classic.

NOTE: If You do not enroll for Dental Insurance within 31 days of becoming eligible, for the first year that You are covered for Dental Insurance, You will only be covered for Type A and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services.

DEFINITIONS

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

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

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

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

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

Your natural or adopted child; Your stepchild who resides with You (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; or a foster child; and who, in each case, is:

- under age 20 and unmarried; or
- between ages 26 and ; and
 - a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
 - unmarried;
 - supported by You; and
 - not employed on a full-time basis.

An adopted child includes a child placed in Your physical custody for purpose of adoption. 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.

A foster child includes a child who has been placed in Your physical custody as the appointed guardian or custodian as long as You have assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with You on more than a temporary or short-term basis.

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

The term does not include any person who:

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

For Texas residents **Child** means the following:

Your natural child, adopted child or stepchild (including the child of a Domestic Partner) who is under age 25 and unmarried. **The term also includes** Your grandchild who is under age 25, unmarried and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Dental Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

DEFINITIONS (continued)

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

The term does not include any person who is insured under the Group Policy as an employee.

For New Mexico residents **Child** means the following:

- Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption), or stepchild (including the child of a Domestic Partner) who in each case is:
 - under age 25,
 - unmarried, and
 - supported by You.

The definition of Child includes newborns.

No Child will be denied Dental Insurance because such Child was born out of wedlock, is not residing with You, or is not claimed by You as a deduction for Federal Income Taxes.

An adopted child includes a child placed in Your physical custody for purpose of adoption. 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.

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

The term does not include any person who:

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

For Utah residents **Child** means the following:

Your natural child, adopted child or stepchild (including the child of a Domestic Partner) who is unmarried and under age 26.

The definition of Child includes newborns.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

The term does not include any person who:

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

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

Contributory Insurance includes: Dental Insurance.

DEFINITIONS (continued)

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that We will pay for such services after any required Deductible is satisfied.

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

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

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

Dental Hygienist means a person trained to:

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

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

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

Dentist means:

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

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

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

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

Domestic Partner means each of two people of the same or opposite sex, one of whom is an employee of the Policyholder, who represent themselves publicly as each other's domestic partner and have:

- registered as domestic partners or members of a civil union with a government agency or office where such registration is available; or
- submitted a domestic partner declaration.

DEFINITIONS (continued)

The domestic partner declaration must establish that:

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

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:

- placing the health of the person afflicted with such condition in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious impairment or dysfunction of any bodily organ or part of such person; or
- serious disfigurement of such person.

Full-Time means Active Work on the Policyholder's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 30 hours a week. This includes part-time employees working at least 20 hours a week.

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

Maximum Allowed Charge means the lesser of:

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

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

DEFINITIONS (continued)

Physician means:

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

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

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

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lowest of:

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

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 one 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 greater than or equal to the charged numbered 90th.

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

Spouse means Your lawful spouse. The term also includes Your Domestic Partner.

The term does not include any person who:

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

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

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

DEFINITIONS (continued)

Year or **Yearly**, for Dental Insurance, means the 12 month period from the policy anniversary to the following policy anniversary.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on July 1, 2009, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after July 1, 2009, You will be eligible for insurance on the first day of the month coincident with or next following the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

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

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

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

Enrollment During Any Dental Enrollment Period

During any enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. If You are not currently enrolled for Dental Insurance but You enroll during an enrollment period, Your Dental Insurance takes effect on the first day of the month following the date of Your request, provided You are Actively at Work on that date. For the first year, You will only be covered for Type A and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services, provided You are Actively at Work on that date.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request. For the first year, You will be covered for Type A and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on the date.

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

Qualifying Event includes:

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

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

1. July 1, 2009; and
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the first day of the month coincident with or next following the date You enter a class eligible for insurance.

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

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

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

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

DATE INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

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

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

If You Do Not Enroll When First Eligible

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During Any Dental Enrollment Period

During any enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. If You are not currently enrolled for Dependent Insurance but You enroll during an enrollment period, Your Dental Insurance takes effect on the first day of the month following the date of Your request, provided You are Actively at Work on that date. For the first year You will only be covered for Type A and Type B Services. After the first year of continuous coverage, You will be covered for all Covered Services, provided You are Actively at Work on that date.

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request. For the first year, You will only be covered for Type A and Type B Services, provided You are Actively at Work on that date. After the first year, You will be covered for all Covered Services, provided You are Actively at Work on that date.

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

Qualifying Event includes:

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

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

DENTAL INSURANCE: SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

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

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date, but not more frequently than annually.

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

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

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) for continuation of insurance. Please contact the Policyholder for information regarding the FMLA.

COBRA CONTINUATION FOR DENTAL INSURANCE

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

AT THE POLICYHOLDER'S OPTION

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

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence up to 4 months;
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 4 months.

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

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

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

DENTAL INSURANCE

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

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

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

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

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

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

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

BENEFIT AMOUNTS

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

In-Network

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

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

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

Out-of-Network

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

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

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

DENTAL INSURANCE (continued)

Emergency Dental Condition

Benefits for Covered Services performed by an Out-of-Network Dentist for Emergency Dental Conditions will be paid as if the Covered Service had been performed by an In-Network Dentist.

Maximum Benefit Amounts

The SCHEDULE OF BENEFITS sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network.

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

When 3 Individual Deductibles have been satisfied, the Yearly Family Deductible will be considered satisfied and no further amount will be applied to Individual Deductibles in that Year.

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

Alternate Benefit

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

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

For example:

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

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

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the

DENTAL INSURANCE (continued)

pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your insurance ends; and
- the device is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 31 days after the date the insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams once every 6 months.
2. Full mouth or panoramic x-rays once every 60 months.
3. Bitewing x-rays once every 12 months.
4. Intraoral-periapical and extraoral x-rays.
5. Cleaning of teeth (oral prophylaxis) once every 6 months.
6. Emergency palliative treatment to relieve tooth pain.
7. Topical fluoride treatment once in a 6 month period.
8. Space maintainers for a Child under age 16, once per lifetime per tooth area.
9. Sealants for a Child under age 16, once every 36 months for permanent molars.
10. Fixed and removable appliances for correction of harmful habits for a Child under age 14.

Type B Covered Services

1. Diagnostic casts.
2. Initial placement of amalgam or resin fillings.
3. Replacement of an existing amalgam or resin fillings, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
4. Sedative fillings.
5. Oral Surgery, except as mentioned elsewhere in this certificate.
6. Consultations, but not more than once in a 12 month period.
7. Root canal treatment, but not more than once in any 24 month period for the same tooth.
8. Simple extractions.
9. Surgical extractions.
10. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
11. Pulp therapy and apexification/recalcification.
12. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
13. Injections of therapeutic drugs.
14. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 24 consecutive months.
15. Biopsy of oral tissue.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

Type C Covered Services

1. Initial installation of full or partial Dentures or implants:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance under this certificate.
2. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
3. Replacement of a non-serviceable Denture if such Denture was installed more than 10 years prior to replacement.
4. 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.
5. Other removable prosthetic services not described elsewhere.
6. Other fixed Denture prosthetic services not described elsewhere.
7. Relinings and rebasings of existing removable Dentures:
 - if at least 6 months have passed since the installation of the existing removable Denture; and
 - not more than once in any 36 month period.
8. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
9. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
10. Initial installation of Cast Restorations.
11. Replacement of any Cast Restoration with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth surface within 10 years of a prior replacement.
12. Core buildup, but no more than once per tooth in a period of 10 years.
13. Posts and cores, but no more than once per tooth in a period of 10 years.
14. Labial veneers, but no more than once per tooth in a period of 10 years.
15. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
16. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
17. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to one time in 6 months less the number of teeth cleanings received during such 6 month period.
18. Implants, but no more than once for the same tooth position in a 10 year period.
19. Repair of implants, but not more than once in a 12 month period.
20. Implant supported prosthetics, but no more than once for the same tooth position in a 10 year period.
21. Tissue conditioning, but not more than once in a 12 month period.
22. Simple repair of Cast Restorations or Dentures, but not more than once in a 12 month period.
23. Occlusal adjustments, but not more than once in a 12 month period.
24. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, once per lifetime.
25. Debridement, but not more than once in a 36 month period.
26. Stress Breakers.
27. Temporary Dentures, but not more than once in a 10 year period.

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist which are supervised and billed by a Dentist, and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic, (For residents of Texas, see notice page section);
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. initial installation of a Denture or implant to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. services paid under any worker's compensation, occupational disease or employer liability law as follows:
 - 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;
 - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law
15. services:
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital
16. services covered under other coverage provided by the Policyholder;
17. temporary or provisional restorations;
18. temporary or provisional appliances;
19. prescription drugs;
20. services for which the submitted documentation indicates a poor prognosis;
21. the following, when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control, such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;

DENTAL INSURANCE: EXCLUSIONS (continued)

22. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
23. caries susceptibility tests;
24. local chemotherapeutic agents;
25. application of desensitizing agents;
26. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
27. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
28. duplicate prosthetic devices or appliances;
29. replacement of a lost or stolen appliance, Cast Restoration or Denture;
30. orthodontic services or appliances;
31. repair or replacement of an orthodontic device;
32. diagnosis and treatment of temporomandibular joint disorders;
33. intra and extraoral photographic images;
34. pulp vitality tests.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

Claim Determination Period means a period that starts on any July 1st and ends on the day before the next July 1st. A Claim Determination Period for any Covered Person will not include periods of time during which that person is not covered under This Plan.

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

- for 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;
- for persons who are not covered in North Carolina, for which You are entitled to benefits under a worker's compensation or similar law or any arrangement that provides for similar compensation.
- arising out of employment for wage or profit.

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

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

- a group insurance plan;
- an HMO;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

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

- Government Plans; or
- Plans which the Policyholder (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

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

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

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim form and the required Proof should be sent to Us within 180 days of the date of a loss.

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

Step 1

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

Step 2

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

Step 3

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

Step 4

The claimant must give Us Proof not later than 180 days after the date of the loss.

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

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of Plan. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 90 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

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

Appealing the Initial Determination

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

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

GENERAL PROVISIONS

Assignment

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

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

GENERAL PROVISIONS (continued)

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

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

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means UNC Hospitals Office of Graduate Medical Education.

The term "Plan Administrator" means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to be the Plan Administrator.

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

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

Not use or further disclose PHI other than as permitted or required by the plan documents entitled "Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor" and "Uses and Disclosures of PHI by 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:

Operations Manager, Director

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

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