Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2024 Dental RFP
March 17, 2023

These responses are provided by MCHCP to questions received from potential bidders for the 2024 Dental RFP.

	Question	Response
1	Is it possible to provide the claims experience by each plan option separated for the same 2021-22 timeframe?	MCHCP currently offers only one dental plan design. Additional detail on the current plan design can be found at http://www.mchcp.org/stateMembers/dental/index.asp.
2	We did not find a census file, just references to total subscribers and dependents. Are you able to provide a census file that contains each subscriber's zip code, rate tier (e.g., Employee only, Employee plus spouse, etc.), and plan option?	Census files are available as Attachments 2 and 3 after receipt of the completed Exhibit A-2 Limited Data Use Agreement. The data fields included in each census file can be found in Attachment 1.
3	We found only one set of rates. Will you please provide current and/or renewal rates for each plan option?	MCHCP currently offers only one dental plan design. The current contract with MetLife expires Dec. 31, 2023; there are no renewal options remaining.
4	Please confirm if MCHCP considers Puerto Rico to be onshore, since technically it is a US territory.	MCHCP does not consider Puerto Rico to be onshore for this contract. Please detail what obligations under the contract are provided in Puerto Rico on Exhibit A-3 Proposed Bidder Modifications for evaluation whether an exception could be granted.
5	Please provide us with current enrollment counts by tier by plan.	MCHCP currently offers only one dental plan design. Please see attached for enrollment by tier.
6	Please provide the MetLife benefits summary with descriptions of coverages, exclusions, limitations, etc.	Please refer to the MCHCP website at http://www.mchcp.org/stateMembers/dental/index.asp.
7	Please provide the MetLife dental certificate/SPD, with a full description of coverages, exclusions, limitations, etc.	Please see attached.
8	What is the current out-of-network reimbursement schedule? Please provide the scheduled amounts of the OON reimbursements for the top 20-25 procedure codes so that we can properly analyze the impact of moving to the requested 90th percentile for OON.	MCHCP does not have the reimbursement schedule as this is a fully-insured product. Please refer to Attachment 6 for in-network claim utilization.
9	What is the current OON reimbursement with MetLife?	The current contract is a MAC Plan for out of network claims.
10	Will you provide network reporting showing network utilization and discounts?	Please refer to Attachment 6 of the RFP.
11	Are there any service issues with MetLife or anything MCHCP is dissatisfied with?	No.

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12	Exhibit A-3 Bidder's Proposed Modifications asks us to clearly identify by subsection number any exceptions to the Request for Proposal (RFP) provisions and include an explanation as to why the bidder cannot comply with the specific provision. Are we to identify all RFP exceptions on this form or only those that apply to the Mandatory Contract Provisions?	All requested modifications by the bidder should be outlined in Exhibit A-3.
13	Are there currrently separate rates for active and retired employees and for different plans?	No. Active employees and retirees pay the same rate. MCHCP currently offers only one dental plan design.

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	Question	Response
14	Have there been any plan changes from 1-1-21 to date? If so, please provide details and effective dates of change.	Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that: •a Cast Restoration was installed for the same tooth; or •a Cast Restoration for the same tooth was replace Core buildup, but no more than once per tooth in a period of 10 Years. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years. Posts and cores, but no more than once per tooth in a period of 10 Years. Labial veneers, but no more than once per tooth in a period of 10 Years. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period. Emergency palliative treatment to relieve tooth pain. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months. •Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months. •Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months. •Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than once every 6 months. If Dentally Necessary, two additional cleanings per Year will also be covered
15	Please provide dental experience split by active and retired.	Active employees and retirees pay the same rate. MCHCP currently offers only one dental plan design.

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	Question	Response
16	If there is currently more than one plan, please provide census that indicates plan option along with all other census information.	MCHCP currently offers only one dental plan design.
17	Please describe in detail what services are required to be onshore (e.g., claims processing, member touchpoints, customer touchpoints, provider touchpoints, IT services, other).	The requirements described in the RFP are required to be onshore.
18	Please provide the current performance guarantees.	Please see attached.
19	Please confirm current and proposed rates exclude commissions.	Confirmed.
20	Please confirm Willis Towers Watson is BOR on the case.	MCHCP does not have a broker of record for this procurement.
21	Please confirm the current benefit administration method.	MCHCP maintains an enrollment system for employees and retirees to select the dental plan. Plan selections are then sent to the Contractor through an eligibility file as described in the RFP.
22	Can we get claims broken out by In- vs. out-of-network?	This will not be provided.
23	Can we get claims for January and February, 2023?	Please see attached.
24	In order to consider providing a quote in a multi-carrier scenario, we need to know the following: 1. Is it the intent of MCHCP to have each carrier offer dual options, or would one carrier offer the basic plan, and one carrier offer the classic plan? 2. If each carrier is to offer a dual choice plan, is it possible that one carrier would offer basic and classic, and the other carrier offer basic and classic with ortho? 3. If each carrier is to offer a dual choice plan, is MCHCP open to allowing one of the carriers to offer plans not requested (or plans that include enhancements), rather than adhering to the requested plan designs?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
25	Are carriers permitted to include minimum participation requirements?	No.
26	Please add services and billed amounts to the Exhibit A-7 Provider Match file.	This will not be provided.
27	If MCHCP chooses to award multiple contracts, will both companies be offering both plan designs selected? For example, if the Basic Plan and Classic Plan with ortho are chosen, would company A and company B both be offering each of the two plans?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.

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	Question	Response
28	If MCHCP chooses to award multiple contracts, and one of the plan designs selected from Exhibit A-8 (tab: Enhanced Benefit Pricing), will both companies be permitted to offer the Enhanced benefit plan at an appropriate rate?	Each contractor would offer both plan designs. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
29	During open enrollment will each employee/retiree be required to actively select their carrier and plan choice (i.e. no default option)?	The Board of Trustees has not yet made a decision regarding passive versus active enrollment.
30	What will the opportunity be to communicate with prospective enrollees?	The opportunity for marketing will be negotiated after contract award.
31	Can MCHCP please confirm the desire to change the current plan offering from a Maximum Allowable Charge (PPO-MAC, PPO fees for non-PPO network reimbursement), to 90th percentile standard R&C, set by an independent third-party, such as FAIR Health, that is updated at least once per year?	Confirmed. If the bidder would like to propose alternative options, MCHCP would like to hear from the bidder what the proposed offering would be. Please provide an explanation of the offering proposed along with proposed rates. However, please be aware that MCHCP retains the right to reject the proposed alternative option.
32	Would it be possible to provide a claims detail file for re-price analysis? We would not ask that you provide any proprietary data and would appreciate it if the file could include the following fields: Date of Service, CDT/ADA Code, Dentist Tax ID, Provider Name, Provider Street Address, Provider City, Provider State Code, Provider Zip Code, and Submitted Fee.	This will not be provided.
33	Can you please provide a provider utilization report for 2022 that includes billed charges?	This will not be provided.
34	Can you please provide a provider utilization report for 2022 that includes paid amount for each provider?	This will not be provided.
35	Has MCHCP made any plan changes to the dental plan in the last few years and if so, can you outline the change(s) made and the year the change was implemented?	Please see response to #14 above.
36	Would it be possible for you to provide the dental claims experience for 2019 and 2020?	This will not be provided.
37	What is the orthodontic lifetime maximum you would like to have included on the Classic Plan with Ortho?	It is as stated in the plan design.
38	We were wondering if your decision is solely based on pricing, or if a much richer plan with a small price increase would be entertained? We would be looking at an increase starting at $1000/yr ($6/pay check). This would be with the second largest dental network in the country.	Please refer to the Introduction and Instructions document for instructions and the evaluation criteria used for potential award of a contract resulting from this RFP.

Missouri Consolidated Health Care Plan
Dental Subscriber Enrollment
March, 2023

Active Employees		
Employee Only		15,062
Employee and Spouse		3,180
Employee and Child(ren)		6,559
Employee, Spouse and Child(ren)		3,700
Subtotal		28,501
Retirees		
Retiree Only		6,491
Retire and Spouse		2,718
Retiree and Child(ren)		328
Retiree, Spouse and Child(ren)		213
Subtotal		9,750
	Total	38,251

MISSOURI CONSOLIDATED HEALTH CARE PLAN

Dental - Monthly

Coverage	Month	Employee Lives	Member Lives	Premium	Claims	EOBs
			State			
Dental	01/01/2019	43,486	63,968	$1,658,984	$768,002	6,527
Dental	02/01/2019	43,667	64,179	$1,663,428	$1,333,695	10,085
Dental	03/01/2019	43,719	64,235	$1,664,572	$1,499,832	11,230
Dental	04/01/2019	43,737	64,223	$1,663,221	$1,649,379	12,201
Dental	05/01/2019	43,725	64,174	$1,662,324	$1,600,056	12,817
Dental	06/01/2019	43,693	64,095	$1,659,052	$1,474,992	10,985
Dental	07/01/2019	43,693	64,095	$1,659,343	$1,611,550	11,650
Dental	08/01/2019	43,585	63,901	$1,653,677	$1,623,064	11,947
Dental	09/01/2019	43,516	63,765	$1,650,090	$1,387,120	10,051
Dental	10/01/2019	43,531	63,762	$1,649,880	$1,605,170	11,886
Dental	11/01/2019	43,615	63,846	$1,651,687	$1,433,950	10,224
Dental	12/01/2019	43,654	63,844	$1,651,633	$1,576,906	10,696
Dental	01/01/2020	44,044	64,558	$1,711,978	$1,524,725	10,779
Dental	02/01/2020	44,130	64,674	$1,714,682	$1,483,545	10,506
Dental	03/01/2020	44,149	64,688	$1,714,625	$1,566,558	10,529
Dental	04/01/2020	44,146	64,654	$1,714,067	$346,996	2,346
Dental	05/01/2020	44,104	64,557	$1,710,748	$748,020	5,759
Dental	06/01/2020	44,017	64,421	$853,058	$1,643,203	11,374
Dental	07/01/2020	43,931	64,298	$1,703,806	$1,723,852	11,973
Dental	08/01/2020	43,736	64,019	$1,696,560	$1,596,044	11,308
Dental	09/01/2020	43,600	63,810	$1,691,039	$1,532,225	10,483
Dental	10/01/2020	43,418	63,507	$1,683,005	$1,497,089	10,113
Dental	11/01/2020	43,287	63,300	$1,677,920	$1,303,218	8,453
Dental	12/01/2020	43,213	63,188	$1,674,144	$1,629,709	10,587
Dental	01/01/2021	43,563	63,908	$1,686,520	$1,409,861	9,510
Dental	02/01/2021	43,495	63,789	$1,683,903	$1,416,984	9,198
Dental	03/01/2021	43,425	63,684	$1,680,877	$1,844,232	12,560
Dental	04/01/2021	43,284	63,455	$1,674,959	$1,702,795	11,274
Dental	05/01/2021	43,204	63,340	$1,672,704	$1,584,895	10,132
Dental	06/01/2021	43,023	63,066	$1,665,663	$1,664,074	11,018
Dental	07/01/2021	42,861	62,838	$1,658,946	$1,644,421	11,066
Dental	08/01/2021	42,717	62,616	$1,653,096	$1,673,022	11,443
Dental	09/01/2021	42,656	62,462	$1,648,412	$1,537,512	10,463
Dental	10/01/2021	42,523	62,248	$1,641,404	$1,557,144	10,890
Dental	11/01/2021	42,416	62,065	$1,636,476	$1,576,453	10,575
Dental	12/01/2021	42,340	61,902	$1,631,582	$1,744,742	11,244
Dental	01/01/2022	42,729	62,588	$1,697,244	$1,386,947	9,458
Dental	02/01/2022	42,718	62,521	$1,694,721	$1,344,623	8,818
Dental	03/01/2022	42,630	62,361	$1,691,540	$1,913,097	12,986
Dental	04/01/2022	42,613	62,287	$1,688,138	$1,763,781	11,553
Dental	05/01/2022	42,674	62,337	$1,688,254	$1,641,781	10,813
Dental	06/01/2022	42,788	62,473	$1,691,863	$1,699,376	11,327
Dental	07/01/2022	42,854	62,493	$1,691,258	$1,534,776	10,203
Dental	08/01/2022	42,973	62,624	$1,693,867	$1,703,819	11,598
Dental	09/01/2022	43,091	62,728	$1,694,609	$1,575,028	10,752
Dental	10/01/2022	43,111	62,711	$1,694,094	$1,564,933	10,781
Dental	11/01/2022	43,152	62,793	$1,697,101	$1,603,122	11,132
Dental	12/01/2022	43,215	62,846	$1,698,600	$1,614,150	10,687
Dental	01/01/2023	43,810	63,808	$1,746,088	$1,492,686	10,463
Dental	02/01/2023	43,810	63,808	$1,746,088	$1,531,922	10,372

Coverage	Month	Employee Lives	Member Lives	Premium	Claims	EOBs
Public Entity						
Dental	01/01/2019	389	471	$11,277	$5,047	42
Dental	02/01/2019	390	472	$11,304	$10,105	64
Dental	03/01/2019	387	468	$11,210	$7,128	67
Dental	04/01/2019	383	465	$11,143	$7,164	64
Dental	05/01/2019	380	460	$11,029	$6,731	89
Dental	06/01/2019	387	467	$11,189	$6,136	63
Dental	07/01/2019	387	467	$11,212	$8,978	76
Dental	08/01/2019	387	468	$11,212	$8,523	68
Dental	09/01/2019	386	467	$11,221	$5,925	50
Dental	10/01/2019	387	466	$11,197	$7,786	65
Dental	11/01/2019	392	472	$11,368	$7,102	59
Dental	12/01/2019	389	468	$11,275	$6,963	60
Dental	01/01/2020	389	468	$11,569	$8,965	56
Dental	02/01/2020	350	425	$10,588	$6,683	65
Dental	03/01/2020	349	425	$10,623	$4,808	41
Dental	04/01/2020	348	425	$10,657	$2,293	11
Dental	05/01/2020	347	423	$10,608	$1,946	23
Dental	06/01/2020	345	420	$5,252	$8,740	63
Dental	07/01/2020	329	398	$9,878	$6,747	53
Dental	08/01/2020	325	391	$9,645	$11,481	68
Dental	09/01/2020	326	392	$9,668	$7,205	59
Dental	10/01/2020	327	392	$9,634	$7,137	47
Dental	11/01/2020	334	398	$9,775	$5,935	37
Dental	12/01/2020	352	423	$10,373	$7,033	56
Dental	01/01/2021	391	473	$11,702	$8,031	52
Dental	02/01/2021	396	477	$11,761	$6,769	57
Dental	03/01/2021	395	475	$11,714	$11,886	73
Dental	04/01/2021	392	474	$11,725	$9,657	73
Dental	05/01/2021	383	464	$11,522	$10,929	60
Dental	06/01/2021	384	464	$11,553	$8,505	61
Dental	07/01/2021	382	461	$11,392	$7,635	56
Dental	08/01/2021	380	461	$11,421	$8,665	67
Dental	09/01/2021	384	463	$11,468	$8,417	65
Dental	10/01/2021	381	459	$11,374	$8,784	58
Dental	11/01/2021	381	457	$11,281	$10,746	64
Dental	12/01/2021	386	461	$11,340	$8,139	71
Dental	01/01/2022	438	536	$13,791	$10,414	60
Dental	02/01/2022	439	536	$13,789	$6,836	58
Dental	03/01/2022	435	531	$13,574	$10,562	94
Dental	04/01/2022	437	534	$13,707	$8,601	76
Dental	05/01/2022	437	532	$13,622	$9,469	74
Dental	06/01/2022	432	527	$13,526	$11,674	79
Dental	07/01/2022	428	521	$13,354	$9,166	67
Dental	08/01/2022	425	517	$13,257	$9,291	76
Dental	09/01/2022	424	517	$13,318	$7,905	68
Dental	10/01/2022	429	522	$13,449	$9,101	72
Dental	11/01/2022	427	522	$13,417	$8,428	67
Dental	12/01/2022	433	528	$13,595	$6,223	59
Dental	01/01/2023	524	663	$17,565	$8,066	72
Dental	02/01/2023	524	663	$17,565	$10,914	80

MetLife Performance Guarantees

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Account Management - Satisfaction. The following category will be measured and reported on Implementation and annually beginning January, 2019.	Contractor guarantees MCHCP's satisfaction with account management services	Satisfactory or better	MetLife will conduct a semi-annual survey to measure satisfaction with account management services. The survey is conducted by a third party and results will be shared with MCHCP. MetLife will receive, from designated customer respondents, an average for the year of at least a 5 rating on a 7 point scale to the question "Overall Satisfaction with the MetLife Account Team" on the MetLife Account Management Survey. Our seven point scale equates a score of 4 or 5 to satisfied and 6 or 7 to very satisfied.	$2,000 plus $0.10 PEPM	17000.00
Account Management - Responsiveness. The following category will be reported and measured quarterly beginning January, 2019.	Timely issues resolution by the account management team (e.g. issues resolvable by account management are acknowledged and responded to within 1 business day)	Acknowledgement and response within 8 business hours	The Client Service Consultant is responsible for documenting all client issues in an action log. This log tracks the receipt date and all status updates through resolution. This log is reviewed weekly by the management team and will be shared with MCHCP.	For each incident not acknowledged within 8 business hours, $500 plus $0.10 PEPM	17000.00
Member Service - Average response time. The following category will be measured and reported quarterly beginning January, 2019.	Average number of seconds for call to be answered by a live customer service representative	25 seconds or less	< = 25 seconds - Based on the overall Book of Business. All incoming calls received by the customer service telephone line will be answered within 25 seconds or less. Response time will be measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a Customer Service Representative.	For each full second above standard, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Member Service - Average abandonment rate. The following category will be measured and reported quarterly beginning January, 2019.	Percent of calls abandoned	< 2%	< 2% - Based on the overall Book of Business. MetLife maintains a level of service less than 2% of all incoming calls received by the customer service telephone line to be answered without the caller hanging up. The Abandonment Rate is defined as the number of incoming calls not reaching a Customer Service Reprentative divided by the total number of incoming calls expressed as a percentage.	For each full percentage point above standard, $2,000 plus $0.10 PEPM	8500.00
Member Service - Response to written inquiries. The following category will be measured and reported quarterly beginning January, 2019.	Average number of days within which written inquiries will be responded to	80 percent of emails wil be responded to within 1 business day	Based on the overall Book of Business. Measured by Customer Service Representative email response timeliness.	For each percentage point above standard, $500 plus $0.01 PEPM	8500.00
Eligibility - Timeliness of Installations. The following category will be measured and reported quarterly beginning January, 2019.	Electronic eligibility files will be installed and eligibility status will be effective within an average of 36 hours of receipt.	95% within 24 hours	We agree to apply 95% of ongoing eligibility file updates within 24 hours of receipt. We will log receipt date/time of the file and track the file through successful application into our system. This average turnaround time is contingent on the quality of the file submitted, which encompasses the file being named correctly and containing valid data.	For each full hour beyond 24 hours, $500 plus $0.10 PEPM	8500.00
Eligibility - Accuracy of Installations. The following category will be reported and measured quarterly beginning January, 2019.	Electronic eligibility records loaded with 99.5% accuracy. This standard is contingent upon receipt of clean eligibility data delivered in an agreed upon format.	100%	We agree to load electronic eligibility records with 100% accuracy based on total member numbers. Reports summarizing the file received and loaded will be provided to the client and Client Service Consultant for verification of accuracy of the file.	For each full percentage point below standard, $2,000 plus $0.10 PEPM	8500.00
Reporting - The following categories will be reported and measured quarterly beginning January, 2019. Penalties will be applied for each month the contractor fails to meet these standards.	Claim file must be submitted to MCHCP's data vendor no later than 15th of the month for prior month's services	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
	Claim file must be submitted to MCHCP's data vendor in proper format on first submission of the month	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include 100 percent of all required financial fields	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include all required key fields (subscriber SSN, member DOB, and member gender)	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
	Data submission to MCHCP's data vendor must include all required key fields (diagnostic coding, provider type, provider ID,etc.)	100%	MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PEPM	8500.00
Reporting - The following categories will be measured and reported quarterly beginning January 1, 2019.	Standard reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter	MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	8500.00
	Customer service reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter	MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PEPM	8500.00
Monthly eligibility audit file - The following category will be measured and reported quarterly beginning January, 2019. Penalties will be applied for each month the contractor fails to meet this standard.	Eligibility audit file must be provided on the second Thursday of each month in the agreed upon format	Audit file available by the second Thursday of each month	MCHCP will determine acceptability of file	For each day file was not transmitted on time, $2,000 plus $0.10 PEPM	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Claims financial accuracy - The following category will be measured and reported quarterly beginning January, 2019.	Percentage of claims processed free of financial error	>= 99%	99.5% - Based on MCHCP-specific results. Financial Accuracy is defined as the performance standard used to evaluate the Dental Processing Groups payment performance in dollar amounts. {(Total dollars of Actual Claims for Benefits and Estimated Claims for Benefits in the Book of Business Sample) - (total dollars of Overpaid Claims + total dollars of Underpaid Claims)} divided by (total dollars of Actual Claims for Benefits and Estimated Claims for Benefits in the Book of Business Sample).	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Claims processing accuracy - The following category will be measured and reported quarterly beginning January, 2019.	Percentage of claims processed correctly	>= 99%	99% Based on MCHCP-specific results. Procedural Accuracy is defined as the performance standard used to evaluate AAR Claim processing performance with respect to claim data line entries. A Procedural Error is defined as any error by the Dental Processing Group that results in the incorrect entry of data within a Line of Entry, including, without limitation, Procedural Errors that result in overpayments or underpayments. Procedural Accuracy Rate will be determined by the following formula and expressed as a percentage: (Total Lines of Entry in Book of Business sample - Procedural Errors in Book of Business Sample) divided by Total Lines of Entry in Book of Business sample).	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Claim turnaround time - Network providers - The following category will be measured and reported quarterly beginning January, 2019.	Percent of claims from network providers processed within 10 days	>= 95%	95% within 10 business days Based on MCHCP-specific results. Turnaround Time is the performance standard used to measure the period of time which transpires from the date a Claim is considered Processed to Conclusion. A Claim is considered Processed to Conclusion on the date when MetLife issues an explanation of benefits.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Claim turnaround time - Out of Network providers - The following category will be measured and reported quarterly beginning January, 2019.	Percent of claims from non-network providers processed within 5 days	>= 95%	95% within 10 business days Based on MCHCP-specific results. Turnaround Time is the performance standard used to measure the period of time which transpires from the date a Claim is considered Processed to Conclusion. A Claim is considered Processed to Conclusion on the date when MetLife issues an explanation of benefits.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Network retention rate - The following category will be measured and reported annually beginning January, 2019.	Network provider retention rate (based on voluntary turnover)	>= 98%	Overall network provider retention rate (based on voluntary dentist turnover) of >= 98% annually. Based on Book of Business.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00
Overall Satisfaction with contractor - The following category will be measured and reported quarterly beginning January, 2019.	Percent of members rating contractor satisfactory or better	95%	MetLife uses a 4 point survey scale to measure customer satisfaction with employees. The scale ranges from Very Satisfied to Very Dissatisfied. We can commit to an employee satisfaction score of 95%, representing employees that rated us as either Very Satisfied or Satisfied.	$2,000 plus $0.10 PEPM for each full percentage point below standard	8500.00

Performance Guarantee	Standard	Guarantee	Measurement Process	Minimum Amt at Risk	Maximum Annual Amt at Risk
Preventive care - The following category will be measured and reported annually beginning January, 2019.	Percent of members accessing preventive care	55 percent of members who are continuously enrolled will receive at least one preventive exam per year	We will provide an annual report following the plan year that includes the percentage of members who have received preventive care for the prior year. In addition, if the percent of members falls below the guarantee, we will proactively complete an outreach to all employees regarding preventive exams.	For each full percentage point below standard, $2,000 plus $0.10 PEPM	8500.00
Network Access - The following category will be measured and reported annually beginning January, 2019.	Percent of members with access to general dentist	94 percent of members will have access to 1 general dentist within 20 miles	GeoAccess reporting	0.5% of premium	
Network Development and Growth - The following category will be measured and reported annually beginning January, 2019.	Percentage growth of network dentist access points	PDP Plus network growth of 5 percent of network dentist access points	MetLife will calculate the Network Growth Penalty, if any, and will notify MCHCP of the calculation no later than ninety (90) days following the end of the applicable Policy Period. MetLife will remit payment of such Network Growth Penalty no later than thirty (30) days following the date of such notification.	0.5% of premium for failing to meet network growth guarantee, and 0.25% of premium for growing network by more than 50% but less than 100% of the 5% target	

MetLife's overall maximum aggregate amount at risk for all performance guarantees combined is 3% of annual premium.

YOUR BENEFIT PLAN

Missouri Consolidated Health Care Plan

State
Full-Time Employees,
excluding residents of Alaska and Montana

Dental Insurance for You and Your Dependents

Certificate Date: January 1, 2019

Missouri Consolidated Health Care Plan
832 Weathered Rock Court
Jefferson City, MO 65101

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.

Missouri Consolidated Health Care Plan

MetLife

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

CERTIFICATE OF INSURANCE

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

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

Policyholder:	Missouri Consolidated Health Care Plan
Group Policy Number:	215367-1-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s):	
For Claim Information	FOR DENTAL CLAIMS: 1-844-222-9106

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW 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.

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

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-844-222-9106

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-844-222-9106

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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

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

For Louisiana Residents (Dental Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

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

For New Hampshire Residents (Dental Insurance):

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

For New Mexico Residents (Dental Insurance):

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

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

For Texas Residents (Dental Insurance):

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

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

For Utah Residents (Dental Insurance):

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

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

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

For Washington Residents (Dental Insurance):

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

1-844-222-9106

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

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

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

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

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

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

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

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF IDAHO

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-844-222-9106

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

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

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Dental Insurance ends because:

    - You cease to be in an Eligible Class; or
    - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

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

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

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

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

To continue Dental insurance under this provision:

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

The request form will be furnished by the Employer.

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

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

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

NOTICE FOR RESIDENTS OF MISSISSIPPI

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-844-222-9106.

Claim Submission

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

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

Initial Determination

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

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

"Clean Claim" means a claim that:

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

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

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

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Clean Claim (Continued)

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

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

Appealing the Initial Determination

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

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

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

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

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

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

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

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

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

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

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

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

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

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

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

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

- the covered person is a Child under the age of 6 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition;

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

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

NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

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

NOTICE FOR RESIDENTS OF TEXAS

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

NOTICE FOR RESIDENTS OF 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.

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 1-844-222-9106.

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 UTAH

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

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

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

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

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

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

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

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

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

Or:

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Appealing the Initial Determination

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

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

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.
MetLife will notify You in writing of its final determination within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the 30 day period, state the reason(s) why an extension is needed, and state when it will make its determination.

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

Policies and Procedures for Emergency and Urgent Care

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

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Urgent Care Submission:

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

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

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

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

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-844-222-9106

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

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance For You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	$50 for the following Covered Services Combined: Type B; Type C	$50 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$2,000 for the following Covered Services: Type A; Type B; Type C. Certain Type A and Type B benefits are not subject to the annual maximum. Those Covered Services include: exams (including problem-focused exams), bitewing x-rays, full mouth or panoramic x-rays, intraoral-periapical –x-rays, X-rays, except as mentioned elsewhere, oral prophylaxis (cleanings, including periodontal cleanings) and topical fluoride treatment.	$2,000 for the following Covered Services: Type A; Type B; Type C. Certain Type A and Type B benefits are not subject to the annual maximum. Those Covered Services include: exams (including problem-focused exams), bitewing x-rays, full mouth or panoramic x-rays, intraoral-periapical –x-rays, X-rays, except as mentioned elsewhere, oral prophylaxis (cleanings, including periodontal cleanings) and topical fluoride treatment

Benefit Waiting Periods

Type A Services.....No waiting period

Type B Services.....No waiting period

Type C Services ..... 12 month waiting period

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.

Certificateholder means a member of an eligible class who is insured under the Group Policy. If an insured employee who is a member of an eligible class dies, or if an insured retired employee who is a member of an eligible class dies, and if such employee's or retired employee's surviving Dependent elects to continue Dental Insurance in effect on the date of the insured employee's or retired employee's death, such surviving Dependent will be deemed the Certificateholder thereafter. If coverage is continued, a newly acquired Child of the insured employee's surviving Spouse is eligible to become enrolled for coverage and a newly acquired spouse of the insured employee's surviving Dependent is eligible to become enrolled for coverage.

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

Your natural or adopted child; Your stepchild; or Your foster child; and who, in each case, is under age 26.

The definition of Child includes newborns.

The definition of Child includes an adopted Child beginning on the later of:

- the child's date of birth; or
- the date You initiate an application for adoption of the child.

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

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

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

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

Contributory Insurance includes: Dental Insurance.

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

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

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

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.

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.

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

Spouse means Your lawful spouse.

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

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

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

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

Full-Time Employee means an employee who qualifies as full-time under the following eligibility rules: There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as Full-Time Regular Employees based on the expectation that they will work an average of 30 or more hours per week based on their position within the Policyholder.
- Employees of the Policyholder who are Variable Hour Employees that qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR INSURANCE

For Eligible Class 1:

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 January 1, 2019, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2019, You will be eligible for insurance on the first day of the calendar month following the date You enter that class.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

For Eligible Class 2:

Eligibility Rules – Employees Who Are Hired on or After January 1, 2019

You will qualify for Variable Hour Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Variable Hour Employee status during the Initial Measurement Period, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Eligibility Rules – Ongoing Employees

If You are classified on or after January 1, 2019 as a Variable Hour Employee by the Policyholder following Your Initial Stability Period, You must work an average of 30 hours or more per week during any Ongoing Measurement Period. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

If You were not initially classified as a Variable Hour Employee by the Policyholder on Your date of hire the following eligibility rules apply on and after January 1, 2019 regardless of whether You were eligible for insurance during the Initial Stability Period:

If You qualify for Variable Hour Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period You will be eligible for insurance during the immediately following Ongoing Stability Period, subject to the Waiting Period, provided that Your employment continues. Your eligibility for insurance will terminate, subject to the Date Your Insurance Ends section, at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Variable Hour Employee status during an Ongoing Measurement Period.

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11^{th}) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13^{th} calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on the first payroll period in January of the immediately preceding calendar year and ends with the start of the first payroll period in January in the immediately subsequent (i.e. current) calendar year.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

For new hires, if You complete the enrollment process within 31 days of becoming eligible for Dental Insurance, such insurance will take effect as follows:

If You are in Eligible Class 1, the Dental Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month following the date You enter Eligible Class 1;

provided You are Actively at Work in Eligible Class 1 on that date.

If You are in Eligible Class 2, i.e., You are a variable hour Employee who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, the Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month following the thirteenth month anniversary of Your date of hire;

provided You are Actively at Work in Eligible Class 2 on that date.

If You are a variable hour Employee who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, the Insurance described in this certificate will take effect on the next January 1 provided You are Actively at Work in Eligible Class 2 on that date.

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

If You Do Not Enroll When First Eligible

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

Enrollment During an Annual Enrollment Period

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

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days or 60 days, dependent on the Qualifying Event as shown below, from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of

a Qualifying Event, will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

You will have 31 days from the date of the following Qualifying Events to make a request:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

You will have 60 days from the date of the following Qualifying Events to make a request:

- 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;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
  - You to provide health coverage for Your child or dependent foster child; or
  - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

6. the date You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
7. the end of the last Stability Period for which You have been determined by the Policyholder to be a variable hour employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a full-time regular employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

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 State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period

Full-Time Employee means an employee who qualifies as full-time under the eligibility rules that follow. There are 2 categories of Full-Time Employees:

- Employees of the Policyholder who are classified by the Policyholder as Full-Time Regular Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.
- Employees of the Policyholder who are Variable Hour Employees that qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

See also Eligibility Definitions below.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

For Eligible Cass 1:

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

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

1. January 1, 2019; and
2. the first day of the calendar month following the date You enter a class eligible for insurance; and
3. the date You obtain a Dependent.

Your eligibility for insurance will continue, subject to the Date Your Insurance Ends section, until such time as Your employment ends or Your employment classification changes to a non-full-time status, as determined by the Policyholder based upon status classification changes and/or a reduction in hours worked.

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

For Eligible Class 2:

Eligibility Rules – Employees Who Are Hired on or After January 1, 2019

If on the date of Your hire, You are classified as a Variable Hour Employee by the Policyholder, You may later qualify for Full-Time Employee status if the Policyholder determines that You have worked an average of 30 or more hours per week during the Initial Measurement Period. If You qualify for Full-Time Employee status during the Initial Measurement Period and if You have a Dependent, You will be eligible for insurance during the Initial Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate when You no longer have any Dependents. If earlier,

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Initial Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

Eligibility Rules – Ongoing Employees

If You are a Variable Hour Employee and were not initially classified or designated as a Full-Time Regular Employee by the Policyholder on Your date of hire the following eligibility rules apply regardless of whether You were eligible for insurance during the Initial Stability Period.

If You qualify for Full-Time Employee status by working an average of 30 or more hours per week as determined by the Policyholder during any Ongoing Measurement Period and if You have a Dependent You will be eligible for insurance during the immediately following Ongoing Stability Period, provided that Your employment continues. Your eligibility for Insurance for Your Dependents will terminate when You no longer have any Dependents. If earlier, Your eligibility for Insurance for Your Dependents will terminate subject to the Date Your Insurance For Your Dependents Ends section, or at the end of the Ongoing Stability Period, unless the Policyholder determines that You re-qualify for Full-Time Employee status during an Ongoing Measurement Period.

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

Eligibility Definitions

For purposes of the above eligibility rules, the following terms and their meanings are indicated.

Initial Measurement Period means a period that starts with the first pay period that begins immediately after Your hire date, and ends on the last day of the pay period that contains the eleventh (11^{th}) month anniversary of Your hire.

Initial Stability Period means a 12 month period that starts on the first day of the 13^{th} calendar month following Your date of hire.

Ongoing Measurement Period means an annual 12 month period that starts on the first payroll period in January of the immediately preceding calendar year and ends with the start of the first payroll period in January in the immediately subsequent (i.e. current) calendar year.

Ongoing Stability Period means the 12 month period that starts on the first day of the calendar year following the end of the immediately preceding Ongoing Measurement Period.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

For new hires, if You complete the enrollment process for Dependent insurance within 31 days of becoming eligible for Dependent insurance, such insurance will take effect for each enrolled Dependent as follows:

If You are in Eligible Class 1, the Dependent Insurance described in this certificate will take effect on the later of:

1. January 1, 2019;
2. the first day of calendar month following the date You enter Eligible Class 1 and have one or more Dependents;

provided You are Actively at Work in Eligible Class 1 on that date and You satisfy the benefit waiting periods as shown in the SCHEDULE OF BENEFITS.

If You are a variable hour Employee who has one or more Dependents and who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during Your Initial Measurement Period, the Dependent Insurance described in this certificate will take effect on the later of:

1. January 1, 2019; and
2. the first day of the calendar month after the thirteenth month anniversary of Your date of hire;

provided You are Actively at Work in Eligible Class 2 on that date.

If You are a variable hour Employee who has one or more Dependents and who has qualified for Full-Time status by working an average of 30 hours or more per week as determined by the Policyholder during an Ongoing Measurement Period, the Dependent Insurance described in this certificate will take effect on the next January 1 provided You are Actively at Work in Eligible Class 2 on that date.

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

If You Do Not Enroll When First Eligible

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

Enrollment During an Annual Enrollment Period

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days or 60 days, dependent on the Qualifying Event as shown below, from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

You will have 31 days from the date of the following Qualifying Events to make a request:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- Your taking leave under the United States Family and Medical Leave Act;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
- You or Your dependent become entitled to Medicare or Medicaid coverage (other than coverage solely for pediatric vaccines); or
- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

You will have 60 days from the date of the following Qualifying Events to make a request:

- 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;
- a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires either:
    - You to provide health coverage for Your child or dependent foster child; or
    - Your spouse, former spouse or other individual to provide coverage for Your child or foster child if that other person does in fact provide that coverage; or
- You or Your dependent lose entitlement to Medicare or Medicaid eligibility.

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.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
8. the day in which You cease to be Actively at Work in Eligible Class 1 and provided that You have not become eligible as a variable hour Employee under Eligible Class 2, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
9. the end of the last Stabilization Period for which You have been determined by the Policyholder to be a variable hour Employee as a member of Eligible Class 2 due to Your work in a prior Measurement Period and provided that You have not become eligible as a Full-Time Regular Employee under Eligible Class 1, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
10. the end of the period for which the last premium has been paid; or
11. the last day of the calendar month the person ceases to be a Dependent.

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

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

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

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

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

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

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;

2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:

    - the loss of a tooth; and
    - the accumulation of amounts toward:
        a) Annual Deductibles;
        b) Annual Maximum Benefits;

3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;

4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:

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

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

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;

2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

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

AT YOUR OPTION – CONTINUATION OF DENTAL INSURANCE FOR YOUR DEPENDENTS AFTER A COBRA CONTINUATION ENDS

When Continuation Is Available

Dental Insurance for Your Dependents may be continued when the continuation period expires under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) if:

- Dental Insurance for Your Dependents as provided under this policy has been continued under the provisions of COBRA;
- such continuation occurred because of:
    1. Your death;
    2. Your legal separation from Your Spouse; or
    3. the dissolution of Your marriage by divorce or annulment; and
- such Spouse is at least 55 years of age when the continuation period expires under COBRA.

What Your Spouse Must Do to Continue Dental Insurance

In order to continue dental insurance under the policy, Your Spouse must notify the Policyholder in Writing:

- of Your death, within 30 days of Your death or, prior to the end of the 36 month continuation of dental insurance under COBRA; or
- of the legal separation or dissolution of the marriage, within 60 days of such separation or entry of the decree of dissolution or, prior to the end of the 36 month continuation of dental insurance under COBRA.

The notice must include the mailing address of Your Spouse.

Within 14 days of receipt of such notice, the Policyholder will send the following to the mailing address specified in the notice:

- a notice of Your Spouse's rights to continue dental insurance;
- the request form to continue coverage with instructions; and
- a statement of the periodic premiums.

Your Spouse will have sixty days after the date of the Policyholder's mailing to request continuation of the Dental Insurance.

Failure of Your Spouse to exercise the election in accordance with this section will terminate the right to continue Dental Insurance.

When Continued Dental Insurance Ends

Continued Dental Insurance will end on the earliest of the following dates:

For a Dependent Child, on the date such Dependent Child ceases to meet the definition of Child or becomes covered for dental coverage under any other group plan;

For all Dependents on:

- the date of expiration of the last period for which the required premium payment was made;
- the date the coverage would otherwise terminate under the policy;
- on the date of Your Spouse's remarriage;
- on the date Your Spouse becomes covered for dental insurance under any other group plan; or
- the date Your Spouse attains age 65.

AT THE POLICYHOLDER'S OPTION

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

Insurance will continue for the following periods:

1. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to part-time work, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
5. if You cease Active Work due to strike, for a period in accordance with the Policyholder's general practice for an employee in Your job class.
6. if You are an insured employee of the Policyholder who dies or if You are a retired employee who dies, Dental Insurance for Your surviving Spouse may be continued for a period in accordance with the Policyholder's general practice for an employee in Your job class and Dental Insurance for Your surviving Child may be continued for a period in accordance with the Policyholder's general practice for an employee in Your job class or until the date such person ceases to qualify as a Child due to reaching the maximum age, if earlier. If coverage is continued, a newly acquired Child of the insured

employee’s surviving Spouse is eligible to become enrolled for coverage and a newly acquired spouse of the insured employee’s surviving Dependent is eligible to become enrolled for coverage.

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

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

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

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

DENTAL INSURANCE

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

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

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-844-222-9106 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 Maximum Allowed Charge.

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

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

DENTAL INSURANCE (continued)

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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 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 and problem-focused exams, but no more than two exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Bitewing x-rays 1 set in a Year.
5. Pulp vitality tests.
6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than twice in a Year. If Dentally Necessary, two additional cleanings per Year will also be covered.
7. Topical fluoride treatment for a Child under age 14 once in a Year.
8. Sealants or sealant repairs which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 5 Years.
9. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 5 Years.
10. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 5 Years.
11. Full mouth debridements, but not more than once per lifetime.
12. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
13. Brush Biopsies once in a 24 month period.

Type B Covered Services

1. Full mouth or panoramic x-rays once every 5 Years.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Emergency palliative treatment to relieve tooth pain.
5. Amalgam fillings.
6. Replacement of an existing amalgam filling, but only if:
   - at least 2 Years have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
7. Resin-based composite fillings.
8. Replacement of an existing resin-based composite filling, but only if:
   - at least 2 Years have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
9. Protective (sedative) fillings.
10. Simple extractions.
11. Injections of therapeutic drugs.
12. Space maintainers for a Child under age 14, once in 5 Years per tooth area.

13. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C Covered Services

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the benefit waiting period that applies.

1. Biopsies of hard or soft oral tissue.
2. Pulp capping (excluding final restoration).
3. Therapeutic pulpotomy (excluding final restoration).
4. Pulp therapy.
5. Apexification/recalcification.
6. Pulpal regeneration, but not more than once per lifetime.
7. 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.
8. Initial installation of full or partial Dentures (other than implant supported prosthetics).
9. Addition of teeth to a partial removable Denture.
10. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 7 Years prior to replacement.
11. Replacement of a non-serviceable removable Denture if such Denture was installed more than 7 Years prior to replacement.
12. 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.
13. Other removable prosthetic services not described elsewhere.
14. Other fixed Denture prosthetic services not described elsewhere.
15. 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.
16. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
17. 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.
18. Precision attachments.
19. Initial installation of Cast Restorations (except implant supported Cast Restorations).
20. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 7 Years have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
21. Prefabricated crown, but no more than one replacement for the same tooth within 7 Years.
22. Core buildup, but no more than once per tooth in a period of 7 Years.
23. Posts and cores, but no more than once per tooth in a period of 7 Years.
24. Labial veneers, but no more than once per tooth in a period of 7 Years.
25. Oral surgery, except as mentioned elsewhere in this certificate.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

26. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image but not more than twice in a Year.
27. Other consultations but not more than twice in a Year.
28. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once every 2 Years for the same tooth.
29. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
30. Periodontal scaling and root planning once per quadrant in any 2 year period.
31. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 3 Year period.
32. Surgical extractions.
33. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 7 Year period.
34. Repair of implants, but no more than once in a 12 month period.
35. Implant supported Cast Restorations, but no more than once for the same tooth position in a 7 Year period**.**
36. Implant supported fixed Dentures, but no more than once for the same tooth position in a 7 Year period**.**
37. Implant supported removable Dentures, but no more than once for the same tooth position in a 7 Year period**.**
38. Tissue conditioning, but not more than once in a 36 month period.
39. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
40. Occlusal adjustments - limited, but not more than once in a 12 month period.
41. Cleaning and inspection of a removable appliance twice in a Year.

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
19. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
20. caries susceptibility tests;
21. local chemotherapeutic agents;
22. fixed and removable appliances for correction of harmful habits;
23. appliances or treatment for bruxism (grinding teeth);
24. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
25. duplicate prosthetic devices or appliances;
26. replacement of a lost or stolen appliance, Cast Restoration or Denture;
27. orthodontic services or appliances;
28. repair or replacement of an orthodontic device;

DENTAL INSURANCE: EXCLUSIONS (continued)

29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
30. diagnostic casts;
31. intra and extraoral photographic images;
32. occlusal adjustments – complete;
33. bacteriological studies for determination of bacteriologic agents;
34. collection and preparation of genetic sample material for laboratory analysis and report.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

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

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

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

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

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

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

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

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

The term does not include any of the following:

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-844-222-9106. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

Step 1
A claimant can request a claim form by calling Us at 1-844-222-9106.

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

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

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

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

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

Claims for Medicaid Eligible Individuals

As required by law, to the extent that payment has been made by the Missouri Division of Medical Services for Covered Services furnished to a medicaid eligible individual, the Missouri Division of Medical Services is considered to have acquired the rights of the medicaid eligible individual to payment by Us for such Covered Services.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-844-222-9106.

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 in which additional information is required. If MetLife needs such an extension, MetLife will send You notification 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 such extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

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

Appealing the Initial Determination

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

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

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

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

Claims for Medicaid Eligible Individuals

As required by law, to the extent that payment has been made by the Missouri Division of Medical Services for Covered Services furnished to a Medicaid eligible individual, the Missouri Division of Medical Services is considered to have acquired the rights of the Medicaid eligible individual to payment by Us for such Covered Services.

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. Except in cases of fraud or misrepresentation We will not request a refund nor offset a claim more than 12 months after an overpayment has occurred.

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.

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 Missouri Consolidated Health Care Plan.

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 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 an individual's benefit or claim issues.

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of PHI 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 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 when no longer needed for the purpose for which disclosure was made, except that, if 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 adequate separation between the Plan and Plan Sponsor 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:

  Director of Vendor Relations, Director of Benefit Administration, Members Services Manager, Member Services Supervisor, Benefit Counselor, Information Technology Specialist

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

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

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

Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Dental Insurance:

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

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

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

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

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

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

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

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2020**

The certificate is changed as follows:

Applicable to Dental Insurance for all State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 10. under **Type C Covered Services** with the following:

   "10. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement."

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 11. under **Type C Covered Services** with the following:

   "11. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement."

3. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 20. under **Type C Covered Services** with the following:

   "20. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:

   - a Cast Restoration was installed for the same tooth; or
   - a Cast Restoration for the same tooth was replaced."

4. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 21. under **Type C Covered Services** with the following:

   "21. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years."

5. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 22. under **Type C Covered Services** with the following:

   "22. Core buildup, but no more than once per tooth in a period of 10 Years."

6. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 23. under **Type C Covered Services** with the following:

   "23. Posts and cores, but no more than once per tooth in a period of 10 Years."

7. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 24. under **Type C Covered Services** with the following:

   "24. Labial veneers, but no more than once per tooth in a period of 10 Years."

8. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 33. under **Type C Covered Services** with the following:

   "33. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period."

9. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 35. under **Type C Covered Services** with the following:

   "35. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period."

10. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 36. under **Type C Covered Services** with the following:

    "36. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period."

11. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 37. under **Type C Covered Services** with the following:

    "37. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period."

12. In **DENTAL INSURANCE,** replace **Alternate Benefit** with the following:

    "**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.
    - 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;

For example:

- 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 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."

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

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

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2021**

The certificate is changed as follows:

Applicable to Dental Insurance

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete the following item under **Type B Covered Services:**

   "4. Emergency palliative treatment to relieve tooth pain."

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, add the following item under **Type A Covered Services:**

   "Emergency palliative treatment to relieve tooth pain."

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

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

CERTIFICATE RIDER

Group Policy No.: **215367-1-G**

Policyholder: **Missouri Consolidated Health Care Plan**

Effective Date: **January 1, 2023**

The certificate is changed as follows:

Applicable to Dental Insurance for all State employees of the Policyholder, excluding residents of Alaska and Montana, who are included in one of the following classes:

Class 1: Full-Time Regular Employees who are employed by the Policyholder and who are classified by the Policyholder as Full-Time Employees based on the expectation that they will work an average of 30 hours or more per week based on their position within the Policyholder.

Class 2: Variable Hour Employees who are employed by the Policyholder and who are Employees of the Policyholder who qualify as Full-Time Employees based on the average weekly number of hours that the employee works during a particular Measurement Period.

1. In **DEFINITIONS**, replace **Maximum Allowed Charge** with the following:

   "**Maximum Allowed Charge** means:

   1. with respect to In-Network Dentists, the lesser of:

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

   2. with respect to Out-of-Network Dentists, the lesser of:

      a. the amount charged by the Out-of-Network Dentist; or
      b. the Out-of-Network scheduled amount for the state where the dental service is performed."

2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 1. under **Type A Covered Services** with the following:

   "1. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months."

Certificate Number 1.2

3. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 2. under **Type A Covered Services** with the following:

   "2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months."

4. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 3. under **Type A Covered Services** with the following:

   "3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months."

5. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 6. under **Type A Covered Services** with the following:

   "6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but no more than once every 6 months. If Dentally Necessary, two additional cleanings per Year will also be covered."

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

Certificate Number 1.2