

**YOUR EMPLOYEE
BENEFIT PLAN**

Hood College

Standard Option

Dental Expense Benefits

Certificate Date: July 1, 2015

Hood College
401 Rosemont Avenue
Frederick, MD 21701

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Benefits are provided through a group policy issued to Hood College by Metropolitan Life Insurance Company.

Hood College

MetLife

Metropolitan Life Insurance Company
New York, New York

CERTIFICATE RIDER

Group Policy No.: 190564-1-G

Policyholder: Hood College

Effective Date: July 1, 2015

The certificate is changed as shown below:

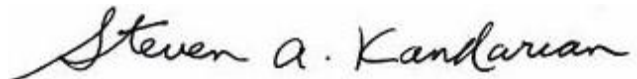
The definition of Domestic Partner is added as follows:

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; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
 4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner affidavit attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

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



Steven A. Kandarian
Chairman, President and Chief Executive Officer

MetLife

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

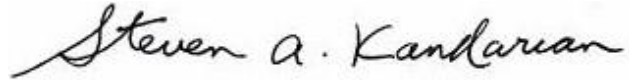
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Steven A. Kandarian
Chairman of the Board, President and Chief Executive Officer

Employer: **Hood College**

Group Policy No.: **190564-1-G**

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

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-438-6388

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

Web: <http://www.tdi.texas.gov>

Email: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

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

1-800-438-6388

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

Sitio Web: <http://www.tdi.texas.gov>

Email: ConsumerProtection@tdi.texas.gov

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

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

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

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

For Alaska Residents (Dental Expense Benefits):

The term also includes newborns.

For Louisiana Residents (Dental Expense Benefits):

The term also includes your grandchildren residing with you. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24.

For Minnesota Residents (Dental Expense Benefits):

The term also includes:

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

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status.

For Montana Residents (Dental Expense Benefits):

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.

For New Hampshire Residents (Dental Expense Benefits):

The age limit for children will not be less than 26, regardless of the child's marital, student status or full-time employment status.

For New Mexico Residents (Dental Expense Benefits):

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 coverage for Dental Expense Benefits under this certificate because:

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

For Texas Residents (Dental Expense Benefits):

The term also includes your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. A child will be considered your adopted child during the period you are a party to a suit in which you are seeking the adoption of the child. In addition, grandchildren must be able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Insurance.

For Utah Residents (Dental Expense Benefits):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. The term includes a child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a child except for the age limit.

For Washington Residents (Dental Expense Benefits):

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.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-438-6388

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

**ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201-1904
(501) 371-2640 or (800) 852-5494**

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

Reasonable and Customary Charges for Out-of-Network services will not be based less than an 80th percentile of the dental charges.

Reasonable Access to a Participating Provider

If you do not have a Participating Provider within 50 miles of your legal residence, We will reimburse you for the cost of Covered Services and materials provided by a Non-Participating Provider at the same benefit level as Participating Provider.

Exclusions

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

Coordination of Benefits or Non-Duplication of Benefits with a Secondary plan

If This Plan is Secondary, This Plan will determine benefits as if the services were obtained from This Plan's In-Network provider under the following circumstances:

- the Primary Plan does not provide benefits through a provider network;
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services through a provider in the Primary plan's network who is not in This Plan's network; or
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services from a provider that is not part of the provider network of the Primary Plan or This Plan because no provider in the Primary Plan's provider network or This Plan's network is able to meet the particular health need of the covered person.

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Expense Benefits

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

Routine Questions on Dental Expense Benefits 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 Expense Benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the PAYMENT OF BENEFITS subsection of the DENTAL EXPENSE BENEFITS section of the certificate.

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

NOTICE FOR RESIDENTS OF ALASKA

Dental Expense Benefits: Procedures For Dental Claims (Continued)

Initial Determination

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

Within 30 days after We receive Proof of your claim, We will approve and pay the claim or We will deny the claim. If We deny the claim, We will provide You with the basis of Our denial or the specific additional information that We need to adjudicate your claim. If We request additional information, We will approve and pay the claim or We will deny the claim within 15 days after We receive the additional information. If the claim is approved and not paid within the time period provided, the claim will accrue at an interest rate of 15 percent per year until the claim is paid.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the denial. 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, or as soon as reasonably possible for situations in which you cannot reasonably meet the deadline. 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.

NOTICE FOR RESIDENTS OF ALASKA

Dental Expense Benefits: Procedures For Dental Claims (Continued)

After MetLife receives your written request, 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. your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. 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.

MetLife will notify you in writing of its final decision within 18 days after MetLife's receipt of your written request for review.

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.

Second Level Appeal

If you disagree with the response to the initial appeal of the denied claim, you have the right to a second level appeal. We shall communicate Our final determination to you within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to you shall include the specific reasons for the determination.

External Appeal

If you disagree with the response to the second appeal of the denied claim, you have the right to an external appeal. We will communicate the decision of the external appeal agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer's decision. Decisions made by an external appeal agency are binding on Us and you unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by you or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

We have the right to recover any amount that is determined to be an overpayment, within 180 days from the date of service, whether for services received by you or your Dependents.

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Expense Benefits 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.

NOTICE FOR RESIDENTS OF ALASKA

Overpayments (Continued)

How We Recover Overpayments

We may recover the overpayment, within 180 days from the date of service, from you by:

- stopping or reducing any future benefits payable for Dental Expense Benefits;
- 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 within 180 days from the date of service, from one or more of the following:

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

California residents please be advised of the following:

IMPORTANT NOTICE

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

**METROPOLITAN LIFE INSURANCE COMPANY
200 PARK AVENUE
NEW YORK, NY 10166
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL
THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY
FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

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 or another government recognized by California as having similar requirements.

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

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

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

Georgia residents please be advised of the following:

IMPORTANT NOTICE

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

Idaho residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

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

**IDAHO DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS
700 WEST STATE STREET, 3RD FLOOR
PO BOX 83720
BOISE, IDAHO 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or
www.DOI.Idaho.gov**

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-800-438-6388**

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

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

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

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

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if your Dental Expense Benefits are in danger of lapsing due to a default on your part, such as nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once you have made a designation, you may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at toll-free telephone number 1-800-942-0854 to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, you, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that you suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR RESIDENTS OF MASSACHUSETTS

Your Employment Ends

With respect to all Personal Benefits and all Dependent Benefits, the 31 day period after the date such benefits would have ended because your employment ended.

With respect to all Personal Benefits and all Dependent Benefits, the 90-day period after the date such benefits would have ended because your employment ended due to a plant closing or partial plant closing.

In any event, such benefits will end on the date you would otherwise be entitled to similar benefits.

NOTICE FOR RESIDENTS OF MASSACHUSETTS

RIGHT TO CONTINUE DENTAL EXPENSE BENEFITS FOR YOUR FORMER SPOUSE WHEN YOU REMARRY

A. When The Right to Continue Dental Expense Benefits is Available

The right to continue Dental Expense Benefits for your former Dependent spouse will be available to you when you remarry if the judgement absolute of divorce dissolving your marriage provides for such continued coverage.

B. What Must Be Done to Continue Dental Expense Benefits

If the divorce judgement provides that Dental Expense Benefits be continued on account of your former Dependent spouse when you remarry, you must:

1. make a written request to the Employer to continue the Dental Expense Benefits; and
2. make any payment which is required for the cost of the continued Dental Expense Benefits.

The request form will be furnished by the Employer.

If the conditions set forth in this Section B are complied with, the Dental Expense Benefits in effect for your Dependent spouse on the date of your remarriage will continue to be in effect until the earliest of the dates set forth in Section C.

C. When Dental Expense Benefits End

Dental Expense Benefits for your former Dependent spouse will end on the earliest of:

1. the date your former Dependent spouse remarries; or
2. the expiration of the period of time specified in the divorce judgement during which you are required to provide dental care coverage for your former Dependent spouse; or
3. the date This Plan is changed to end the Dental Expense Benefits for your class; or
4. the date your former Dependent spouse becomes entitled to enroll for Medicare; or
5. if a payment which is required by the Employer for the cost of the Dental Expense Benefits on account of your former Dependent spouse is not made, the last day of the period for which a required payment was made; or
6. the date your former Dependent spouse is eligible for similar types of benefits under any other group medical plan; or
7. the date the Employer fails to pay the required premium to us for your former Dependent spouse's Dental Expense Benefits; or
8. the date you are no longer eligible for coverage under This Plan; or
9. the date you choose not to participate in This Plan.

NOTICE FOR RESIDENTS OF MISSISSIPPI

DENTAL EXPENSE BENEFITS: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Expense Benefits

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

Routine Questions on Dental Expense Benefits 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 Expense Benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the PAYMENT OF BENEFITS subsection of the DENTAL EXPENSE BENEFITS 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 Expense Benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

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

"**Clean Claim**" means a claim that:

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

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

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

NOTICE FOR RESIDENTS OF MISSISSIPPI (continued)

Clean Claim (Continued)

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

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

Appealing the Initial Determination

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

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

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

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

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

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

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

Reasonable and Customary Charges for Out-of-Network services will not be based less than an 80th percentile of the dental charges.

Reasonable Access to a Participating Provider

If you do not have a Participating Provider within 50 miles of your legal residence, We will reimburse you for the cost of Covered Services and materials provided by a Non-Participating Provider at the same benefit level as Participating Provider.

Exclusions

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

Coordination of Benefits or Non-Duplication of Benefits with a Secondary plan

If This Plan is Secondary, This Plan will determine benefits as if the services were obtained from This Plan's In-Network provider under the following circumstances:

- the Primary Plan does not provide benefits through a provider network;
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services through a provider in the Primary plan's network who is not in This Plan's network; or
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services from a provider that is not part of the provider network of the Primary Plan or This Plan because no provider in the Primary Plan's provider network or This Plan's network is able to meet the particular health need of the covered person.

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Expense Benefits

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

Routine Questions on Dental Expense Benefits 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 Expense Benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the PAYMENT OF BENEFITS subsection of the DENTAL EXPENSE BENEFITS section of the certificate.

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

NOTICE FOR RESIDENTS OF ALASKA

Dental Expense Benefits: Procedures For Dental Claims (Continued)

Initial Determination

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

Within 30 days after We receive Proof of your claim, We will approve and pay the claim or We will deny the claim. If We deny the claim, We will provide You with the basis of Our denial or the specific additional information that We need to adjudicate your claim. If We request additional information, We will approve and pay the claim or We will deny the claim within 15 days after We receive the additional information. If the claim is approved and not paid within the time period provided, the claim will accrue at an interest rate of 15 percent per year until the claim is paid.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the denial. 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, or as soon as reasonably possible for situations in which you cannot reasonably meet the deadline. 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.

NOTICE FOR RESIDENTS OF ALASKA

Dental Expense Benefits: Procedures For Dental Claims (Continued)

After MetLife receives your written request, 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. your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. 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.

MetLife will notify you in writing of its final decision within 18 days after MetLife's receipt of your written request for review.

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.

Second Level Appeal

If you disagree with the response to the initial appeal of the denied claim, you have the right to a second level appeal. We shall communicate Our final determination to you within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to you shall include the specific reasons for the determination.

External Appeal

If you disagree with the response to the second appeal of the denied claim, you have the right to an external appeal. We will communicate the decision of the external appeal agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer's decision. Decisions made by an external appeal agency are binding on Us and you unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by you or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

We have the right to recover any amount that is determined to be an overpayment, within 180 days from the date of service, whether for services received by you or your Dependents.

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Expense Benefits 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.

NOTICE FOR RESIDENTS OF ALASKA

Overpayments (Continued)

How We Recover Overpayments

We may recover the overpayment, within 180 days from the date of service, from you by:

- stopping or reducing any future benefits payable for Dental Expense Benefits;
- 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 within 180 days from the date of service, from one or more of the following:

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

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Dental Expense Benefits for a Dependent child may be continued past the age limit if that child is a full-time student and benefits end 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.

Benefits will continue if such Dependent 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 Dependent 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 When Benefits Ends section entitled this continuation will continue until the earliest of the date:

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

NOTICE FOR RESIDENTS OF TEXAS

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

NOTICE FOR RESIDENTS OF TEXAS

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

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

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

Or:

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

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

DENTAL EXPENSE BENEFITS: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

For claims for Dental Expense Benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the PAYMENT OF BENEFITS subsection of the DENTAL EXPENSE BENEFITS 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.

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

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

Policies and Procedures for Emergency and Urgent Care

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

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

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

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.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166
1-800-638-5433

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

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

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MetLife

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

Certifies that, subject to the terms and conditions of Group Policy No. 190564-1-G insuring Employees of
Hood College

the certificate that relates to Dental Insurance issued to each Employee is amended on the effective date of the Employees certificate as follows:

BY substituting the language in the section entitled "PAYMENT OF BENEFITS" stating "We will pay benefits when we receive satisfactory written proof of your claim" with the following:

"We will pay benefits within 30 days of the date we receive satisfactory written proof of your claim."

G. 23000-END-29

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE AND DEPENDENTS)

AMOUNT

DENTAL EXPENSE BENEFITS

	In-Network	Out-of-Network
Covered Percentage for:		
Type A Expenses	80%	80%
Type B Expenses	50%	50%
Type C Expenses	50%	50%
Deductibles for:		
Annual Individual Deductible	\$50 for the following Covered Dental Expenses Combined: Type B; Type C	\$50 for the following Covered Dental Expenses Combined: Type B; Type C
Annual Family Deductible	\$150 for the following Covered Dental Expenses Combined: Type B; Type C	\$150 for the following Covered Dental Expenses Combined: Type B; Type C
Maximum Benefit:		
Annual Individual Maximum (For One Dental Expense Period)	\$1,000 for the following Covered Dental Expenses: Type A; Type B; Type C	\$1,000 for the following Covered Dental Expenses: Type A; Type B; Type C

NOTE(S)

If a dental bill is expected to be \$300 or more, see DENTAL EXPENSE BENEFITS, section F. PRE-DETERMINATION OF BENEFITS.

COORDINATION OF BENEFITS

The Dental Expense Benefits are subject to the provisions of the form entitled COORDINATION OF BENEFITS.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

For Texas Residents: Upon receipt of services for a Covered Dental Expense, you may assign Dental Expense Benefits to the Dentist providing such care.

C. Refund to Us for Overpayment of Benefits

If we pay Dental Expense Benefits to you for expenses incurred, or supposed to have been incurred on your own account or on account of a Dependent, and it is found that we paid more Dental Expense Benefits to you than we should have paid because:

1. all or some of those expenses were not actually incurred by the Covered Persons in your Family; or
2. any Covered Person in your Family was repaid for all or some of those expenses by a source other than from:
 - a. an insurer under a policy of insurance (including a policy written in accordance with a no fault law) issued to you in your name; and
 - b. an insurer under a policy of insurance (including a policy written in accordance with a no fault law) issued to a Covered Person in your Family who ordinarily lives in your home; and
 - c. us;

we will have the right to a refund from you. The amount of the refund is the difference between:

1. the amount of Dental Expense Benefits paid by us for those expenses; and
2. the amount of Dental Expense Benefits which should have been paid by us for those expenses.

However, at our option, we may recover the excess amount by reducing or offsetting any future benefits payable to such person by the amount of the overpayment.

D. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
 - a. to accept or to waive the required notice or proof of a claim; nor
 - b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you will be considered at "Active Work":

1. on any day in which you are performing in the usual way all the regular duties of your work; or
2. on any day in which you are absent from work for any reason other than:
 - a. your sickness; or
 - b. your injury; or
 - c. a medical leave of absence.

"Covered Person" means an Employee or a Dependent on whose account benefits are in effect under This Plan.

For residents of Alaska, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Texas, Utah and Washington, the Dependent definition with respect to child is modified as explained in the Notice pages of this certificate - please consult the Notice.

"Dependent" means your lawful Spouse (including your Domestic Partner) or your natural child except for:

1. a person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
2. a person who is eligible under This Plan as an Employee; and
3. a child who is 26 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

- a. that child is and remains unable to work in self-sustaining employment because of:
 - i. physical handicap; or
 - ii. mental incapacity; and
- b. that child is and remains chiefly dependent upon you for support; and
- c. that child is and remains a Dependent, as defined, except for the age limit; and
- d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and
- e. you make any payment which is required by the Employer.

Subject to the same conditions which apply to a natural child, child also includes:

- a. a child who resides with you and is fully supported by you; and
- b. a child who is legally adopted; and
- c. a stepchild (wherever the term "stepchild" appears in this certificate it shall be read to include the children of your Domestic Partner); and
- d. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree); and
- e. a grandchild who resides with and is principally supported by the Employee and is in the Employees court ordered custody;
- f. a child who resides with and is principally supported by the Employee and is under the Employee's testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration;
- g. a child for whom the Employee or Employees spouse is required by a Child Health Insurance Enforcement Order to provide dental insurance coverage.

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. the service performed by the practitioner is within the scope of his or her license.

Domestic Partner - For the Domestic Partner Definition, please refer to the Domestic Partner Definition Rider in the front of this certificate.

"Employee" means a person who is employed and paid for services by the Employer on a full-time basis as determined by the Employer working a minimum of 18.75 hours per week.

"Family" means you and your Dependents.

"No Fault Law" means a motor vehicle liability law or other similar law which requires that benefits be provided for personal injury without regard to fault.

"Occupational Injury" means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

"Occupational Sickness" means a sickness which entitles the Covered Person to benefits under a worker's compensation or occupational disease law.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"Qualifying Events" means a change in your family, employment or group coverage status which would affect your Benefits under This Plan due to one or more of the following:

1. marriage;
2. birth, adoption or placement for adoption of a dependent child;
3. divorce, legal separation or annulment;
4. death of a dependent; or
5. a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage.

"Spouse" means your lawful spouse. Wherever the term "Spouse" appears in this certificate it shall, unless otherwise specified, be read to include your Domestic Partner.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

"We", **"us"** and **"our"** mean Metropolitan.

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

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are an Employee on July 1, 2015, that is your Personal Benefits Eligibility Date.

If you become an Employee after July 1, 2015, your Personal Benefits Eligibility Date is the first day of the month coincident with or next following the date you become an Employee of the Employer

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

A. Making a Request for Benefits

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

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

- a. when you are first eligible for Personal Benefits; or
- b. when you have a Qualifying Event and want to make a change in your coverage for Personal Benefits to be more consistent with your new family status; or
- c. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the thirty-one day period following your Personal Benefits Eligibility Date; or
- c. within thirty-one days of a Qualifying Event.

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
 - b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.
2. If you make a request to be covered for Personal Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Active Work Requirement.
 3. If you make a request to be covered for Personal Benefits or a request for change(s) in Personal Benefits within thirty-one days of a Qualifying Event, your Personal Benefits or the change(s) in Personal Benefits will become effective on the first day of the calendar month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

4. If you make a request to be covered for Personal Benefits during an annual enrollment period, but after Your Personal Benefits Eligibility Date, Your Personal Benefits will become effective on the July 1st following the date of Your request, subject to the Active Work Requirement.
5. If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the calendar month following the annual enrollment period, subject to the Active Work Requirement.

B. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Benefits under This Plan, you must make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

Requests to be insured for Dependent Benefits may only be made:

- a. during the thirty-one day period following your Dependent Benefits Eligibility Date; and
- b. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; and
- c. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Dependent Benefits, requests for changes in your Dependent Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
 - b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.
2. If you make a request to be insured for Dependent Benefits within thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective and on the later of:
 - a. your Dependent Benefits Eligibility Date; or
 - b. the effective date of your Personal Benefits.
 3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within thirty-one days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective on the latest of:
 - a. the date of the Qualifying Event;
 - b. the effective date of your Personal Benefits; or
 - c. the date of your request;and provided that the change in coverage is consistent with your new family status.
 4. If you make a request to be insured for Dependent Benefits during an annual enrollment period, but after your Personal Benefits Eligibility Date; your Dependent Benefits will become effective on the later of:
 - a. July 1st following the date of your request; and
 - b. the effective date of your Personal Benefits.

5. If you make a request to change your Dependent Benefits during an annual enrollment period, your Dependent Benefits will become effective on the first day of the calendar month following the annual enrollment period.

A request for coverage on a dependent child for whom the Employee or Employees spouse is required by a Child Health Insurance Enforcement Order to provide dental coverage is always a timely request.

B. Reinstatement of Benefits

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

C. New Dependents

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

Form G.23000-D2

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

"Covered Dental Expense" means:

1. For In-Network Benefits

The charges based on the Preferred Dentist Program Table of Maximum Allowed Charges for the types of dental services shown in section C. These services must be:

- a. performed or prescribed by a Dentist who is a Participating Provider; and
- b. necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

No more than the Maximum Allowed Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Maximum Allowed Charge is the lower of:

- a. the amount charged by the Participating Provider for the service or supply; and
- b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

2. For Out-of-Network Benefits

The charges for the types of dental services shown in section C. These services must be:

- a. performed or prescribed by a Dentist who is not a Participating Provider; and
- b. necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

No more than the Reasonable and Customary Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Reasonable and Customary Charge is the lowest of:

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

An example of how the 90th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Reasonable and Customary Charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 90th percentile of charges is the charge that is equal to the charge numbered 90th.

There may be more than one way to treat a dental problem. If, in our view, an adequate method or material which costs less could have been used, the Dental Expense Benefits will be based on the method or material which costs less. The rest of the cost will not be a Covered Dental Expense. See section E for examples that show how this works.

"Geographic Area" means an area determined by the zip code of the provider. A Geographic Area may contain only one zip code or a combination of adjacent zip codes.

"Deductible Amount" means the amount of Covered Dental Expenses shown in the SCHEDULE OF BENEFITS. The Deductible Amount is an annual amount.

The Deductibles during any one Dental Expense Period will not apply to Covered Dental Expenses for your Family after you incur Covered Dental Expenses for Covered Persons in your Family and those expenses equal the Family Deductible Amount.

"Dental Expense Period" means a period which starts on any July 1st and ends on the next June 30th.

"Dentist" means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a Doctor will be considered for Dental Expense Benefits as if it were performed or prescribed by a Dentist.

"Covered Percentage" means the percentage or percentages shown in the SCHEDULE OF BENEFITS.

"In-Network Benefits" means the Dental Expense Benefits provided under This Plan for covered dental services that are provided by a Dentist who is a Participating Provider.

"Out-of-Network Benefits" means the Dental Expense Benefits provided under This Plan for covered dental services that are not provided by a Dentist who is a Participating Provider.

"Preferred Dentist Program Table of Maximum Allowed Charges" means our fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

"Preferred Dentist Program" means our program to offer a Covered Person the opportunity to receive dental care from Dentists who are designated by us as Participating Providers. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for the services rendered.

"Participating Provider" means a Dentist who has been selected by us for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

"Non-Participating Provider" means a Dentist who is not a Participating Provider.

"Preferred Dentist Program Directory" means the list which consists of selected Dentists who:

1. are located in the Covered Person's area; and
2. have been selected by us to be Participating Providers and part of the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

The list will be periodically updated.

B. COVERAGE

1. When Benefits May Be Payable

We will pay Dental Expense Benefits if you incur Covered Dental Expenses:

- a.** for a Covered Person during a Dental Expense Period; and
- b.** while you are covered for the Dental Expense Benefits for that Covered Person or under the circumstances set forth in section H; and
- c.** the Covered Dental Expenses are more than the Deductible Amount.

We will also pay Dental Expense Benefits if you incur Out-of-Network Covered Dental Expenses:

- a.** for a Covered Person during a Dental Expense Period; and
- b.** while you are covered for the Dental Expense Benefits for that Covered Person; and
- c.** while you are covered for the Dental Expense Benefits for that Covered Person or under the circumstances set forth in section H; and
- d.** the Covered Dental Expenses are more than the Deductible Amount.

An expense is "incurred" on the date the type of dental service for which the charge is made is completed.

2. How Benefits Are Determined

Benefits will be equal to the Covered Percentage of those Covered Dental Expenses which are more than the Deductible Amount.

An expense is "incurred" on the date the type of dental service for which the charge is made is completed, except for purposes of applying the Deductible Amount. The Deductible Amount will be applied based on when Dental Expense Benefit claims for Covered Dental Expenses are processed by us. The Deductible Amount will be applied to Covered Dental Expenses in the order that Dental Expense Benefit claims for Covered Dental Expenses are processed by us, regardless of when a Covered Dental Expense is "incurred".

When several Covered Dental Expenses are incurred on the same date and Dental Expense Benefits for the Covered Dental Expenses are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Dental Expense. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

However, the sum of all benefits for all Covered Dental Expenses incurred for a Covered Person during any one Dental Expense Period will not be more than the Maximum Benefit For One Dental Expense Period shown in the SCHEDULE OF BENEFITS.

In order to determine what are the amounts of Covered Dental Expenses, we may ask for X-rays and other diagnostic and evaluative materials. If they are not given to us, we will determine Covered Dental Expenses on the basis of the information which is available to us. This may reduce the amount of benefits which otherwise would have been payable.

3. How the Preferred Dentist Program Works

Free Choice Of A Dentist:

A Covered Person is always free to choose the services of a Dentist who is either:

- a. a Participating Provider; or
- b. a Non-Participating Provider.

Benefits under This Plan will be determined and paid in either case, except that the Covered Person will generally incur less out-of-pocket cost if a Participating Provider is chosen.

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

Type A Expenses

1. Oral exams and problem-focused exams but no more than twice in a Dental Expense Period.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Full mouth or panoramic x-rays once every 3 years.
5. Bitewing x-rays 2 sets every 12 months.
6. Intraoral-periapical x-rays.
7. X-rays, except as mentioned elsewhere.
8. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
9. Genetic test for susceptibility to oral diseases.
10. Diagnostic casts.
11. Cleaning of teeth (oral prophylaxis) twice in a year.
12. Emergency palliative treatment to relieve tooth pain.
13. Topical fluoride treatment for a Dependent child under age 19 twice in a year.
14. Space maintainers for a Dependent child under age 14
15. Sealants or sealant repairs for a Dependent child under age 19 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 36 months.
16. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 36 months.

Type B Expenses

1. Amalgam fillings.
2. Resin-based composite fillings.
3. Protective (sedative) fillings.
4. Oral Surgery, except as mentioned elsewhere in this certificate.
5. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
6. Other consultations, but not more than twice in a 12 month period.
7. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once in any 24 month period for the same tooth.
8. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
9. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
10. Full mouth debridements, but not more than once per lifetime.
11. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
12. Simple extractions.
13. Surgical extractions.
14. 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.
15. Pulp capping (excluding final restoration).
16. Therapeutic pulpotomy (excluding final restoration).
17. Pulp therapy.
18. Apexification/recalcification.
19. Pulpal regeneration, but not more than once per lifetime.
20. Local chemotherapeutic agents.
21. 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.
22. Injections of therapeutic drugs.
23. 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.
24. Re-cementing of Cast Restorations or Dentures.

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

"Dentures" means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.
25. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
26. Tissue conditioning.

27. Simple Repairs of Cast Restorations or Dentures other than recementing.
28. Prefabricated crown, but no more than one replacement for the same tooth within 5 years.
29. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
30. Occlusal adjustments.
31. Pins, but no more than once per tooth in a period of 5 years.

Type C Expenses

1. Initial installation of full or partial Dentures (other than implant supported prosthetics):
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
2. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 years prior to replacement.
3. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 years prior to replacement.
4. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
5. Initial installation of Cast Restorations.
6. 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 within 5 years of the initial installation or a prior replacement.
7. Core buildup, but no more than once per tooth in a period of 5 years.
8. Posts and cores, but no more than once per tooth in a period of 5 years.
9. Labial veneers, but no more than once per tooth in a period of 5 years.
10. Fixed and removable appliances for correction of harmful habits.
11. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in 5 year period:
 - when needed to replace congenitally missing teeth; or
 - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
12. Repair of implants, but no more than once in a 12 month period.
13. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5 year period.
14. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5 year period.
15. Implant supported removable Dentures, but no more than once for the same tooth position in a 5 year period.

D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
2. Services 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:
 - a. scaling and polishing of teeth; or
 - b. fluoride treatments.
3. Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
 - a. it otherwise is a Covered Dental Expense; and
 - b. it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
 - c. it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.

For residents of Texas see notice page section.

4. Services or supplies which are covered under any workers' compensation or occupational disease law.
5. Services or supplies which are covered under any employer liability law.
6. Services or supplies which any employer is required by law to furnish in whole or in part.
7. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
8. Service or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person, except, this provision will not apply to Medicaid. Services or supplies for which a Covered Person is not required to pay.
9. Services or supplies for which a Covered Person is not required to pay, except, this provision will not apply to Medicaid.
10. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
11. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
12. Instruction for oral care such as hygiene or diet.
13. Periodontal splinting.
14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. 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:
 - a. refers a Covered Person to; or
 - b. directs an or a person under contract with the Health Care Practitioner to refer a Covered Person to a Health Care Entity in which:
 - a. the Health Care Practitioner; or
 - b. the Health Care Practitioner's immediate family; or
 - c. both.

own a Beneficial Interest or have a Compensation Agreement. For the purposes of this provision, 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.

17. Caries susceptibility tests.
18. Modification of removable prosthodontic and other removable prosthetic services.
19. Biopsies of hard or soft oral tissue.
20. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
21. Initial installation of a Denture or implant to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
22. Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
23. Adjustment of a denture or bridge made within 6 months after installation by the same Dentist who installed it;
24. Duplicate prosthetic devices or appliances.
25. Replacement of a lost or stolen appliance, crown, denture or bridgework;
26. Orthodontic services or appliances.
27. Repair or replacement of an orthodontic device.
28. Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders.
29. Intra and extraoral photographic images.

E. EXAMPLES OF ALTERNATE BENEFITS

Dental Expense Benefits will be based on the materials and method of treatment which cost the least and which, in our view, meet generally accepted dental standards.

1. Amalgam and Composite Fillings

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

2. Inlays, Onlays, Crowns and Gold Foil

If a tooth can be repaired to our satisfaction according to generally accepted dental standards by a less costly method than an inlay, onlay, crown or gold foil, Dental Expense Benefits will be based on the adequate method of repair which costs the least.

3. Crowns, Pontics, and Abutments

Veneer materials may be used for front teeth or bicuspid. However, Dental Expense Benefits will be based on the adequate veneer materials which cost the least.

4. Bridgework and Dentures

Dental Expense Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the Dental Expense Benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your Dental Expense Benefits will be, see section F.

F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be \$300 or more, before the Dentist starts the treatment, a Covered Person can find out what Dental Expense Benefits will be paid under This Plan. To do this, the Covered Person should send a claim form to us in which the Dentist tells us:

1. the work to be done; and
2. what the cost will be.

We will then tell the Covered Person what Dental Expense Benefits This Plan will pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan will pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan will pay.

This method should not be used for:

1. emergency treatment; or
2. routine oral exams; or
3. X-rays, scaling and polishing, and fluoride treatments; or
4. dental services which cost less than \$300.

G. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person ends. This will apply even if we have pre-determined benefits for dental services. However, benefits will be paid for Covered Dental Expenses incurred within 90 days after the date the Dental Expense Benefits end for a Covered Person for the following services:

1. for a prosthetic device if the Dentist prepared the abutment teeth and made impressions while Dental Expense Benefits for the Covered Person were in effect; or
2. for a crown if the Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; or
2. for root canal therapy if the Dentist opened the tooth while the Dental Expense Benefits for the Covered Person were in effect.

H. PAYMENT OF BENEFITS

Dental Expense Benefits will be paid to:

1. you; or
2. the Dentist; or
3. the non-insuring parent; or
4. the Maryland Department of Health and Mental Hygiene,

depending on:

1. whether or not the benefits have been assigned to the Dentist; and
2. whether or not the expenses are for a Dependent Child who is covered under a Child Health Insurance Enforcement Order of which we have received proof and Maryland law requires us to pay the Dental Expense Benefits to a particular person or state agency as a result of the Child Health Insurance Enforcement Order.

If the Covered Person is not a Dependent Child covered by a Child Health Insurance Enforcement Order of which we have received proof, we will pay Dental Expense Benefits to:

1. the Dentist, if you have assigned benefits to the Dentist, or
2. you, in all other cases.

If the Covered Person is a Dependent Child covered by a Child Health Insurance Enforcement Order of which we have received proof, we will pay benefits to the first of the following which applies:

1. the Dentist, if the person or state agency which incurred the Covered Dental Expenses for the Dependent 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 Expense 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 Covered Dental Expenses for the Dependent Child.
4. you, in all other cases.

We will pay benefits when we receive satisfactory written proof of your claim.

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

Form G.23000-13G

CLAIM PROCEDURES FOR DENTAL BENEFITS

A. Claim Forms

To make a claim under this insurance, a claim form may be obtained by calling 1-800-942-0854 or by downloading a claim form from our website at www.metlife.com/dental. If we do not provide the claim form within 15 days after notice of claim is received, the claimant is considered to have complied with the requirements of the policy as to proof of loss if the claimant submits, within the time fixed in the policy for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which claim is made.

B. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred.

C. Late Proof

If proof is not given on time, the delay will not cause a claim to be denied:

- if it was not reasonably possible to submit the proof within the required time;
- if the proof is furnished as soon as reasonably possible; and
- if the proof is furnished no later than 1 year from the time proof is otherwise required, except for cases involving the absence of legal capacity.

D. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

Form G.23000-H7

WHEN BENEFITS END

- A. All of your benefits will end on the date your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.
- B. If This Plan ends in whole or in part, your benefits which are affected will end.
- C. Your Dependent Benefits will end on the earlier of:
 - 1. the date that the Dependent ceases to be your Dependent; or
 - 2. the date of your death.
- D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.
- E. Coverage for Dental Benefits on a dependent child who is covered under a Child Health Insurance Enforcement Order will not cease before the date allowed under Section 490(W) of the Maryland Insurance Laws.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

**CONDITIONS UNDER WHICH YOUR ACTIVE
WORK IS DEEMED TO CONTINUE**

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than two months following the date the leave of absence or layoff begins.

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

Form G.23000-L

COORDINATION OF BENEFITS

A. Definitions

"Plan" means a plan which provides benefits or services for, or by reason of, dental care and which is:

1. a group insurance plan; or
2. a group blanket plan, but not including school accident-type coverages covering students in:
 - a. a grammar school;
 - b. a high school; or
 - c. a college;

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

3. a group practice plan; or
4. a group service plan; or
5. a group prepayment plan; or
6. any other plan which covers people as a group; or
7. a governmental program or coverage required or provided by any law.

In no event will Plan include coverage which is required or provided;

1. by Medicaid; or
2. an automobile reparations (no-fault) act or law; or
3. by a Specified Disease policy or an Intensive Care Policy as defined in Chapter 470S of the Maryland Ann. Code.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

"This Plan" means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under Government Plans will not be affected by these Coordination of Benefits provisions.

"Primary Plan/Secondary Plan" When This Plan is a Primary Plan, it means that This Plan's benefits are determined:

1. before those of the other Plan; and
2. without considering the other Plan's benefits.

When This Plan is a Secondary Plan, it means that This Plan's benefits:

1. are determined after those of the other Plan; and
2. may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more of those other Plans and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means any reasonable and customary charge which meets all of the following tests:

1. it is a charge for an item of necessary dental expense; and
2. it is an expense which a Covered Person must pay; and
3. it is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expenses do not include:

- a. expenses for services rendered because of:
 1. an Occupational Sickness; or
 2. an Occupational Injury.
- b. any amount of benefits reduced under a Primary Plan because the Covered Person does not comply with the Plan provisions. Examples of such provisions are those related to:
 1. second surgical opinions;
 2. precertification of admissions or services; and
 3. preferred provider arrangements.

Only benefit reductions based upon provisions similar in purpose to those described in the prior sentence and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision will not be used by a Secondary Plan to refuse to pay benefits because a Health Maintenance Organization member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its contract, is not obliged to pay for providing those services.

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

"Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

B. Effect on Benefits

1. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - a. the other Plan has rules coordinating its benefits with those of This Plan; and
 - b. both those rules and This Plan's rules in subsection 3 of this Section B require that This Plan's benefits be determined before those of the other Plan.
2. If This Plan is a Secondary Plan, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:
 - a. the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
 - b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

the benefits described in item 2(a) of this section B will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been given on time.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

3. Rules for Determining the Order in which Plans Determine Benefits. When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:
 - a. Non-dependent/Dependent. The Plan which covers that person other than as a dependent (for example, as an employee, member, subscriber or retiree) determines its benefits before the Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - i. Secondary to the Plan covering the person as a dependent; and
 - ii. Primary to the Plan covering the person as other than a dependent (e.g., a retired person);

then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

- b. Child Covered under More than One Plan.** When This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
- i.** the Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - 1.** the parents are married;
 - 2.** the parents are not separated (whether or not they ever have been married); or
 - 3.** a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

For example, if one parent's birthday were January 8 and the other parent's birthday were March 3, then the Plan covering the parent with the January 8 birthday would determine its benefits before the Plan covering the parent with the March 3 birthday.
 - ii.** if both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.
 - iii.** if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that Plan has that actual knowledge of the terms of the court decree.
 - iv.** if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:
 - 1.** the Plan of the Custodial Parent;
 - 2.** the Plan of the spouse of the Custodial Parent;
 - 3.** the Plan of the Non-Custodial Parent;
 - 4.** the Plan of the spouse of the Non-Custodial Parent.
- c. Active/Laid-off or Retired Employee.** The Plan which covers that person as an active employee (or as that employee's dependent) is Primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.
- d. Continuation Coverage.** The Plan which covers the person as an active employee, member or subscriber (or as that employee's dependent) is Primary to a Plan which covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule d shall not apply.
- e. Longer/Shorter Time Covered.** If none of the above rules determines the order of benefits, the Plan which has covered the Employee for the longer time determines its benefits before the Plan which covered that person for the shorter time.

C. Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. We have the right to decide which facts we need. We may get facts from or give them to any other organization or person. We need not tell, nor get the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

D. Facility of Payment

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

E. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this Coordination of Benefits provision, we may recover the excess from one or more of:

1. the persons we have paid or for whom we have paid;
2. insurance companies; or
3. other organizations.

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

Form G.23000-N7

NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

The fact that a Dentist may recommend that a Covered Person receive a dental service does not mean:

1. that the dental service will be deemed to be Necessary; or
2. that benefits under This Plan will be paid for the expenses of the dental service.

Metropolitan will make the decision as to whether the dental service:

1. is Necessary in terms of generally accepted dental standards; and
2. is qualified for benefits under This Plan.

"Necessary" means a dental service that is required for the treatment or management of a sickness or injury. Necessary services do not include services provided mainly for convenience.

Metropolitan will base its decision on objective medical information, including information obtained through:

1. consultations with Doctors; or
2. review of standard medical literature; or
3. technological assessment reports of government agencies and private professional organizations.

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

If Your appeal of a MetLife decision involves a question of 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 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.

Our Home Office is located at 200 Park Avenue, New York, New York 10166.

Form G.23000-E

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

ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE HOOD COLLEGE DENTAL EXPENSE BENEFITS PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Hood College
401 Rosemont Avenue
Frederick, MD 21701
301-696-3592

EMPLOYER IDENTIFICATION NUMBER: 52-0591608

PLAN NUMBER	COVERAGE	PLAN NAME
506	Dental Expense Benefits	Hood College Health and Welfare Benefits Plan

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 WHEN BENEFITS END subsection 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 TO PREMIUM

If you enroll for Dental Expense Benefits coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a plan year basis as follows:

For Dental Insurance: Beginning each July 1st and ending each 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 Expense Benefits Claims

Procedures for Presenting Claims for Dental Expense 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.

Routine Questions

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 benefits, the claimant must complete the appropriate claim form and submit the required proof.

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.

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means Hood College.

The term "Plan Administrator" means Hood College.

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

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;
- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

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

Executive Director of Human Resources & Benefits Administrator

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

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

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Hood College 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 Hood College 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.