

**YOUR BENEFIT PLAN**

**Loyola University Maryland**

**All Full-Time Employees**

**Copay Dental Plan**

**Dental Insurance for You and Your Dependents**

**Certificate Date: July 1, 2012**

Loyola University Maryland  
4501 North Charles Street  
Baltimore, MD 21210

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.

Loyola University Maryland

# MetLife

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

## CERTIFICATE RIDER

**Group Policy No.:** This Certificate Rider is applicable to policies with a situs of Maryland to which certificate form GCERT2000 is attached, to the extent such GCERT2000 certificate(s) provide coverage for Dental Insurance.

**Policyholder:** Any Policyholder of a policy described above.

**Effective Date:** July 1, 2013

The certificate is changed as follows:

By revising the frequency limit in the Covered Services section of your GCERT2000 certificate, as described below:

If the frequency limit for any of the preventive services shown below is once every 6 months or twice every 12 months, the frequency limit for that service is changed to twice in a Year. If the frequency limit for any of the preventive services shown below is once every 12 months, twice every 24 months, or twice in 2 Years, the frequency limit for that service is changed to once in a Year.

- oral exams
- problem-focused exams
- screenings
- patient assessments
- cleanings of teeth
- topical fluoride treatments

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

# MetLife®

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

## CERTIFICATE RIDER

**Group Policy No.:** 113743-1-G

**Policyholder:** Loyola University Maryland

**Effective Date:** July 1, 2012

The Group Dental Insurance Certificate is changed as follows:

To add the following definition of Child to the certificate: (for residents of Louisiana, Minnesota, Montana, New Mexico, and Utah, the Child definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

**Child** means the following:

Your natural or adopted child; Your stepchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case, is under age 26.

The definition of Child includes newborns.

The definition of Child includes a child for whom You or Your Spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance.

The definition of Child includes grandchildren, under the limiting age, who are unmarried, reside with and are principally supported by You, and are in Your court ordered custody.

The definition of Child includes a child who resides with and is principally supported by You and is under Your testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration.

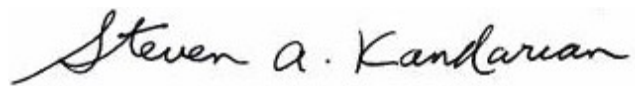
An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

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

**The term does not include** any person who:

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

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



Steven A. Kandarian  
Chairman, President and Chief Executive Officer



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:** Loyola University Maryland  
**Group Policy Number:** 113743-1-G  
**Type of Insurance:** Dental Insurance  
**MetLife Toll Free Number(s):**  
**For Claim Information** FOR DENTAL CLAIMS: 1-800-942-0854

**THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.**

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

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

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

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

### **For Minnesota Residents (Dental Insurance):**

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

### **For Montana Residents (Dental Insurance):**

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

### **For New Mexico Residents (Dental Insurance):**

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

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

### **For Utah Residents (Dental Insurance):**

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

### **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 THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.**

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

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

## NOTICE FOR RESIDENTS OF 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.

For purposes of determining who may become a Covered Person, the term does not include any person who:

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

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

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

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

## **NOTICE FOR RESIDENTS OF 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, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043  
1-800-721-3272 or [www.DOI.Idaho.gov](http://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 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 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 RESIDENTS OF NORTH CAROLINA**

**Read your Certificate Carefully.**

**This Certificate Contains a Pre-existing Condition Limitation.**

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

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

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

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

## NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Insurance will continue if such Child:

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

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

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

## NOTICE FOR RESIDENTS OF 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](http://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 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 been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
1-877-310-6560 - toll-free  
1-804-371-9691 - locally  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

Or:

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

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

## **NOTICE TO RESIDENTS OF VIRGINIA**

### **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

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

You may contact the Virginia Office of the Managed Care Ombudsman either by dialing toll free at (877) 310-6560, or locally at (804) 371-9691, via the internet at Web address [www.scc.virginia.gov](http://www.scc.virginia.gov), email at [ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov), or mail to:

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

### **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.

#### **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.

## **NOTICE TO RESIDENTS OF VIRGINIA (continued)**

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

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

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

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

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

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

### **Urgent Care Submission:**

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

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



## 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, NY 10166-0188  
1-800-638-5433

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

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

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## SCHEDULE OF BENEFITS

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

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

### BENEFIT

### BENEFIT AMOUNT AND HIGHLIGHTS

#### Dental Insurance

For You and Your Dependents	In-Network	Out-of-Network Covered Percentage of the Maximum Allowed Charge
Preventive and Diagnostic Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	80%
Basic Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	50%
Major Covered Services	We will pay an amount equal to the Maximum Allowed Charge less the Co-Payment for a Covered Service	30%
Orthodontic Covered Services	40%	40%
<b>Deductibles for:</b>		
Yearly Individual Deductible	None	\$75 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	None	\$225 for the following Covered Services Combined: Type B; Type C
<b>Maximum Benefit:</b>		
Yearly Individual Maximum	\$1,250 for the following Covered Services: Type A; Type B; Type C	\$750 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	\$1,250	\$750

## 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, absences, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

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

**Child** - For the Child Definition, please refer to the Child Definition Rider in the front of this certificate. For residents of Minnesota, Montana, New Mexico, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate; please consult the Notice.

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

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

Contributory Insurance includes: Dental Insurance.

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

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

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

**Deductible** means a specified dollar amount You or Your Dependents must pay the Dentist or other Provider for Out-of-Network Covered Services as described in the SCHEDULE OF BENEFITS.

**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.

## DEFINITIONS (continued)

**Dentist** means:

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

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

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

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

**Full-Time** means, for purposes of the insurance described in this certificate, You are Actively at Work and considered to be employee of the Policyholder in one of the following employment categorizations as determined and defined by the Policyholder:

*Regular full-time employee:* an employee of the Policyholder appointed by the university president or a designee to authorized, budgeted full-time positions with an employment-duration of nine (9) or more months in a 12-month period in a specific division and department of the Policyholder, and full-time employees are required to work at least 37.5 hours each week.

*Core employee (Core Employment):* an employee of the Policyholder appointed by the university president or a designee to authorized, budgeted positions with an employment-duration of nine (9) or more months in a 12-month period. Core employees (Core Employment) are (is being) employed for a specific job description a specific division and department of the Policyholder, and employees classified as Core Employees are required to work at least 30 hours each week.

*Half-time employee (Half-time Employment):* an employee of the Policyholder appointed by the university president or a designee to authorized, budgeted positions within a specific department. Half-time employees (Half-time Employment) are (is being) employed for a specific job description a specific division and department of the Policyholder, and employees classified as Half-time Employees are required to work at least 22.5 hours each week for an entire 12-month period.

If You do not meet the criteria, established by the Policyholder, in accordance with Your employment categorization as determined by Your employment with the Policyholder, You will not be considered to be Full-Time for purposes of the insurance described in this certificate.

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

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

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

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

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



## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**All Full-Time employees of the Policyholder.**

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

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

If You are in an eligible class on July 1, 2012, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after July 1, 2012, You will be eligible for insurance on the first day of the month following the date You enter that class.

### **ENROLLMENT PROCESS FOR DENTAL INSURANCE**

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

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

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Enrollment When First Eligible**

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

If You are not Actively at Work on the date the insurance would otherwise take effect, the 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 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. If You are not currently enrolled for Dental Insurance but You enroll during an enrollment period, the Dental Insurance takes effect one year after Your request. Otherwise 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.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

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

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

**Qualifying Event** includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the 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.

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

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS**

### **ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE**

**All Full-Time employees of the Policyholder.**

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

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

If You are in an eligible class on July 1, 2012, You will be eligible for Dependent insurance on the later of:

1. the first day of the month following the date You enter a class eligible for insurance;
2. the date You obtain a Dependent.

If You enter an eligible class after July 1, 2012, You will be eligible for Dependent insurance on the later of:

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

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

### **ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE**

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

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

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

### **DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS**

#### **Enrollment When First Eligible**

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

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

#### **If You Do Not Enroll When First Eligible**

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

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

### **Enrollment During 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. If You are not currently enrolled for Dependent Insurance but You enroll during an enrollment period, the Dependent Insurance takes effect one year after Your request. Otherwise the changes to Your Dependent Insurance made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

### **Enrollment Due to a Qualifying Event**

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

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

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

**Qualifying Event** includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage.

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.

You may also enroll Your Dependents for Dental Insurance under this plan if you did not enroll them when they were first eligible and:

- Your Dependents had coverage under your Spouse's plan and Your Spouse dies or Your Spouse's employment was involuntarily terminated for reasons other than cause;
- You notify us within 6 months that coverage under the other plan has ended;
- You elect to enroll Your Dependents for Dental Insurance under this policy; and
- for any contributory Dental Insurance for Your Dependents, You give Written permission to deduct premiums from your pay.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

If You or Your Spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance for a Child and:

- You are not enrolled for dental insurance; and/or
- Your child is not enrolled for dental insurance,

We will enroll You and/or Your Child without regard to enrollment period restrictions.

If You do not make a request for coverage on a dependent child as required by a Child Health Enforcement Order; and:

- You are insured for dental insurance; and
- no other reasonable dental insurance is in effect on the child,

then a request for dental insurance may be made by:

- another parent of the child;
- the Maryland Support Enforcement Agency; or
- the Maryland Department of Health and Mental Hygiene.

### **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 the Group Policy ends;
4. the date insurance for Your Dependents ends under the Group Policy;
5. the date insurance for Your Dependents ends for Your class;
6. 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;
7. the end of the period for which the last premium has been paid; or
8. the last day of the calendar month in which 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;
    - c) Lifetime Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
  - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
  - the date this Dental Insurance ends.

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

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

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY INCAPACITATED 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 incapacity as defined by applicable law. Proof of such incapacity 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 incapacity; and
- continues to qualify as a Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

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

### **COBRA CONTINUATION FOR DENTAL INSURANCE**

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

### **AT THE POLICYHOLDER'S OPTION**

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

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff, up to 6 months;
2. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 6 months;
3. for the period You cease Active Work in an eligible class due to injury or sickness, up to 6 months.

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

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-942-0854 or by visiting Our website at [www.metlife.com/dental](http://www.metlife.com/dental).

### **BENEFIT AMOUNTS**

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

#### **In-Network**

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

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

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

#### **Out-of-Network**

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



## **DENTAL INSURANCE (continued)**

- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

### **Maximum Benefit Amounts**

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

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

### **Deductibles**

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

The Yearly Individual Deductible is an amount shown in the SCHEDULE OF BENEFITS that You and each Dependent must pay for Covered Services to which such Deductible applies each Year.

We apply amounts used to satisfy Yearly Individual Deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met.

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

### **Alternate Benefit**

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

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

For example:

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

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You 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.

## **DENTAL INSURANCE (continued)**

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 maybe performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

### **Orthodontic Covered Services**

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Insurance is in effect for the person receiving the orthodontic treatment; and
- proof is given to Us that the orthodontic treatment is continuing.

If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

### **Benefits for Orthodontic Services We Will Pay After Insurance Ends**

We will pay for benefits for orthodontic covered services for a course of treatment in effect at the time your insurance ends for:

- 60 days after the date insurance ends if the orthodontist has agreed to or is receiving monthly payments; or
- until the later of 60 days after insurance ends or the end of the quarter in progress if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

### **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.

## **DENTAL INSURANCE (continued)**

### **Benefits We Will Pay After Insurance Ends**

We will pay benefits for a 90 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 90 days after the date the insurance ends.

We will pay benefits for a 90 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 90 days after the date the insurance ends.

We will pay benefits for a 90 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 90 days after the date the insurance ends.

In addition, for other services, We will pay benefits for Covered Services received within 90 days of the day on which your insurance ends if the treatment:

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a Dentist's office.

## **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**

### **Type A Covered Services**

1. Oral exams and problem-focused exams but no more than one exam every 6 months.
2. Full mouth or panoramic x-rays once every 60 months.
3. Bitewing x-rays:
  - 1 set every 6 months for a Child; and
  - 1 set every Year for everyone else.
4. Intraoral-periapical x-rays.
5. X-rays, except as mentioned elsewhere.
6. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
7. Diagnostic casts.
8. Cleaning of teeth (oral prophylaxis) once every 6 months.
9. Topical fluoride treatment for a Child under age 14, once in 12 months.
10. Space maintainers for a Child under age 19.

### **Type B Covered Services**

1. Emergency palliative treatment to relieve tooth pain.
2. Amalgam fillings.
3. Resin-based composite fillings.
4. Protective (sedative) fillings.
5. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any Year less the number of teeth cleanings received during such Year.
6. Sealants for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
7. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
8. Pulp capping (excluding final restoration).
9. Therapeutic pulpotomy (excluding final restoration).

### **Type C Covered Services**

1. Pulp therapy.
2. Apexification/recalcification.
3. 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.
4. Local chemotherapeutic agents.
5. Injections of therapeutic drugs.
6. Installation of full or partial Dentures (other than implant supported prosthetics).
7. Addition of teeth to a partial removable Denture.
8. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 years prior to replacement.

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

9. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 years prior to replacement.
10. 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.
11. 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.
12. Re-cementing of Cast Restorations or Dentures.
13. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
14. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 36 months.
15. Core buildup, but no more than once per tooth in a period of 36 months.
16. Posts and cores, but no more than once per tooth in a period of 36 months.
17. Labial veneers, but no more than once per tooth in a period of 36 months.
18. Oral Surgery, except as mentioned elsewhere in this certificate.
19. Root canal treatment, but not more than once in any 24 month period for the same tooth.
20. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
21. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
22. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
23. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
24. 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 60 month period.
25. Repair of implants, but not more than once in a 12 month period.
26. Implant supported Cast Restorations, but no more than once for the same tooth position in a 60 month period.
27. Implant supported fixed Dentures, but no more than once for the same tooth position in a 60 month period.
28. Implant supported removable Dentures, but no more than once for the same tooth position in a 60 month period.
29. Simple repair of Cast Restorations or Dentures other than recementing.
30. Replacement of any Cast Restoration with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth surface within 36 months of a prior replacement.
31. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
32. Consultations, but not more than twice in a 12 month period.
33. Full mouth debridements but not more than once per lifetime.
34. Cone Beam Imaging, not more than once for the same tooth position in 60 months.
35. Tissue conditioning.
36. Occlusal adjustments.

## **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)**

### **Orthodontic Covered Services**

Orthodontia, for a Child under 26.

## DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist which are supervised and billed by a Dentist, and which are for:
  - scaling and polishing of teeth; or
  - fluoride treatments;
5. services which are primarily cosmetic unless such service is:
  - required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part; or
  - required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
  - 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 not required to pay; or
  - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. 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;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. modification of removable prosthodontic and other removable prosthetic services;

## **DENTAL INSURANCE: EXCLUSIONS (continued)**

24. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
25. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
26. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
27. duplicate prosthetic devices or appliances;
28. replacement of a lost or stolen appliance, Cast Restoration or Denture;
29. repair or replacement of an orthodontic device;
30. diagnosis and treatment of temporomandibular joint disorders;
31. intra and extraoral photographic images;
32. services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.



## DENTAL INSURANCE: COORDINATION OF BENEFITS

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

### DEFINITIONS

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

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

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

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

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

**The term does not include:**

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

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

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

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

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

**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.

## **DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)**

**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;
- personal injury protection benefits which applicable state or federal law requires to be afforded without regard to fault under motor vehicle insurance policies; 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:

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

will not be affected by these Coordination of Benefits provisions.

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

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

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

## DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

### RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

**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.

## **DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)**

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

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

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

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

### **EFFECT ON BENEFITS OF THIS PLAN**

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

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

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

### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

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

### **FACILITY OF PAYMENT**

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

## **DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)**

### **RIGHT OF RECOVERY**

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

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

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

## FILING A CLAIM

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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-942-0854. Dental claim forms can also be downloaded from [www.metlife.com/dental](http://www.metlife.com/dental). The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

### CLAIMS FOR DENTAL INSURANCE BENEFITS

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

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

#### **Step 1**

A claimant can request a claim form by calling Us at 1-800-942-0854.

#### **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](http://www.metlife.com/dental). The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

### **Routine Questions on Dental Insurance Claims**

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

### **Claim Submission**

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate. We will pay any benefits payable within 30 days of Our receipt of such Proof.

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

### **Initial Determination**

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

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

If MetLife denies Your claim in whole or in part, We will send You a written notice of Adverse Decision within 5 working days after the decision has been made or orally communicated to You. This written decision will state the reason why Your claim was denied and reference the specific Plan provision(s) on which the denial is based and include the name, business address and business phone number of the MetLife employee responsible for MetLife's internal appeal process. 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. You may authorize a health care provider to pursue an appeal on your behalf by submitting a written statement to MetLife that acknowledges the representation. 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:

## DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

- 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. If You do not provide sufficient information to complete our internal appeal process, MetLife will notify you within 5 working days of the Filing Date and provide assistance in gathering the necessary information without further delay. Upon receipt of all required information, MetLife's review will look at the claim anew and deference will not be given to initial denials. 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 45 working days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 working 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 working 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 within 5 working days after the final decision has been made or is orally communicated to You. This written decision will state the reason(s) why the claim You appealed is being denied and references any specific Plan provision(s) on which the denial is based and include the name, business address and business phone number of the MetLife employee who is responsible for MetLife's internal grievance process. 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.

If You should need assistance in preparing, mediating or filing an appeal, You may contact the Health Advocacy Unit either by dialing 1-877-261-8807 (phone) or 1-410-576-6571 (fax), via the Internet at [heau@oag.state.md.us](mailto:heau@oag.state.md.us) or by mail to the Health Education and Advocacy Unit / 200 St. Paul Place / Baltimore, Maryland 21202.



## DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

### YOUR RIGHT TO REQUEST A CLAIM REVIEW WITH THE COMMISSIONER OF INSURANCE

If Your appeal of a MetLife decision involves a question of Dental Necessity, You may file a complaint with the Commissioner within 30 days under the following conditions:

- You have completed MetLife's internal review procedures; and
- You have received a final written decision and the appeal was not resolved to your satisfaction; or
- You do not receive a final written decision within 45 working days or 75 working days if We receive Your written consent for an extension of 30 working days.

You may request an external appeal by contacting the Maryland Insurance Administration at Appeals and Grievance Unit/ 200 St. Paul Place / Baltimore, Maryland 21202. The telephone number is 1-410-468-2000 and the facsimile number is 1-410-468-2270.

The following definitions apply to this section:

**Adverse Decision** means a determination by Us that a delivered dental service was not dentally necessary, appropriate or efficient and results in a denial of coverage of the service.

**Filing Date** means the earlier of:

- 5 days after the date of mailing; or
- the date of receipt.

**Health Care Provider** means:

- an individual who is licensed under the Health Occupations Article to provide dental care services in the ordinary course of business or practice of a profession and is a treating provider of a member; or
- a hospital as defined in s19-301 of the Health General Article.

## **GENERAL PROVISIONS**

### **Assignment**

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

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

### **Dental Insurance: Who We Will Pay**

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

If Dental Insurance benefits are paid on behalf of a Dependent Child who is covered by a Child Health Insurance Enforcement Order for which We have received Proof, We will pay such benefits according to the following order:

1. the Dentist, if the person or state agency which incurred the expenses for the Covered Service for the Child assigned the benefits to the Dentist;
2. the Maryland Department of Health and Mental Hygiene if it incurred the expenses or if it previously notified us that it is administering the coverage for the benefit of the Child and that the dental insurance benefits should be paid to the Maryland Department of Health and Mental Hygiene;
3. the non-insuring parent, if the non-insuring parent incurred the expenses for Covered Services for the Child;
4. You, in all other cases.

If the person on whose behalf dental insurance benefits are paid is not a Dependent Child who is covered by a Child Health Insurance Enforcement Order for which We have received Proof, We will pay benefits for Covered Services to:

- the Dentist, if You have assigned benefits to the Dentist, or
- You, in all other cases.

### **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, attached to the Group Policy; and
3. any amendments and/or endorsements to the Group Policy.

A change in the policy will not be valid:

1. until approved by an executive officer of MetLife; and
2. unless the approval is endorsed on the policy or attached to the policy.

## **GENERAL PROVISIONS (continued)**

### **Contestability: Statements Made by You**

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

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

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

### **Conformity with Law**

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

### **Overpayments**

#### **Recovery of Dental Insurance Overpayments**

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

An overpayment occurs if We determine that:

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

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

#### **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.

**\$15 PDP COPAY SCHEDULE**



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

**CERTIFICATE RIDER**

**Group Policy No.:** 113743-1-G

**Policyholder:** Loyola University Maryland

**Effective Date:** July 1, 2012

As of the above effective date, the certificate for all Employees is changed by adding the following PDP Copay Schedule.

		Area 1	Area 2	Area 3	Area 4
Service Category	Description				
Diagnostic	Periodic Exams	\$ 0	\$ 0	\$ 0	\$ 0
	Full Mouth and Bitewing X-Rays	\$ 5	\$ 5	\$ 5	\$ 10
	Fluoride	\$ 5	\$ 5	\$ 5	\$ 5
	Prophylaxis	\$ 15	\$ 15	\$ 15	\$ 15
Preventive	Exams	\$ 5	\$ 5	\$ 5	\$ 10
	Periapical first film and occlusal	\$ 7	\$ 8	\$ 10	\$ 10
	Extraoral X-ray	\$ 25	\$ 25	\$ 30	\$ 30
	Additional Periapicals	\$ 5	\$ 5	\$ 5	\$ 5
	Sealants / Preventative Resin	\$ 15	\$ 15	\$ 15	\$ 20
	Restoration				
	Space Maintainers - unilateral	\$ 120	\$ 140	\$ 150	\$ 165
Space Maintainers - bilateral	\$ 165	\$ 190	\$ 205	\$ 235	
Restorative	Amalgams - 1 Surface	\$ 35	\$ 40	\$ 45	\$ 55
	Amalgams - 2 Surfaces	\$ 40	\$ 50	\$ 55	\$ 65
	Amalgams - 3 or More Surfaces	\$ 55	\$ 60	\$ 65	\$ 80
	Resin-based composite, anterior, 1 Surface	\$ 40	\$ 45	\$ 50	\$ 60
	Resin-based composite, anterior, 2 Surfaces	\$ 50	\$ 55	\$ 60	\$ 75
	Resin-based composite, anterior, more than 2 surfaces	\$ 60	\$ 65	\$ 75	\$ 90
	Inlays	\$ 415	\$ 465	\$ 515	\$ 575
	Crowns/Onlays, Metal/Porcelain	\$ 450	\$ 510	\$ 560	\$ 635
	Additional procedures to new crown	\$ 80	\$ 90	\$ 100	\$ 115
	Recementation -	\$ 40	\$ 45	\$ 45	\$ 50
	Inlays / Onlays / Crowns / Cast / Prefabricated post and core				
	Prefabricated Crowns	\$ 105	\$ 115	\$ 120	\$ 140
	Resin Windows	\$ 115	\$ 130	\$ 145	\$ 180
	Post and Cores	\$ 115	\$ 130	\$ 145	\$ 180
	Prefabricated Crowns / Posts and Cores, each additional	\$ 10	\$ 15	\$ 20	\$ 25
	Protective (Sedative) Filling	\$ 20	\$ 25	\$ 25	\$ 35
	Core buildup, including any pins	\$ 80	\$ 90	\$ 100	\$ 125
	Cast post and core	\$ 170	\$ 190	\$ 210	\$ 230
	Crown repairs	\$ 80	\$ 90	\$ 95	\$ 130

**\$15 PDP COPAY SCHEDULE**

Endodontics	Pulpal therapy	\$ 40	\$ 45	\$ 50	\$ 65
	Root canal, anterior	\$ 290	\$ 320	\$ 355	\$ 415
	Root canal, bicuspid	\$ 340	\$ 380	\$ 425	\$ 490
	Root canal, molar	\$ 465	\$ 520	\$ 575	\$ 640
	Root canal retreatment, anterior	\$ 355	\$ 395	\$ 440	\$ 500
	Root canal retreatment, bicuspid	\$ 400	\$ 450	\$ 500	\$ 580
	Root canal retreatment, molar	\$ 525	\$ 590	\$ 650	\$ 740
	Apexification, initial	\$ 120	\$ 135	\$ 150	\$ 175
	Apexification, interim	\$ 70	\$ 75	\$ 85	\$ 105
	Apexification, final	\$ 180	\$ 200	\$ 220	\$ 275
	Apicoectomy	\$ 270	\$ 295	\$ 330	\$ 380
	Apicoectomy, additional root	\$ 130	\$ 145	\$ 160	\$ 200
	Root amputation / hemisection	\$ 195	\$ 215	\$ 240	\$ 270
	Periodontics	Soft tissue surgery - gingivectomy (per quadrant)	\$ 220	\$ 270	\$ 275
Gingivectomy - up to 3 contiguous teeth or bounded spaces		\$ 120	\$ 135	\$ 155	\$ 170
Gingival Flap Proc: more than 3 contiguous teeth or bounded teeth spaces/quad		\$ 235	\$ 265	\$ 290	\$ 340
Gingival Flap Proc: less than 3 contiguous teeth or bounded teeth spaces/quad		\$ 145	\$ 165	\$ 200	\$ 210
Apically Positioned Flap		\$ 125	\$ 140	\$ 155	\$ 180
Clinical crown lengthening		\$ 360	\$ 400	\$ 445	\$ 485
Osseous surgery (more than 3 contiguous teeth or bounded teeth spaces/quad)		\$ 490	\$ 550	\$ 605	\$ 665
Osseous surgery (less than 3 contiguous teeth or bounded teeth spaces)		\$ 315	\$ 340	\$ 375	\$ 420
Bone replacement graft - first site in quadrant		\$ 170	\$ 190	\$ 190	\$ 220
Bone replacement graft - each additional site in quadrant		\$ 115	\$ 140	\$ 140	\$ 140
Guided tissue regeneration		\$ 175	\$ 210	\$ 220	\$ 265
Surgical revision per tooth		\$ 60	\$ 65	\$ 70	\$ 100
Pedicle Soft Tissue Grafts		\$ 270	\$ 300	\$ 325	\$ 410
Other Soft Tissue Grafts		\$ 350	\$ 400	\$ 430	\$ 500
Other Soft Tissue Grafts per tooth		\$ 425	\$ 485	\$ 535	\$ 600
Soft tissue surgery - Distal or Proximal Wedge		\$ 145	\$ 160	\$ 175	\$ 210
Scaling and root planing (4 or more teeth per quadrant)		\$ 85	\$ 105	\$ 110	\$ 125
Scaling and root planing (1-3 teeth)		\$ 70	\$ 80	\$ 80	\$ 85
Periodontal maintenance		\$ 40	\$ 45	\$ 45	\$ 55
Prostodontics (Removable)		Complete dentures	\$ 590	\$ 660	\$ 730
	Partial dentures - resin base	\$ 440	\$ 525	\$ 550	\$ 630
	Partial dentures - cast metal base	\$ 720	\$ 795	\$ 875	\$ 955
	Denture adjustments	\$ 30	\$ 45	\$ 45	\$ 55
	Denture repairs	\$ 80	\$ 90	\$ 95	\$ 105
	Denture rebase	\$ 220	\$ 245	\$ 275	\$ 310
	Denture reline - Chairside/Office	\$ 120	\$ 140	\$ 155	\$ 175
	Denture reline - Lab	\$ 185	\$ 205	\$ 230	\$ 255
	Tissue conditioning	\$ 60	\$ 65	\$ 75	\$ 110

**\$15 PDP COPAY SCHEDULE**

Implant Services	Surgical Placement, Implant Body	\$ 920	\$ 1,035	\$ 1,160	\$ 1,255
	Surgical Placement, Epostal	\$ 1,705	\$ 1,920	\$ 2,130	\$ 2,380
	Dental Implant support connect	\$ 390	\$ 435	\$ 485	\$ 555
	Prefabricated Abutment	\$ 315	\$ 355	\$ 390	\$ 390
	Custom Abutment	\$ 415	\$ 465	\$ 510	\$ 525
	Implant Maintenance Procedure	\$ 35	\$ 40	\$ 45	\$ 50
	Implant Removal, by report	\$ 155	\$ 170	\$ 185	\$ 210
	Radiographic / Surgical Implant index	\$ 105	\$ 120	\$ 135	\$ 145
Prosthodontics (Fixed)	Fixed partial denture pontics	\$ 470	\$ 515	\$ 570	\$ 635
	Retainer	\$ 180	\$ 205	\$ 230	\$ 265
	Recementation - Bridges	\$ 50	\$ 60	\$ 60	\$ 75
	Fixed partial denture repair	\$ 80	\$ 85	\$ 90	\$ 120
Oral Surgery	Simple extractions	\$ 50	\$ 65	\$ 65	\$ 85
	Surgical removal of erupted tooth	\$ 90	\$ 115	\$ 125	\$ 155
	Removal of impacted tooth, soft tissue/partial bony	\$ 135	\$ 150	\$ 165	\$ 210
	Removal of impacted tooth, full bony	\$ 190	\$ 235	\$ 240	\$ 260
	Alveoplasty with an extraction	\$ 85	\$ 100	\$ 110	\$ 135
	Alveoplasty with an extraction (1-3 teeth per quadrant)	\$ 55	\$ 60	\$ 65	\$ 80
	Alveoplasty without an extraction	\$ 135	\$ 150	\$ 165	\$ 210
	Alveoplasty without an extraction (1-3 teeth per quadrant)	\$ 80	\$ 95	\$ 100	\$ 125
	Incision and drainage, Intraoral	\$ 75	\$ 75	\$ 85	\$ 115
	Incision and drainage, Extraoral	\$ 110	\$ 125	\$ 140	\$ 170
	Frenulectomy/Frenuloplasty	\$ 135	\$ 150	\$ 180	\$ 225
	Excision of hyperplastic tissue	\$ 155	\$ 175	\$ 195	\$ 235
	Excision of pericoronal gingival	\$ 70	\$ 75	\$ 80	\$ 105
Adjunctive General Services	Palliative treatment	\$ 25	\$ 25	\$ 30	\$ 40
	General Anesthesia or intravenous sedation, first 30 minutes	\$ 155	\$ 175	\$ 205	\$ 215
	General Anesthesia, each additional 15 minutes	\$ 55	\$ 60	\$ 75	\$ 95
	Intravenous sedation, each additional 15 minutes	\$ 35	\$ 40	\$ 45	\$ 55
	Consultation	\$ 40	\$ 45	\$ 50	\$ 65
	Occlusal adjustment - limited	\$ 35	\$ 45	\$ 60	\$ 75
	Occlusal adjustment - complete	\$ 170	\$ 200	\$ 220	\$ 270
Orthodontics	If your plan covers orthodontics, payments will be based on a percentage of the total benefit available. A lifetime orthodontic benefit maximum applies. Please refer to your plan overview for more details.				

**\$15 PDP COPAY SCHEDULE**

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

Area 1	Area 2
<p>Alabama; for zip codes 350-352 and 354-369                      Arkansas; for zip codes 716-720, 723-726 and 728-729                      Florida; for zip codes 320-329, 333-339, 342, 344, 346-347 and 349                      Georgia; for zip codes 307-310 and 312                      Idaho; for zip codes 832-835 and 838                      Illinois; for zip codes 604-605, 609-620, 622, 624-629                      Indiana; for zip codes 460-465, 469, 471-474, 476-478                      Iowa; for zip codes 500-501, 504-509, 512-516 and 520-528                      Kansas; for zip codes 661, 667-669, 671 and 673-679                      Kentucky; for zip codes 400-418 and 421-427                      Louisiana; for zip codes 700-701, 703-708 and 710-714                      Maryland; for zip codes 206, 210-212 and 214-219                      Michigan; for zip codes 486-487                      Minnesota; for zip codes 561-562 and 564-567                      Mississippi; for zip codes 386-395                      Missouri; for zip codes 630-633, 635-641 and 644-657                      Nebraska ; for zip codes 680-681 and 683-693                      New York; for zip codes 104, 120-126, 140-143 and 147-149                      Ohio; for zip codes 430-450, 452-456 and 458-459                      Oklahoma; for zip codes 730-731, 733-734, 736-741 and 743-749                      Pennsylvania; for zip codes 150-168, 170-174, 180, 182-188 and 190-192                      Puerto Rico; for zip codes 006-007 and 009                      Tennessee; for zip codes 370-372, 374-375 and 377-385                      Texas; for zip codes 750-753, 755-799                      Utah; for zip codes 840-847                      Virginia; for zip codes 224-225, 227, 230-233, 236, 238-244 and 246                      West Virginia for zip codes 247-248, 250-253, 255-257, 260 and 262-268                      Wisconsin; for zip codes 530, 534-535, 538-540 and 544-549                      Wyoming; for zip codes 820-831</p>	<p>Arizona; for zip codes 850-853, 855-857, 859-860 and 863-865                      Arkansas; for zip codes 721-722 and 727                      California; for zip codes 917-925, 936-938 and 953                      Colorado; for zip codes 800-802, 804-807 and 809-815                      District of Columbia; for zip codes 200, 202-205                      Florida; for zip codes 330-332 and 341                      Georgia; for zip codes 300-306, 311, 313-316, 318-319 and 398                      Hawaii; for zip codes 967-968                      Idaho; for zip codes 836-837                      Illinois; for zip codes 600-603, 606-608 and 623                      Indiana; for zip codes 466-468, 470, 475 and 479                      Iowa; for zip codes 502-503                      Kansas; for zip codes 660, 662, 664-666, 670 and 672                      Kentucky; for zip code 420                      Maryland; for zip codes 207-209                      Massachusetts; for zip codes 010 and 012-013                      Michigan; for zip codes 480-485, 488-497 and 499                      Minnesota; for zip codes 550-551, 553-556, 559-560 and 563                      Mississippi; for zip codes 396-397                      Missouri; for zip codes 634 and 658                      Montana; for zip codes 590-597 and 599                      Nevada; for zip codes 889-891                      New Jersey; for zip codes 070-073, 077, 080-084 and 086-087                      New Mexico; for zip codes 870-875 and 877-884                      New York; 103, 109-119, 127-138 and 144-146                      North Carolina; for zip codes 270, 278 and 283-286                      North Dakota; for zip codes 580-588                      Ohio; for zip code 451                      Oklahoma; for zip code 735                      Pennsylvania; for zip codes 169, 175-179, 181, 189 and 193-196                      South Carolina; for zip codes 291-293 and 295-299                      South Dakota; for zip codes 570 and 572-577                      Tennessee; for zip codes 373 and 376                      Texas; for zip codes 754 and 885                      Virginia; for zip codes 201, 220-222, 226, 228-229, 234-235, 237 and 245                      West Virginia; for zip codes 249, 258-259 and 261                      Wisconsin; for zip codes 531-532, 541-543</p>

**\$15 PDP COPAY SCHEDULE**

Area 3	Area 4
<p>California; for zip codes 900-908, 912-916, 926-928, 930, 932-934, 952 and 955-961            Colorado; for zip codes 803 and 808            Connecticut; for zip codes 060, 063-064 and 067            Georgia; for zip code 317            Iowa; for zip codes 510-511            Maine; for zip codes 044, and 046-047            Massachusetts; for zip codes 011 and 014-027            Michigan; for zip code 498            Minnesota; for zip codes 557-558            Montana; for zip code 598            Nevada; for zip codes 893 and 898            New Jersey; for zip codes 074-076, 078-079, 085 and 089            New York; for zip codes 100-102, 105-108 and 139            North Carolina; for zip codes 271-277, 279-282 and 287-289            Ohio; for zip code 457            Oregon; for zip codes 970-979            Rhode Island ; for zip codes 028-029            South Carolina: for zip codes 290 and 294            South Dakota: for zip code 571            Vermont; for zip codes 052-054 and 056-059            Virgin Islands: for zip code 008            Virginia: for zip code 223            Washington; for zip codes 985-986, 988, 990-992 and 994            West Virginia; for zip code 254            Wisconsin: for zip code 537</p>	<p>Alaska; for zip codes 995-999            California; for zip codes 910-911, 931, 935, 939-951 and 954            Colorado; for zip code 816            Connecticut; for zip codes 061-062, 065-066 and 068-069            Delaware; for zip codes 197-199            Guam; for zip code 969            Maine; for zip codes 039-043, 045 and 048-049            Nevada; for zip codes 894-895 and 897            New Hampshire; for zip codes 030-038            New Jersey: for zip code 088            Vermont: for zip codes 050-051            Washington; for zip codes 980-984 and 989 and 993</p>

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



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

## ERISA INFORMATION

### NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Loyola University Maryland  
4501 North Charles Street  
Baltimore, MD 21210

**EMPLOYER IDENTIFICATION NUMBER:** 52-0591623

<b>PLAN NUMBER</b>	<b>COVERAGE</b>	<b>PLAN NAME</b>
510	Dental Insurance	Loyola University Maryland

### TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

### AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's designated agent to accept service of process.

### ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

### PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

### CONTRIBUTIONS

You must make a contribution to the cost of Dental Insurance.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

### PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each July 1st and ending on the following June 30th.

## **Qualified Domestic Relations Orders/Qualified Medical Child Support Orders**

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

### **CLAIMS INFORMATION**

#### **Dental Benefits Claims**

##### **Procedures for Presenting Claims for Dental Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. Dental claim forms can also be downloaded from [www.metlife.com/dental](http://www.metlife.com/dental).

#### **Routine Questions**

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

#### **Claim Submission**

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

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

#### **Initial Determination**

After you submit a claim for dental benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

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

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

#### **Appealing the Initial Determination**

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

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

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

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

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

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

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation.

### **Urgent Care Claim Submission**

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

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

### **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

### **NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE**

COBRA is a federal law that requires most group health plans to give their employees and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may be able to continue coverage under This Plan for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Plan for up to 36 months. Also, your covered children may be able to continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan. Group health plans for employers with fewer than 20 employees, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

- a. the end of the 18, 29 or 36 month continuation period, as the case may be;
- b. the date of expiration of the last period for which the required payment was made;
- c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent's preexisting condition;
- d. the date your employer ceases to provide any group health plan for its employees.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Plan. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Employer within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Employee does not make that election. However, covered Employees may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

If you do not elect COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

### **Qualifying Event Due To Bankruptcy Of Employer**

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under This Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's covered spouse and covered dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under This Plan.

### **If You Elect Cobra**

If you choose COBRA coverage and pay the required premiums, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active Employees, spouses or dependent children. This means that if the coverage for similarly situated Employees, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

### **Duration Of Cobra Coverage**

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

**Disability.** If any person entitled to COBRA coverage (the covered Employee, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Employee, covered spouse or covered dependent child must notify the Employer's COBRA Administrator within 60 days of the **latest** of: (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Employee's coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or
- The last day of the 29th month of total coverage.

A person entitled to COBRA coverage must notify the COBRA Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. This Plan reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage terminates.

**Subsequent Qualifying Events.** If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Employee and the spouse divorce, the covered Employee dies, the covered Employee becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Plan, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Employer's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

### **Premiums For Cobra Coverage**

A person entitled to COBRA coverage is entirely responsible for paying the premiums for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

### **Initial Premium Payment**

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under This Plan will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

## **STATEMENT OF ERISA RIGHTS**

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Dental Plan Insurance**

Continue dental insurance for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **FUTURE OF THE PLAN**

It is hoped that the Plan will be continued indefinitely, but Loyola University Maryland reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Loyola University Maryland shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.



## **Uniformed Services Employment And Reemployment Rights Act**

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

### **Continuation of Group Dental Insurance:**

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

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

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

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

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

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