MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

CERTIFICATE OF INSURANCE

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

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

Policyholder:	Trustees of the CSEA Child Care Providers Trust Fund
Group Policy Number:	TS 05368700-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s):	
For General Information	1-800-275-4638

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance For You and Your Dependents		
For All Active Participating Child Care Providers Not Enrolled in Medicaid		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Deductibles for:	In-Network	Out-of-Network
Yearly Individual Deductible	$0	$0
Yearly Family Deductible	$0	$0
Maximum Benefit:	In-Network	Out-of-Network
Yearly Individual Maximum	$1,000 for the following Covered Services: Type A, Type B & Type C	$1,000 for the following Covered Services: Type A, Type B & Type C

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job as a Participating Child Care Provider.

You will be deemed to be Actively at Work during weekends or vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

For Dental Insurance, Your natural child; Your adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

A proposed adoptive child is eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

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

The term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is insured under the Group Policy as a Participating Child Care Provider.

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

Contributory Insurance includes: Dependent Dental Insurance.

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

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

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

DEFINITIONS

CSEA means the Civil Service Employees Association.

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services.

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

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

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

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

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

Fund means the CSEA Child Care Providers Trust Fund.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with Us to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

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

DEFINITIONS

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Noncontributory Insurance includes: Dental Insurance for You

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

Participating Child Care Provider means a covered child care provider under the Collective Bargaining Agreement between CSEA/VOICE Local 100A and CSEA/CCPT Local 100B and the State of New York OCFS, October 1, 2013 to September 30, 2017, who has satisfied the eligibility requirements of the Fund and is participating in the benefits provided by the Fund. A covered child care provider is an operator of a licensed group family day care home as defined in New York Social Services Law section 390(1)(d) or of a registered family day care home as defined in New York Social Services Law section 390(1)(e) or is an individual providing child care in a residence to one or more children who are receiving child care assistance under New York Social Services Law section 390 located outside New York City.

Physician means:

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

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

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

Spouse means Your lawful Spouse. The term also includes Your Domestic Partner.

The term does not include any person who:

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

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

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

Year or **Yearly** means the 12 month period that begins January 1.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Participating Child Care Providers Not Enrolled in Medicaid

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

For All Active Participating Child Care Providers Not Enrolled in Medicaid

If You are in an eligible class on May 01, 2016, You will be eligible for insurance on that date.

If You enter an eligible class after May 01, 2016, You will be eligible for insurance on the first day of the month coincident with or next following the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

If You complete the enrollment process for Dental Insurance during the first 15 days of the calendar month, such insurance will take effect on the first day of the following calendar month, provided You are Actively at Work on that date.

If You complete the enrollment process for Dental Insurance on the 16th or later day of the calendar month, such insurance will take effect on the first day of the calendar month subsequent to the following calendar month, provided You are Actively at Work on that date.

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

Rules for Contributory Insurance

If You complete the enrollment process for Contributory Dental Insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and

- the first day of the following calendar month, if You enroll during the first 15 days of the calendar month; or
- the first day of the calendar month subsequent to the following calendar month, if You enroll on the 16th or later day of the calendar month

provided You are Actively at Work on that date. If You are not Actively at Work on that date, it will take effect on the day You return to Active Work.

Effect of Discontinuing Dental Insurance

If You discontinue Dental Insurance at any time, You will not be able to re-enroll, unless You have an Enrollment Qualifying Event.

Enrollment Due to an Enrollment Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance if You have an Enrollment Qualifying Event.

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

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

Enrollment Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the date You cease to be a Participating Child Care Provider as defined in the DEFINITIONS section; or
5. the date You become enrolled in Medicaid.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Active Participating Child Care Providers Not Enrolled in Medicaid Who Are Eligible Members of CSEA/VOICE Local 100A or CSEA/CCPT Local 100B

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

For All Active Participating Child Care Providers Not Enrolled in Medicaid Who Are Eligible Members of CSEA/VOICE Local 100A or CSEA/CCPT Local 100B

If You are in an eligible class on May 01, 2016, You will be eligible for Dependent insurance on that date.

If You enter an eligible class after May 01, 2016, You will be eligible for Dependent insurance on the first day of the month coincident with or next following the date You enter that class.

No person may be insured as a Dependent of more than one Participating Child Care Provider.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You will be notified how much You will be required to contribute.

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

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Rules for Noncontributory Insurance

If You complete the enrollment process for Noncontributory Dependent Dental Insurance during the first 15 days of the calendar month, such insurance will take effect on the first day of the following calendar month, provided You are Actively at Work on that date.

If You complete the enrollment process for Noncontributory Dependent Dental Insurance on the 16th or later day of the calendar month, such insurance will take effect on the first day of the calendar month subsequent to the following calendar month, provided You are Actively at Work on that date.

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

Rules for Contributory Insurance

If You complete the enrollment process for Contributory Dependent Dental Insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the first day of the following calendar month, if You enroll during the first 15 days of the calendar month; or
- the first day of the calendar month subsequent to the following calendar month, if You enroll on the 16th or later day of the calendar month

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

Effect of Discontinuing Dependent Dental Insurance

If You discontinue Dependent Dental Insurance at any time, including through the failure to pay required premiums, You will not be able to re-enroll, unless You have an Enrollment Qualifying Event.

Enrollment Due to an Enrollment Qualifying Event

You may enroll for Dependent Insurance for which You are eligible or change the amount of Your Dependent Insurance if You have an Enrollment Qualifying Event.

If You discontinue Dependent Dental Insurance and subsequently have an Enrollment Qualifying Event, You will have 31 days from the date of that change to make a request to re-enroll. This request must be consistent with the nature of the Enrollment Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of an Enrollment Qualifying Event will take effect on the first day of the month coincident with or next following the date of Your request, if You are Actively at Work on that date.

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

Enrollment Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date Your Dental Insurance ends;
2. the date You die, except as stated in the subsection entitled SURVIVING SPOUSE BENEFIT below;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the date You become enrolled in Medicaid;
7. the date You cease to be an eligible member of CSEA/VOICE Local 100A or CSEA/CCPT Local 100B;
8. the end of the period for which the last premium has been paid;
9. the date the person ceases to be a Dependent.

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

SURVIVING SPOUSE BENEFIT

If You die, Your covered Spouse may continue Dental Insurance with premium payments. Dental Insurance will end under this Survivor Benefit at the earliest of:

1. the date Your Spouse becomes insured under another group type plan;
2. the date the Group Policy ends; or
3. the date Your Spouse remarries.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

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

- remains incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap as defined by applicable law; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

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

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

DENTAL INSURANCE

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

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

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-275-4638 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

In-Network

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

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

- any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network

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

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

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

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the Schedule of Benefits.

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

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

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

Alternate Benefit

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

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

For example:

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

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

DENTAL INSURANCE (CONTINUED)

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your Insurance ends if:

- the Covered Service was begun by a Dentist while You are insured for Dental Insurance; and
- the treatment requires more than one visit to complete.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months.

2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, are limited to once every 6 months.

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), are limited to once every 6 months.

4. Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months.

5. Bitewing x-rays but not more than:

- 1 set every 6 months for a Child under age 19; and
- 1 set every calendar year for everyone else.

6. Full mouth or panoramic x-rays once every 60 months.

7. Cleaning of teeth (oral prophylaxis) once every 6 months.

8. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.

9. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.

10. Diagnostic casts.

11. Topical fluoride treatment for a Child under age 14, but not more than once in 12 months.

12. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth in a lifetime.

13. Preventive resin restorations, which are applied to non-restored first and second permanent molars, but not more than once per tooth in a lifetime.

14. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, but not more than once per tooth in a lifetime.

15. Space maintainers for a Child under age 19.

16. 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 four times in any calendar year less the number of teeth cleanings received during such calendar year.

Type B Covered Services

1. Intraoral-periapical x-rays.

2. Dental x-rays except as mentioned elsewhere in this certificate.

3. Protective (sedative) fillings.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

4. Initial placement of amalgam fillings.

5. Replacement of an existing amalgam filling, but only if:

   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.

6. Initial placement of resin fillings.

7. Replacement of an existing resin filling, but only if:

   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.

8. Emergency palliative treatment to relieve tooth pain.

9. 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.

10. Simple extractions.

11. Surgical extractions.

12. Oral surgery except as mentioned elsewhere in this certificate.

13. Pulp capping (excluding final restoration).

14. Pulp therapy.

15. Therapeutic pulpotomy (excluding final restoration).

16. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.

    Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.

17. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period.

18. Simple Repairs of Cast Restorations but not more than once in a 12 month period.

19. Repair of Dentures but not more than once in a 12 month period.

20. Addition of teeth to fixed and permanent Denture to replace natural teeth:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

21. Addition of teeth to a partial removable Denture:

    - to replace natural teeth.

22. Re-cementing of Cast Restorations or Dentures but not more than once in a 12 month period.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

23. Repair of implant supported prosthetics but not more than once in a 12 month period.

24. Local chemotherapeutic agents.

25. Injections of therapeutic drugs.

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

Type C Covered Services

1. 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.

2. Other consultations, but not more than twice in a 12 month period.

3. Apexification/recalcification.

4. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.

5. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 36 month period.

6. Tissue Conditioning, but not more than once in a 36 month period.

7. Prefabricated crown, but no more than one replacement for the same tooth surface within 5 calendar years.

8. Initial installation of Cast Restorations (except an implant supported Cast Restoration).

9. Replacement of Cast Restorations (except an implant supported Cast Restoration), but only if at least 5 years have passed since the most recent time that:

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

10. Core buildup, but no more than once per tooth in a period of 5 calendar years.

11. Labial veneers, but no more than once per tooth in a period of 5 calendar years.

12. Post and cores, but no more than once per tooth in a period of 5 calendar years.

13. Initial installation of fixed and permanent Denture:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

14. Replacement of a non-serviceable fixed and permanent Denture if such Denture was installed more than 5 calendar years prior to replacement.

15. Initial installation of full or removable Dentures:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

16. 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.

17. Replacement of a non-serviceable full or removable Denture if such Denture was installed more than 5 calendar years prior to replacement.

18. Adjustments of Dentures:

- if at least 6 months have passed since the installation of the existing removable Denture; and
- not more than once in any 12 month period.

19. 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.

20. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 60 month period:

- when needed to replace congenitally missing teeth; or
- when needed to replace natural teeth.

21. Cleaning and inspection of a removable appliance once every 6 months.

22. Repair of implants, but not more than once in a 12 month period.

23. Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period:

- when needed to replace congenitally missing teeth; or
- when needed to replace natural teeth.

24. Occlusal adjustments, but not more than once in a 12 month period.

25. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging but cone beam imaging for this treatment will not be covered more than once for the same tooth position in a 60 month period.

DENTAL INSURANCE: EXCLUSIONS

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

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic.
5. Services or appliances which restore or alter occlusion or vertical dimension.
6. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
7. Restorations or appliances used for the purpose of periodontal splinting.
8. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
9. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
10. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
11. Missed appointments.
12. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
13. Services covered under other coverage provided by the Policyholder.
14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. Prescription drugs.
17. Services for which the submitted documentation indicates a poor prognosis.
18. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.

DENTAL INSURANCE: EXCLUSIONS (CONTINUED)

Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.

The term does not include:

- any plan, program or coverage provided by a government as an employer; or
- Medicare.

19. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
20. Caries susceptibility tests.
21. Precision attachments, except when the precision attachment is related to implant prosthetics.
22. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
23. Fixed and removable appliances for correction of harmful habits.
24. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
25. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging.
26. Orthodontic services or appliances.
27. Repair or replacement of an orthodontic device.
28. Duplicate prosthetic devices or appliances.
29. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
30. Intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Plan's network of providers; or
    - any other similar provisions.

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

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

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

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

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

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

The term does not include any of the following:

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

The provisions of This Plan limit benefits based on benefits or services provided under:

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

will not be affected by these Coordination of Benefits provisions.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both insured under This Plan as Participating Child Care Providers, each person's insurance will be treated as a separate Plan.

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

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

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-275-4638. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 120 days of the date of a loss.

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

Step 1
A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2
We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

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

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, he may send Us Proof using any form sufficient to provide Us with the required Proof.

Step 4
The claimant must give Us Proof not later than 120 days after the date of the loss.

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

Time Limit on Legal Actions. A legal action on a claim for Dental Insurance benefits may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 2 years after the date such Proof is required.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

INTERNAL PROCEDURES FOR CLAIM REVIEW BY METLIFE

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

Claim Submission

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

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

Urgent Care Claim Submission and Appeals

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 dialing 1-800-275-4638. 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.

Initial Determination for Claims Other Than Urgent Care Claims

After You submit a claim for Dental Insurance benefits to MetLife, MetLife will review Your claim and notify You in Writing 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. MetLife will make a determination and provide notice to You in writing within 15 calendar days of the earlier of MetLife's receipt of the information or the end of the 45 day period.

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.

The denial will also include a statement of your right to make an appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

It will also describe Your right to bring civil action to enforce Your rights under the Plan.

Appealing the Initial Determination – First Level of Review

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 Insured
- 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 such as diagnostic materials, x-rays, or narrative.

MetLife will acknowledge Your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. 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 dental 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.

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.

A denial of Your first request for appeal will also include a statement of your right to make a second appeal to MetLife and a description of how to make that appeal, and the deadlines which apply.

Each denial of an appeal will also describe Your right to bring civil action to enforce Your rights under the Plan, or to petition the Secretary of the Department of Labor to bring such an action, under Section 502(a) of ERISA.

Finally, each denial of an appeal will describe Your right to request an additional, external review under New York state law.

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. Decisions on Your appeal in the second level of review will be made no later than 30 days after receipt of the request for reconsideration.

After MetLife receives Your written request for a second level of review, MetLife will conduct a full and fair review of Your claim. Deference will not be given to the initial denial or the initial appeal, and MetLife's review will look at the claim anew. The review on the second 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 or on the initial appeal. The person who will review Your second appeal will not be the same person as the person who made the initial decision or the person who made the decision on the initial appeal to deny Your claim. In addition, the person who is reviewing the second appeal will not be a subordinate of the person who made the initial decision or the person who made the decision on the initial appeal to deny Your claim. If the initial denial or the denial on the initial appeal is based in whole or in part on a dental 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 or on the initial appeal, and will not be a subordinate of any person who was consulted on the initial determination or the initial appeal.

If Your second level of review also denies Your claim, Your Written notice of denial will contain the same items of information that were contained in Your initial appeal notice.

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 four months 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. This applies both to Urgent Care Claims and non-Urgent Care Claims.

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 four months:

- 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 1-800-275-4638 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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)

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 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.

Submission of Information

If Your case is determined to be eligible for external review, You will be notified by the New York Insurance Department 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 to the Insurance Department within four months:

- 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 four month 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.

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)

The Cost to You for an External Appeal

We may charge You a fee of up to $25.00 for an external appeal with an annual limit on filing fees for an insured of $75.00. If We determine that the fee will pose a hardship, You will not be required to pay a fee. We may charge the Dentist a fee of up to $50.00 for an external appeal.

If the external appeal agent overturns the Final Adverse Determination, the fee will be refunded to You or to the Dentist, depending on who paid the fee.

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.

GENERAL PROVISIONS

Assignment

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

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

Dental Insurance: Who We Will Pay

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

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. Your rights, the rights of the Policyholder and the rights of any beneficiary under this certificate will not be affected by any provision unless it is contained in the contract with the Policyholder.

The entire contract with the Policyholder is made up of the following:

1. the group policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a Written application or enrollment form;
- You have Signed the application or enrollment form; and
- a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

Misstatement of Age

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will make an equitable adjustment of the benefits and/or premiums.

Conformity with Law

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

Gender

Male pronouns will be read as female where applicable.

GENERAL PROVISIONS (CONTINUED)

Overpayments

Recovery of Dental Insurance Overpayments

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

An overpayment occurs if We determine that:

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

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

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

We may recover such overpayment in accordance with that agreement.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

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

"THIS IS THE END OF THE CERTIFICATE OF INSURANCE. THE FOLLOWING ERISA INFORMATION IS PROVIDED BY THE POLICYHOLDER"

THIS "SUMMARY PLAN DESCRIPTION" (AS REFERRED TO IN THE METLIFE CERTIFICATE) IS EXPRESSLY MADE PART OF THE CERTIFICATE AND IS LEGALLY ENFORCEABLE AS PART OF THE CERTIFICATE WITH RESPECT TO ITS TERMS AND CONDITIONS. THIS "SUMMARY PLAN DESCRIPTION" DOCUMENT RELATES ONLY TO THE BENEFITS PROVIDED UNDER THIS CERTIFICATE AND IS NOT INTENDED TO REPLACE THE OVERALL SUMMARY PLAN DESCRIPTION OF THE PLAN ("SPD"). YOU SHOULD CONSULT THE SPD OF THE PLAN FOR INFORMATION AND RULES CONCERNING ALL COVERAGES OFFERED UNDER THE PLAN.

ERISA INFORMATION

NAME OF THE PLAN
CSEA Child Care Providers Trust Fund Welfare Benefit Plan ("Plan")

NAME AND ADDRESS OF POLICYHOLDER
Board of Trustees of the CSEA Child Care Providers Trust Fund ("Trustees")
1 Lear Jet Lane, Suite 4
Latham, New York 12110
(518) 257-1000

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER
EIN: 81-2197772
Plan No. 520

TYPE OF ADMINISTRATION
The dental benefits under the MetLife certificate are insured and administered by Metropolitan Life Insurance Company ("MetLife"). The Plan as a whole is administered by the Trustees.

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS, AND PHONE NUMBER
Board of Trustees of the CSEA Child Care Providers Trust Fund
1 Lear Jet Lane, Suite 4
Latham, New York 12110
(518) 257-1000

AGENT FOR SERVICE OF LEGAL PROCESS
For disputes arising under the MetLife certificate and benefits insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside. For disputes arising under the Plan, service of legal process may be made upon the Trustees at the above address.

ELIGIBLITY FOR PARTICIPATION; DESCRIPTION OF BENEFITS
The overall SPD for the Plan and the MetLife certificate describe the eligibility requirements for benefits provided under the Plan and certificate. Eligibility decisions will be made by the Trustees (or their designee) in their sole discretion, and such decisions will be given full force and effect unless it can be shown that the decision was arbitrary and capricious.

Fully insured dental benefits are provided as described in the MetLife certificate by:

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

FINANCING OF THE BENEFITS UNDER THE METLIFE CERTIFICATE
The benefits provided for Participating Child Care Providers under the MetLife certificate are funded by the Civil Service Employees Association, Inc., Local 1000, AFSCME ("Plan Sponsor"), which makes contributions to the Plan on behalf of eligible Providers. Coverage for eligible Dependents is provided on a self-pay basis by Participants forwarding premium contributions to the Plan (or its designee) on their behalf.

Premiums for the coverage under the MetLife certificate and group policy are due and payable on the first day of each month for which insurance coverage is to be provided. If payment is not received within 31 days after the due date, coverage will terminate on the earlier of the 31st day following the due date and the date requested in writing by the Trustees, provided such request is made before such 31st day.

PLAN YEAR
The Plan Year of the Plan is the twelve-month period ending each December 31st.

TERMINATION OR MODIFICATION OF BENEFITS
The Plan Sponsor and the Trustees reserve the right to amend, change, modify, or terminate the coverage provided under the MetLife certificate and group policy, or the benefits otherwise provided under the Plan, at any time. Your consent or the consent of your beneficiary is not required to amend, or change, modify, or terminate any such benefits.

In the event Your coverage ends in accord with the Date Your Insurance Ends provision of Your certificate, You may still be eligible to receive benefits. The circumstances under which such benefits are available are described in Your MetLife certificate.

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Plan (or its designee) 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 1-800-275-4638.

Claim Submission
For claims for dental benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the Filing a Claim section of the certificate.

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

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

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

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

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

- Name of Participant;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination; and
- 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.

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.

FEDERAL CONTINUATION OF COVERAGE LAW

A. What is COBRA Continuation Coverage?

COBRA provides that you, your spouse, and your dependent children are entitled to elect to continue coverage under the MetLife certificate on a self-pay basis under the Plan under certain circumstances if coverage would otherwise stop. This is known as "COBRA Continuation Coverage." If eligible, your spouse and your dependent children may elect COBRA Continuation Coverage even if you do not.

B. Which Participants are eligible for COBRA Continuation Coverage?

COBRA Continuation Coverage may generally be elected by individuals covered by a plan as employees upon loss of coverage under the plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including due to a strike, walkout, or layoff.

For purposes of the benefits in the MetLife certificate, a Participating Child Care Provider will be permitted to elect COBRA Continuation Coverage if he or she loses coverage under the Plan because he or she is no longer a Participating Child Care Provider as defined in the certificate. For purposes of this Section, this situation is known as a "Qualifying Loss of Coverage."

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

C. When is a spouse eligible for COBRA Continuation Coverage?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

(1) Your death.

(2) Your spouse's loss of coverage under the Plan due to you sustaining a Qualifying Loss of Coverage.

(3) Divorce or judicial order of legal separation from your spouse.

(4) Your enrollment in Part A or Part B of Medicare.

D. When does my dependent child become eligible for COBRA Continuation Coverage?

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

(1) Your death.

(2) Your dependent child's loss of coverage under the Plan due you sustaining a Qualifying Loss of Coverage.

(3) Divorce or judicial order of legal separation of the dependent child's parents.

(4) Your enrollment in Part A or Part B of Medicare.

(5) The dependent child ceases to qualify as an Eligible Dependent under the Plan.

If, while you are receiving COBRA Continuation Coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your COBRA Continuation Coverage. You must, however, notify the Plan immediately of such a change.

Under New York law, COBRA Continuation Coverage is generally available for up to 36 months following the loss of employer-sponsored coverage due to job loss. If federal COBRA Continuation Coverage has been exhausted under an insured group health plan, qualified beneficiaries will have the opportunity to extend coverage under New York law for an additional 18-month period for up to a total of 36 months following the date federal COBRA Continuation Coverage began.

E. How is a person eligible for COBRA Continuation Coverage notified of his or her eligibility?

You (or, in the event of your death, your spouse or dependent child) have the obligation to notify the Plan of an event that would entitle you, your spouse, or dependent child to COBRA Continuation Coverage. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Plan within the time limits may result in your ineligibility for COBRA Continuation Coverage.

After the Plan receives notice of the occurrence of one of the above events, it will notify each eligible individual whether he or she has the right to elect COBRA Continuation Coverage and will send the materials necessary to make the proper election. In general, the Plan will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the events described above or after it has determined that your regular group health care coverage has terminated.

F. When must the election be made?

The Participating Child Care Provider, spouse, and dependent children each have independent election rights. Covered Participants may elect COBRA Continuation Coverage on behalf of their spouses and parents may elect COBRA Continuation Coverage on behalf of their children. Each individual will have at least 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect COBRA Continuation Coverage, whichever date is later, to inform the Plan that he or she wants COBRA Continuation Coverage.

If no election of COBRA Continuation Coverage is timely made, the individual's group health coverage will terminate. You will not have another opportunity to elect COBRA Continuation Coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA election form is received by the Plan on or before the due date. If you change your mind after first rejecting COBRA Continuation Coverage, your COBRA Continuation Coverage will begin on the date the completed election form is received by the Plan.

G. What type of benefits are available in COBRA Continuation Coverage?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA Continuation Coverage. However, no life insurance, disability benefits, accidental death and dismemberment benefits, or other non-health benefits will be included.

H. What are the consequences of failing to elect or waiving COBRA Continuation Coverage?

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above.

You also have the right to request special enrollment in Marketplace coverage within 60 days after losing your job-based health coverage. These coverage options may coast less than COBRA Continuation Coverage.

You will also have the same special enrollment right at the end of COBRA Continuation Coverage if you get COBRA Continuation Coverage for the maximum time available to you.

I. How long does COBRA Continuation Coverage last?

If the election is due to a Qualifying Loss of Coverage, COBRA Continuation Coverage will end 18 months after your other coverage ended. However, if you, your spouse, or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA Continuation Coverage. If you are the disabled person, your spouse, and your dependent children also qualify for 29 months of this coverage. For certain other situations, such coverage is available for 36 months. COBRA Continuation Coverage will end at an earlier time for any of the following reasons:

(1) The Plan Sponsor no longer provides group health coverage to Participating Child Care Providers.

(2) Failure to pay the monthly premium on time.

(3) The individual becomes covered under another group health plan (other than one sponsored by the Plan Sponsor).

(4) The individual enrolls in Part A or Part B of Medicare.

(5) Circumstances are such that the individual's participation could be canceled if the individual were an active Participating Child Care Provider.

If any of these events occur, the Plan will send you a Notice of Termination of Coverage, explaining the reason the COBRA Continuation Coverage terminated early, the date coverage terminated, and any rights you, your spouse, or your dependent child may have under the Plan to elect alternate coverage.

J. What is the cost of COBRA Continuation Coverage and how is the cost computed?

Each month, any individual electing COBRA Continuation Coverage will be required to make a payment to the Plan (or its designee) to continue COBRA Continuation Coverage. The monthly premium will be based on the average cost which the Plan incurs annually per Participating Child Care Provider plus a two percent administrative charge. The extra 11 months of COBRA Continuation Coverage available to disabled participants will be at a monthly charge based on one and one-half times the average annual per Participating Child Care Provider cost incurred by the Plan.

K. Is there anything else I should know about COBRA Continuation Coverage?

COBRA Continuation Coverage is described in greater detail in a letter sent out by the Plan to each Participating Child Care Provider when the Participating Child Care Provider becomes eligible to participate in the Plan's COBRA Continuation Coverage or when COBRA first became applicable to the Plan, if later. If you have any questions concerning COBRA Continuation Coverage, you should contact the Plan.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA") and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

DOMESTIC PARTNER CONTINUATION COVERAGE UNDER NEW YORK STATE LAW

If your Domestic Partner is covered as your Dependent for purposes of the MetLife certificate under the Plan, the Domestic Partner may also be entitled to continuation coverage if the coverage would otherwise stop, provided that the Domestic Partner elects to continue health care coverage by making premium payments to the Plan pursuant to the Plan's COBRA provisions. This COBRA Continuation Coverage will be offered to a Domestic Partner if coverage under the Plan ends for the following reasons:

(1) Your death;

(2) Your Domestic Partner's loss of coverage under the Plan due you sustaining a Qualifying Loss of Coverage.

(3) Your enrollment in Medicare; or

(4) The dissolution of your relationship with the Domestic Partner.

Such coverage will be subject to the terms and conditions of Federal COBRA Continuation Coverage, set forth above.

PLAN PRIVACY INFORMATION

The Plan will be operated in accordance with the HIPAA privacy laws and regulations thereunder. For more information, see the Plan's SPD.

RIGHTS OF PARTICIPANTS

As a Participating Child Care Provider participating in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits
Examine without charge, at the office of the Plan or at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, 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 EBSA.

Obtain, upon written request to the Trustees, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Trustees may make a reasonable charge for the copies.

Receive a summary of the Plan's annual fiscal report. The Trustees are required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse, or your dependent children 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 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 the 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 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 the 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 the 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 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 a 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 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 Trustees (or their designee). 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 EBSA, U.S. Department of Labor, Boston Regional Office, JFK Federal Building, Room 3575, Boston, Massachusetts 02203, (617) 565-9600 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.

MetLife

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- process claims and other transactions
- perform business research
- confirm or correct your information
- market new products to you
- help us run our business
- comply with applicable laws

Sharing Your Information With Others

We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)

- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. Select "Privacy Policy" at the bottom of the home page. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions/More Information

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
MetLife Insurance Company USA
SafeGuard Health Plans, Inc.
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company