

YOUR BENEFIT PLAN

Mills College - Student Health Plan

All Students

Dental Insurance

Certificate Date: August 15, 2009

Mills College - Student Health Plan
5000 MacArthur Boulevard
Oakland, CA 94613

TO OUR STUDENTS:

All of us appreciate the protection and security insurance provides.

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

Mills College - Student Health Plan



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Mills College - Student Health Plan
Blanket Policy Number: 141855-1-G
Type of Insurance: Dental Insurance
**MetLife Toll Free Number(s):
For Claim Information** FOR DENTAL CLAIMS: 1-800-942-0854

PLEASE AFFIX THE STICKER
SHOWING THE STUDENT'S
NAME AND EFFECTIVE DATE
IN THIS SPACE.

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

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.

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

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 ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third
Little Rock, Arkansas 72204-1904
1-800-852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1-877-310-6560 - toll-free
1-804-371-9032 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

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

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

You may contact the Virginia Office of the Managed Care Ombudsman either by dialing toll free at (877) 310-6560, or locally at (804) 371-9032, via the internet at Web address www.scc.virginia.gov, email at ombudsman@scc.virginia.gov, or mail to:

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

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

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

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.

TABLE OF CONTENTS

Section	Page
CERTIFICATE FACE PAGE	1
NOTICES	2
SCHEDULE OF BENEFITS	12
DEFINITIONS	13
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.....	15
Eligible Classes	15
Date You Are Eligible for Insurance	15
Enrollment Process For Dental Insurance.....	15
Date Your Insurance Takes Effect	15
Date Your Insurance Ends	16
SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER BLANKET DENTAL COVERAGE	17
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT	18
COBRA Continuation.....	18
CAL-COBRA CONTINUATION FOR DENTAL INSURANCE	19
CONTINUATION OF DENTAL BENEFITS AFTER COBRA OR CAL-COBRA CONTINUATION ENDS.....	21
DENTAL INSURANCE	22
DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES.....	25
Type A Covered Services.....	25
Type B Covered Services.....	25
DENTAL INSURANCE: EXCLUSIONS	27
DENTAL INSURANCE: COORDINATION OF BENEFITS.....	29
NOTICE – PROOF OF LOSS – PAYMENT OF CLAIMS	33
DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS.....	34
GENERAL PROVISIONS.....	36
Assignment.....	36
Dental Insurance: Who We Will Pay	36
Entire Contract.....	36

TABLE OF CONTENTS (continued)

Section	Page
Incontestability: Statements Made by You	36
Conformity with State Statutes	36
Legal Actions	36
Overpayments	37

SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Blanket Policy. You will only be insured for the benefits:

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	80%
Type B Services	80%	60%
Deductibles for:		
Yearly Individual Deductible	\$25 for the following Covered Services Combined: Type B	\$25 for the following Covered Services Combined: Type B
Maximum Benefit:		
Yearly Individual Maximum	\$1,000 for the following Covered Services: Type A; Type B;	\$1,000 for the following Covered Services: Type A; Type B;

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.

Cast Restoration means an inlay, onlay, or crown.

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

For Students - Dental Insurance for You.

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that We will pay for such services after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your **dental** condition which is:

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

Deductible means the amount You 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 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 Policy. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

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

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

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.

DEFINITIONS (continued)

Maximum Allowed Charge means the lesser of:

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

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

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.

Reasonable and Customary Charge is the lowest of:

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

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

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.

Student means all registered undergraduate and graduate students of Mills College including registered international students, who have not waived enrollment in the student health insurance plan.

We, Us and Our mean MetLife.

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

Year or Yearly, for Dental Insurance, means the 12 month period that begins January 1.

You and Your means a Student who is insured under the Blanket Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Students of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

You will be eligible for insurance made available to You on the date such insurance takes affect under the Blanket Policy in this certificate on the later of:

1. Fall coverage period for Students is August 15 through January 14.
2. Spring coverage period for Students is January 15 through August 14.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

Mills college doesn't require written application from Students. Mills College will maintain records of all Students registered in each academic semester and will enroll all Students, other than those who provide proof that they have other health coverage that meets the minimum requirements, for coverage under this plan in each academic semester for which they are registered.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

When You become eligible for insurance, insurance will be limited to the Interim insurance shown in the SCHEDULE OF BENEFITS. Such limitation will continue until the next annual enrollment period following the date You first became eligible.

You will be able to enroll for Dental Insurance under the rules of the flexible benefits plan during the next dental enrollment period, following the date You become eligible for such insurance. When You complete the enrollment process during the annual enrollment period, such insurance will take effect on either August 15th or January 15 following the enrollment period.

If You Do Not Enroll When First Eligible

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

Enrollment During Any Dental Enrollment Period

During any enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your Insurance made during an enrollment period will take effect on either August 15th or January 15th.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Blanket Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the last day of the semester in which you are no longer deemed a Student.

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

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER BLANKET DENTAL COVERAGE

The following rules will apply if this Dental Insurance replaces other group dental coverage provided to You by the Policyholder.

Prior Plan means the group dental coverage provided to You by the Policyholder on the day before the Replacement Date.

Replacement Date means the effective date of this Dental Insurance under the Blanket Policy.

Rules if You were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;
2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
 - the loss of a tooth; and
 - the accumulation of amounts toward:
 - a) Annual Deductibles;
 - b) Annual Maximum Benefits;
3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;
4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
 - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
 - the date this Dental Insurance ends.

Rules if You were NOT covered under the Prior Plan on the Day Before the Replacement Date:

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

COBRA CONTINUATION

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

CAL-COBRA CONTINUATION FOR DENTAL INSURANCE

If Dental Insurance for You ends, You may qualify for continuation of such insurance under Cal Cobra, section 10128.50 et seq. Of the California Insurance Code.

Events that Allow Continuation, and Length of Continuation

You may continue dental insurance under This plan for a period of up to 36 months, if Your dental insurance would otherwise end because:

1. Your employment ends for any reason other than Your gross misconduct, or
2. Your hours worked are reduced.

The Policyholder must notify us of Your termination or reduction of hours within 31 days after Your termination or reduction of hours.

Termination of Coverage

With respect to each person who continues insurance, the continued insurance will end on the earliest of:

1. the end of the 36 month continuation period;
2. the date of expiration of the last period for which the required payment was made;
3. the date this plan or coverage for Your class is cancelled;
4. the date the person becomes entitled to Medicare;
5. the date a person becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;
6. the date a person becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);
7. the date a person becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;
8. The first day of the first month that begins more than 31 days after the date of final determination under Title I or Title XVI of the Social Security Act that the person is no longer disabled.

Notice and Election of Coverage

When You become entitled to continue insurance under the plan because of:

- Your termination or
- Your reduction of hours worked,

We will send You, at Your last known address, the necessary premium information and enrollment forms and disclosures within 14 days. You will then have 60 days to elect to continue insurance from the latest of:

1. the date of the event that gives a right to continue coverage;
2. the date You are given notice of a right to continue coverage; and
3. the date coverage under this plan ends.

CAL-COBRA CONTINUATION FOR DENTAL INSURANCE (continued)

When You become entitled to continue insurance under the plan because of:

1. Your receipt of a determination of disability under the terms of the Social Security Act,
2. Your divorce,
3. Your legal separation,
4. Your death, or
5. Your becoming eligible for Medicare.

You must notify us within 60 days. If We do not receive notice within 60 days, the person or persons who would otherwise have been entitled to continue insurance will be disqualified from having dental insurance continued. Your notice and request for continued insurance must be in writing and delivered to Us by first class mail or other reliable means of delivery including personal delivery, express mail, or private courier company.

Cost of Continued Insurance

Any person who elects to continue insurance under the plan must pay not more than 110% of the full cost of that insurance (including both the share You now pay and the share Your Policyholder now pays).

Premium Payment

The first premium payment must be made within 45 days of Your election to continue insurance. Your first premium payment must be sufficient to pay all required premiums and all premiums due. The premium payment must be sent to Us by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company. After the first premium payment Your payments for continued coverage must be made on the first day of each month in advance. Failure to submit the correct premium amount within the 45-day period will disqualify the person(s) to whom the premium relates from receiving continued insurance.

Exceptions

This right to continue coverage under This plan does not apply:

1. to a person who is not a resident of California;
2. to a person who is covered by or eligible to be covered by Medicare;
3. to a person who is covered or who becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;
4. to a person who is covered, or becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);
5. to a person who is covered, or becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;
6. to a person who fails to meet any one or more of the time limits set forth above for notice and election of coverage;
7. to a person who fails to submit the correct premium when or before it is due;
8. if at the time coverage under this plan ends the Policyholder has 20 or more employees; or
9. if the Policyholder fails to notify Us of Your termination or reduction in hours within 31 days.

CONTINUATION OF DENTAL BENEFITS AFTER COBRA OR CAL-COBRA CONTINUATION ENDS

Continuation Of Dental Benefits For You After Cobra Or Cal-Cobra Continuation Ends

If Dental Insurance for You ends under COBRA or Cal-Cobra because You have exhausted the continued benefit, You will be eligible to continue such Dental Insurance for an additional period of time under this provision if:

1. You were age 60 or older with 5 or more years of service with your employer at the time Your employment ended, and You became eligible for COBRA or Cal-COBRA at that time;
2. You elected to continue Dental Insurance for You under COBRA or Cal-COBRA when eligible; and
3. You are under age 65 and are not eligible for benefits under Medicare.

To continue Dental Insurance under this provision, You must elect to continue coverage by notifying Us within 30 days before the date the COBRA or Cal-COBRA continuation ends. The Dental Insurance will then continue to the earliest of the following:

1. the date You attain age 65;
2. the date You become covered for dental insurance under another group plan;
3. the date You become entitled to Medicare;
4. the date premiums cease to be paid to Us for the continued insurance; or
5. the date Dental Insurance under the policy ends for all active employees, or for the class of active employees to which You belonged before Your employment terminated.

The premium for continued insurance may be up to 213% of the premium charged active members of the group.

DENTAL INSURANCE

If You 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, the extent to which benefits, if any, are payable will be determined according to the conditions set forth in this certificate.

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

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

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

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

BENEFIT AMOUNTS

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

The Covered Percentage for Covered Services performed by an In-Network Dentist is higher than the Covered Percentage for Covered Services performed by an Out-of-Network Dentist.

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:

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

DENTAL INSURANCE (continued)

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 Reasonable and Customary Charge.

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

- the Deductible; and
- any other part of the Reasonable and Customary Charge for which We do not pay benefits; and
- any amount in excess of the Reasonable and Customary 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.

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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.

If a charge is incurred for a Covered Service during the last 3 months of any Year and is applied to the Deductible of that Year, such charge will also be applied to the Deductible for the next Year.

Alternate Benefit

If it is determined according to generally accepted dental standards 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.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You 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 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 for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 31 days after the date the insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams twice in a Year.
2. Full mouth or panoramic x-rays once every 60 months.
3. Bitewing x-rays, 1 set in a Year.
4. Intraoral-periapical and extraoral x-rays.
5. Cleaning of teeth (oral prophylaxis) twice in a Year.
7. Emergency palliative treatment to relieve tooth pain.
8. Topical fluoride treatment for a Student under age 19, once in a Year.
6. Space maintainers for a Student under age 19.

Type B Covered Services

1. Amalgam or resin fillings.
2. Oral Surgery, except as mentioned elsewhere in this certificate.
3. Consultations, but not more than twice in a 12 month period.
4. Root canal treatment, but not more than once in any 24 month period for the same tooth.
5. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
6. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
7. Simple extractions.
8. Surgical extractions.
9. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any Year less the number of teeth cleanings received during such 12 month period.
10. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
11. Pulp therapy and apexification/recalcification.
12. 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.
13. Injections of therapeutic drugs.
14. Re-cementing of Cast Restorations or Dentures.
15. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.
16. Tissue conditioning.
17. Simple Repairs of Cast Restorations or Dentures.
18. Sealants for a Student under age 16, once per tooth every 36 months.
19. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
20. Occlusal adjustments.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

21. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
22. Diagnostic casts
23. Local chemotherapeutic agents
24. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.

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 before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist which are supervised and billed by a Dentist, and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. services:
 - covered under any workers' compensation or occupational disease law;
 - covered under any employer liability law; or
 - received at a facility maintained by the Policyholder.
15. services covered under other coverage provided by the Policyholder;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
 - claim form completion;
 - infection control, such as gloves, masks, and sterilization of supplies; or
 - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. sedative fillings;
24. initial installation of, or replacement of, Cast Restorations;
25. prefabricated stainless steel crown or prefabricated resin crown;

DENTAL INSURANCE: EXCLUSIONS (continued)

26. labial veneers;
27. core buildup and cast post and core;
28. initial installation or replacement of Dentures or Implants;
29. relinings and rebasings of Dentures;
30. modification of removable prosthodontic and other removable prosthetic services;
31. implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
32. repair of implants;
33. fixed partial Dentures;
34. other fixed Denture services;
35. fixed and removable appliances for correction of harmful habits;
36. appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
37. precision attachments associated with fixed and removable prostheses;
38. replacement of a lost or stolen appliance, Cast Restoration or Denture;
39. orthodontic services or appliances;
40. repair or replacement of an orthodontic device;
41. diagnosis and treatment of temporomandibular joint disorders;
42. intra and extraoral photographic images.
43. implant supported prosthetics.
44. other fixed Denture prosthetic services not described elsewhere.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

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

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

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

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

The term does not include:

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

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

Claim Determination Period means a period that starts on any 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.

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

- a group insurance plan;
- an HMO;
- 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;
- any other coverage required or provided by any law or any governmental program.

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;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

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

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

Will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both insured under This Plan as Certificateholders, 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 Policyholder (or an affiliate) contributes to or sponsors.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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.

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, subscriber or certificateholder (or as that employee’s, member’s, subscriber’s or certificateholder’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.

NOTICE - PROOF OF LOSS - PAYMENT OF CLAIMS

NOTICE AND PROOF OF LOSS

Notice of Claim: Written notice of claim must be given to MetLife within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to MetLife, or to any authorized agent of MetLife, with information sufficient to identify the insured, shall be deemed notice to MetLife. Notice of Claim may be sent to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Claims Forms: MetLife, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to MetLife, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which MetLife is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIM

Time of Payment of Claim: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid (to the insured) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured) monthly, and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: If any indemnity of this policy shall be payable to the estate of the insured, or to an insured who is a minor or otherwise not competent to give a valid release, MetLife may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the insured who is deemed by MetLife to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge MetLife to the extent of such payment.

PHYSICAL EXAMINATION

MetLife at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Policyholder 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 1-800-942-0854.

Claim Submission

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

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

Initial Determination

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

Such notification will be provided to You within a 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of 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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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 Member, Participant, or Certificateholder
- Name of the Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

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

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

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

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

GENERAL PROVISIONS

Assignment

The rights and benefits under the Blanket 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 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. The entire contract with the Policyholder is made up of the following:

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

Incontestability: Statements Made by You

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

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

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

Conformity with State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

Legal Actions

No civil action shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action will be brought after the expirations of 3 years after the time written proof of loss is required to be furnished.

GENERAL PROVISIONS (continued)

Overpayments

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

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

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

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

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

PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means Mills College - Student Health Plan.

The term "Plan Administrator" means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to be the Plan Administrator.

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

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

Not use or further disclose PHI other than as permitted or required by the plan documents entitled "Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor" and "Uses and Disclosures of PHI by the Plan Sponsor for Required Purposes" above;

Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

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

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

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

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

IV. Security

As a condition of the Plan Sponsor receiving electronic PHI (“ePHI”) from the Plan, the Plan Documents are hereby amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

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