

**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



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

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 MINNESO**

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

## **Notice Regarding Your Rights and Responsibilities**

### **Rights:**

- x We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- x 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.
- x 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.
- x You may request a written response from MetLife to any written concern or complaint.
- x You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.

### **Responsibilities:**

- x 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.
- x 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.
- x You should follow the treatment plans and health care recommendations agreed upon by You and the dentist.





**NOTICE FOR RESIDENTS OF CALIFORNIA**

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE  
POLICYHOLDER OR THE METLIFE CLAIM OFFICE**

**NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA**

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

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



## **NOTICE FOR RESIDENTS OF ILLINOIS**

### **IMPORTANT NOTICE**

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

MetLife  
200 Park Avenue  
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## NOTICE FOR 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:
  - x You cease to be in an Eligible Class; or
  - x 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:

- x the date Your former Spouse remarries;
- x 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;
- x the date coverage is provided under any other group health plan;
- x the date Your former Spouse becomes entitled to Medicare;
- x 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;
- x the date of expiration of the last period for which the required premium payment was made; or
- x 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:

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

- x 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;
- x 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- x 18 months.

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

- x the end of the maximum continuation period;
- x the date this Dental Insurance ends;
- x the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- x the date You are entitled to enroll for Medicare;
- x if You do not pay the required premium to continue Your Dental Insurance; or
- x 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:

- x Your employment ends due to Your gross misconduct;
- x this Dental Insurance ends for all Dependents;
- x this Dental Insurance is changed, for the class of employees to which You belong, to end Dental Insurance for Dependents;
- x the Dependent is entitled to enroll in Medicare; or
- x 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:

- x Your right to continue Your Dental Insurance for Your Dependents;
- x the amount of premium payment that is required to continue Your Dental Insurance for Your Dependents;
- x the manner in which You or Your former Spouse must request to continue Your Dental Insurance for Your Dependents and pay premiums; and
- x 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:

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

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

- x send a written request to continue Dental Insurance for Your Dependents; and
- x 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:

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

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

## 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:

- x re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- x re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- x continues to qualify as a Child, except for the age limit; and
- x 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 ELIGIBILITYeas1,Es -1

## 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:

- x Life Insurance
  - o \$500,000 in death benefits
  - o \$200,000 in cash surrender or withdrawal values
- x 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
- x 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 TO RESIDENTS OF VIRGINIA**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

## **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 t



## 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**

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## **DEFINITIONS**

As used in this certificate, the terms listed below will

## DEFINITIONS (continued)

**Dentist** means:

- x a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- x 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 Ch





## **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:

- x marriage;
- x the birth, adoption or placement for adoption of a dependent child;
- x divorce, legal separation or annulment;
- x the death of a dependent;
- x Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;  
or
- x 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 (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 e

## **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:

- x You are not enrolled for dental insurance; and/or
- x 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:

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

then a request for dental insurance may be made by:

- x another parent of the child;
- x the Maryland Support Enforcement Agency; or
- x 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:
  - x the loss of a tooth; and
  - x 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:
  - y the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
  - y 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: INSURANY3ur Depis Deb7.Tw1Tc0 Tw( )Tj/TT4 1 Tf0 -10 cour

**CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

## 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:

- x identify Yourself as an insured in the Preferred Dentist Program; and
- x 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 Youe pess c46.0838 rot be(red Id )dt behtmai29(ss cai2.6(nonadju)5.2(s)-ilabl)5.2(s)-3rel(rizt be)5.2(h)You s2(ip Allow7d



## **DENTAL INSURANCE (continued)**

x 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.Amounts

## **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:

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

If the initial placement was made prior to this Dental

**DENTAL INSURANCE (continued)**

**DENTAL INSURANCE: DESCRIPT**

## 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:
  - x if at least 6 months have passed since the installation of the existing removable Denture; and
  - x 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:
  - x scaling and polishing of teeth; or
  - x fluoride treatments;
5. services which are primarily cosmetic unless such service is:
  - x 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
  - x 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:
  - x covered under any workers' compensation or occupational disease law;
  - x covered under any employer liability law;
  - x for which the Employer of the person receiving such services is not required to pay; or
  - x 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:
  - x claim form completion;
  - x infection control, such as gloves, masks, and sterilization of supplies; or
  - x 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



## 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:

- x a covered person must pay it; and
- x 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:**

- x expenses for services performed because of a Job-Related Injury or Sickness;
- x 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;
- x 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
- x 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:
  - x second surgical opinions;
  - x pre-certification of services;
  - x use of providers in a Plan's network of providers; or
  - x 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:

- x for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- x 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

## **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.

## **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 rule0 T

## **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:

- x the person We have paid or for whom We have paid;
- x insurance companies; or
- x 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

## **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**

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

- x Name of Employee
- x Name of the Plan
- x Reference to the initial decision
- x Whether the appeal is the first or second appeal of the initial determination
- x 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 /





## **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.



**\$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 -				
	Inlays / Onlays / Crowns / Cast /				

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**\$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

**\$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

**\$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
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,	

**\$15 PDP COPAY SCHEDULE**

Area 3	Area 4
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	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 Ha09pa0sha0i(re; for zip )6(ca0)7((de (0)6.337).3(0)6.3(- -1.3



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



## **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).

- x Name of Employee
- x Name of the Plan
- x Reference to the initial decision
- x Whether the appeal is the first or second appeal of the initial determination
- x 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

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.

**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

### **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 t



## **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