YOUR EMPLOYEE
DENTAL BENEFIT PLAN

TOWN OF RIVERHEAD

MetLife

Town of Riverhead
200 Howell Avenue
Riverhead, New York 11901

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 Town of Riverhead by Metropolitan Life Insurance Company.

Town of Riverhead

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

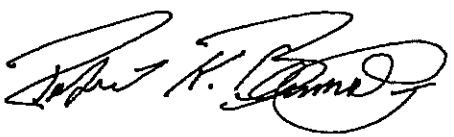
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

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.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Town of Riverhead**

Group Policy No.: **5001364-G**

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

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

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

For Texas Residents:

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

1-800-638-5433

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 - 475-1771

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.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-638-5433

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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:

1-800-638-5433

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
LITTLE ROCK, ARKANSAS 72201-1904

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
1 MADISON AVENUE
NEW YORK, NY 10010
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)

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.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

- **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

- **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

- **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

- **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

- **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

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 this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

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

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

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

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
1 Madison Avenue
New York, NY 10010
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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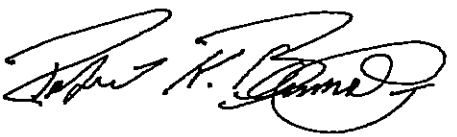
MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Endorsement

This certificate is hereby endorsed as follows:

With respect to Employees who are Texas residents, for Dental Expense Benefits, the term "dependent" includes the Employee's unmarried grandchild who is under age 25, living in the Employee's household and a dependent of the employee for federal income tax purposes at the time the grandchild is enrolled for coverage.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

G.23000-LEG-TXDEP

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE AND DEPENDENT)	In-Network	Out-of-Network
DENTAL EXPENSE BENEFITS		
ANNUAL DEDUCTIBLE AMOUNT (For Type A, Type B, and Type C Expenses)		
Individual	$50	$50
Family	$150	$150
COVERED PERCENTAGE		
Type A Expenses	100%	100%
Type B Expenses	85%	85%
Type C Expenses	50%	50%
Type D Expenses	50%	50%

MAXIMUMS

For Orthodontic Treatment Aggregate Maximum Benefit (For All Dental Expense Periods)	$1,000
Lifetime Deductible for Orthodontic Treatment	$50
For Other Covered Dental Expenses Maximum Benefit (For One Dental Expense Period)	$1,000

NOTE(S)

Expenses for orthodontia, including any procedures necessary for such treatment, will be considered Covered Dental Expenses only if the Dependent child has not reached age 19.

Covered Dental Expenses for orthodontia are not included in the Maximum Benefit For One Dental Expense Period.

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

Dental Expense 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 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 paid for 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 issued to you in your name; and

    b. an insurer under a policy of insurance 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 proof of a claim; nor

b. to extend the time within which 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 are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;

2. provided you are not disabled.

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

"Dependent" means your spouse or your unmarried child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;

2. a person who is eligible under This Plan as an Employee;

3. a person who lives outside the United States or Canada;

4. a child who:

   a. is 19 years of age or older and who is employed on a full-time basis; or

   b. is 19 years of age or older and who is not a full-time student at an approved school, as determined by the Employer; or

   c. is 25 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 illness, developmental disability, or mental retardation, as defined in the Mental Hygiene Law of New York State; 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.

Child includes:

a. a child who is supported solely by you and permanently living in the home of which you are the head; and

b. a child who is legally adopted; and

c. a stepchild who lives in your home provided the natural parent's signature, approving such coverage, is included on the enrollment form.

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.

"Employee" means a person who is employed and paid for services by the Employer on a full-time basis.

"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.

"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.

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

September 1, 1995; and

With respect to Full-time Employees:

If you become an Employee after September 1, 1995, your Personal Benefits Eligibility Date is the day after the date you complete four months of continuous service as an Employee of the Employer.

With respect to Part-time Employees:

If you become an Employee after September 1, 1995, your Personal Benefits Eligibility Date is the day after the date you complete one year of continuous service as 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

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date provided you are then Actively at Work as an Employee. If you are not then Actively at Work as an Employee, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Effective Date

Your Dependent Benefits will become effective on the later of:

1. your Dependent Benefits Eligibility Date; and

2. the effective date of your Personal Benefits.

On the effective date of your Dependent Benefits you will be insured for Dependent Benefits for all persons who are then your Dependents.

B. New Dependents

Dependent Benefits with respect to a person who becomes your Dependent while you are insured for Dependent Benefits will be effective on the date such person becomes your Dependent.

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 usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or

b. the usual charge of most other Dentists or other providers in the same geographic area for the same or similar services or supplies; or

c. the actual charge for the services or supplies.

With respect to In-Network Benefits and Out-of-Network Benefits, 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.

"Deductible Amount" means the amount 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 January 1 and ends on the next December 31.

"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; and

c. the In-Network Covered Dental Expenses are more than the In-Network 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. the sum of the In-Network Covered Dental Expenses and Out-of-Network Covered Dental Expenses are more than the Out-of-Network 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. However:

a. 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; and

b. The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment during all Dental Expense Periods will not be more than the applicable Aggregate Maximum Benefit For All Dental Expense Periods as 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

1. Type A Expenses

a. Oral exams but not more than once every 6 months.

b. X-rays:

i. full mouth X-rays but not more than once every 36 months; and

ii. bitewing X-rays but not more than once every 6 months.

c. Preventive treatment:

i. scaling and polishing of teeth (oral prophylaxis) but not more than once in a six month period; and

ii. topical fluoride treatment for a Dependent child under 19 years of age but not more than one per Dental Expense Period.

d. Space maintainers .

2. Type B Expenses

a. Amalgam or resin fillings.

b. Extractions.

c. Root canal treatment.

d. Periodontal maintenance where periodontal treatment (such as osseous surgery, gingivectomy, gingivoplasty, or gingival curettage) has been previously performed, but the total of:

i. the number of covered periodontal maintenance treatments; and

ii. the number of covered oral prophylaxes;

will not exceed four treatments in a Dental Expense Period.

e. Oral surgery.

f. Administration of general anesthesia, when dentally necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.

g. Injections of antibiotic drugs.

h. Relinings and rebasings of existing removable dentures but not more than once in 36 months.

i. Emergency palliative treatment.

j. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

3. Type C Expenses

a. Those services needed to replace one or more natural teeth which are lost while Dental Expense Benefits for the Covered Person are in effect for:

i. Installation of fixed bridgework done for the first time.

ii. Installation for the first time of:

1. a partial removable denture; or

2. a full removable denture.

b. Replacing an existing removable denture if it is needed because of the loss of one or more natural teeth after the existing denture was installed and the existing denture can no longer be used; or

c. Replacing an existing removable denture or fixed bridgework if it is needed because the existing denture or bridgework can no longer be used and was installed at least 5 years prior to its replacement.

d. Replacing an existing immediate temporary full denture by a new permanent full denture when:

i. the existing denture can not be made permanent; and

ii. the permanent denture is installed within 12 months after the existing denture was installed.

e. Repair or re-cementing of:

i. crowns; or

ii. inlays or onlays; or

iii. dentures; or

iv. bridgework.

f. Inlays, onlays and crown restorations, but not more than one such restoration to the same tooth surface within 5 years of the prior restoration.

4. Type D Expenses

Orthodontia, including appliance therapy for a Dependent child under age 19.

The Aggregate Maximum Benefit for orthodontia is shown in the SCHEDULE OF BENEFITS.

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 not performed 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.

4. Replacement of a lost, missing or stolen crown, bridge or denture.

5. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.

6. Services or supplies which are covered by any employers' liability laws.

7. Services or supplies which any employer is required by law to furnish in whole or in part.

8. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's employer.

9. Repair or replacement of an orthodontic appliance.

10. Services 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.

11. Services or supplies for which a Covered Person is not required to pay.

12. Services or supplies which are deemed experimental in terms of generally accepted dental standards.

13. 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.

14. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.

15. Any duplicate appliance or prosthetic device.

16. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.

17. Application of sealant material.

18. Instruction for oral care such as hygiene or diet.

19. Periodontal splinting.

20. Temporary or provisional restorations.

21. Temporary or provisional appliances.

22. Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.

23. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.

24. Charges for broken appointments.

25. Charges by the Dentist for completing dental forms.

26. Sterilization supplies.

27. Services or supplies furnished by a family member.

28. Treatment of temporomandibular joint disorders.

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 bicuspids. 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 may pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan may pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan may 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. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available to a Covered Person under a Government Plan, as defined below, they will not be considered for Dental Expense Benefits under This Plan. This provision will apply whether or not the Covered Person is enrolled for all Government Plans for which that Covered Person is eligible.

This provision will not apply to a Government Plan if that Government Plan requires that Dental Expense Benefits under This Plan be paid first.

A "Government Plan" is any plan, program or coverage, other than Medicare:

1. which is established under the laws or the regulations of any government; or

2. in which any government participates other than as an employer.

H. 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 end. This will apply even if we have pre-determined benefits for dental services. However, benefits for Covered Dental Expenses incurred for a Covered Person for the following services will be paid after Dental Expense Benefits end:

1. For a prosthetic device if:

   a. the Dentist prepared the abutment teeth and made impressions while Dental Expense Benefits for the Covered Person were in effect; and

b. the device is installed within 60 days after the date the Dental Expense Benefits end; or

2. For a crown if:

a. the Dentist prepared the tooth for the crown while the Dental Expense Benefits for the Covered Person were in effect; and

b. the crown is installed within 60 days after the date the Dental Expense Benefits end; or

3. For root canal therapy if:

a. the Dentist opened into the pulp chamber while the Dental Expense Benefits for the Covered Person were in effect; and

b. the treatment is finished within 60 days after the date the Dental Expense Benefits end.

I. PAYMENT OF BENEFITS

Dental Expense Benefits will be paid to:

1. the Dentist, if you have assigned benefits directly to the Dentist; or

2. 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 possible.

Form G.23000-13E

NOTICE OF AN ABUSED DEPENDENT'S RIGHT TO CONTINUE DENTAL BENEFITS NEBRASKA RESIDENTS ONLY

This provision applies only to Dependents who are not eligible for continued coverage under COBRA, 29 U.S.C.161 et seq.

A covered Dependent who is the subject of abuse by Employee may continue coverage under This Plan if the benefits of the Dependent end:

1. because the Employee has divorced, separated from, or lost custody of the subject of abuse; or

2. because the coverage of that Employee ends voluntarily or involuntarily, other than because the Dental benefits of This Plan end;

that Dependent may continue coverage under This Plan.

The Dependent will have 60 days after the benefits end to elect to continue coverage. That Dependent must provide evidence which is satisfactory to us that the Dependent is the subject of abuse by the Employee.

The continued benefits will end on first to occur of the following:

1. the date the Dental benefits of This Plan end;

2. the date a Dependent child no longer qualifies as a covered Dependent because of age; and

3. the date Dependent coverage ends because the Employee retires or reaches an age limit or any other limit for the coverage of Dependents.

Any person who elects to continue coverage under This Plan must pay the full cost of that coverage (including both the share the Employee now pays and the share the Employer now pays), plus any additional amounts permitted by law. The payments for continued coverage must be made on the first day of each month in advance.

G.23000-Leg-26-5

WHEN BENEFITS END

A. All of your benefits will end on the last day of the calendar month in which 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.

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), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

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, except Medicaid, but including any motor vehicle No Fault coverage which is required by law.

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:

1. Government Plans; or

2. Plans which the Employer (or an affiliate) contributes to or sponsors;

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.

If you or your Dependents had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

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.

PROCEDURES FOR CLAIM REVIEW

INTERNAL PROCEDURES FOR CLAIM REVIEW BY METLIFE

First Level of Review

MetLife maintains a procedure by which a denied claim may be appealed. In the event a claim is denied, you can request a review of your claim. This request for review should be sent in writing to Group Claims Review, at the address of the MetLife office which processed the claim. This request should be sent to us within 60 days after you receive notice of denial of the claim.

When requesting a review, please state the reason you believe the claim was improperly denied. You and your Dentist should submit any information that is appropriate such as diagnostic materials, x-rays, or narrative. Decisions on your appeal will be made no later than 60 days after receipt of the request for review.

Second Level of Review

If the appeal is not resolved to your satisfaction, you can appeal the action to second level of review for reconsideration. This is second level of review is done through senior level consultants who make the final recommendations. Decisions on your appeal in the second level of review will be made no later than 60 days after receipt of the request for reconsideration.

Please note, by undertaking a second level review you may foreclose your right to an external appeal as an external appeal must be filed within 45 days of the Final Adverse Determination of the first level review.

EXTERNAL PROCEDURES FOR CLAIM REVIEW OUTSIDE OF METLIFE

New York state law gives you the right to an external appeal when payment of benefits for dental services have been denied on the basis

that the services are not dentally necessary or that the services are experimental or investigational.

If you have received a Final Adverse Determination after our first level of review, you can request an external appeal by completing an application form and sending it to the New York State Insurance Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Final Adverse Determination means a written notification from us that your claim for dental benefits has been denied through our appeal process.

You may obtain an application form or any additional information by calling us at 1-800-638-5433 or by calling the New York Insurance Department at 1-800-400-8882. You may also obtain an application or further information by visiting the New York Insurance Department's web site at www.ins.state.ny.us.

Eligibility for an External Appeal

To be eligible for an external appeal, payment of benefits for dental services must have been denied on the basis that the services are not dentally necessary or that the services are experimental or investigational and:

- you must have received a Final Adverse Determination as a result of our internal utilization review appeal process; or
- you and MetLife must have agreed to waive that appeal process.

If you do not file a request for an external appeal with the state within this 45 day period, you will not be eligible for an external appeal. MetLife has two levels of internal appeals, you must file a request for external appeal within 45 days of your receipt of the Final Adverse Determination from our first level appeal process to be eligible for an external appeal.

If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible

for an external appeal and your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

You may only appeal a service or procedure that is a Covered Service under this certificate. The external appeal process may not be used to expand your dental coverage.

Eligibility for an Expedited External Appeal

If your attending Dentist attests that a delay in providing the treatment or service poses an imminent or serious threat to your health you may request an expedited appeal. When requesting an expedited appeal, make sure you give the Attending Physician Attestation form to your Dentist to complete. Your appeal will not be forwarded to the external appeal agent until your Dentist sends this attestation to the Insurance Department.

Time Periods for External Appeals

For standard appeals, the external appeal agent must make a determination within 30 days of receiving your request for an external review from the state. If additional information is requested, the external appeal agent has five additional business days to make a determination.

For expedited appeals, the external appeal agent must make a determination within three days of receiving your request for an external review from the state.

The Cost to You for an External Appeal

We may charge you a fee of up to $50.00 for an external appeal. If We determine that the fee will pose a hardship, you will not be required to pay a fee.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to you.

Submission of Information

If your case is determined to be eligible for external review, you will be notified of the certified external appeal agent assigned to review your

case.

MetLife will send your dental and treatment records to the external appeal agent.

When the external appeal agent reviews your case, the agent may request additional information from you or your Dentist. This information should be sent immediately to the external appeal agent.

You and your Dentist can submit information even when the external appeal agent has not requested specific information. You must submit this information Department within 45 days:

- of when you received the Final Adverse Determination; or
- of receiving written confirmation from us that the internal appeal process has been waived.

Once the external appeal agent makes a determination or your 45 day time period ends, you will not be able to submit additional information.

The external appeal application contains a release of medical records provision that you must sign to authorize the release of medical and treatment records, including HIV, mental health and alcohol and drug abuse records to the certified external appeal agent assigned to review your appeal.

Notification of a Decision

When the external appeal agent has made the decision:

- for standard appeals, you and MetLife will be notified in writing within two business days; or
- for expedited appeals, you and MetLife will be notified immediately by telephone or fax. Written notification will follow.

The decision of the external appeal agent is binding on you and MetLife.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

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

DISCLOSURE STATEMENT - (NEW YORK)

METROPOLITAN LIFE INSURANCE COMPANY

Required Disclosure Statement

The insurance evidenced by this certificate provides dental insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

Metropolitan Life Insurance Company
One Madison Avenue, New York, NY 10010-3690

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