

YOUR BENEFIT PLAN

Ohio Public Employees Retirement System

Dental Insurance for You and Your Dependents

**All Participants not including Residents of
Louisiana, Mississippi, Montana or Texas**

Certificate Date: January 1, 2019

Low Option Dental Plan

Certificate Number 19

Ohio Public Employees Retirement System
277 East Town Street
Columbus, OH 43215-4642

TO OUR PARTICIPANTS:

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.

Ohio Public Employees Retirement System

MetLife

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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Ohio Public Employees Retirement System

Group Policy Number: 128809-G

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):

For Claim Information FOR DENTAL CLAIMS: 1-888-262-4874

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

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.

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.

IF YOU ARE COVERED BY OTHER DENTAL INSURANCE, PLEASE READ THE PROVISIONS ENTITLED COORDINATION OF BENEFITS

Notice: If You or Your family members are covered by more than one health care plan, you may not be able to collect benefits from all plans. Each plan may require you to follow its rules or use specific dentists and it may be impossible to comply with all plans at the same time. Read all of the rules very carefully, including the coordination of benefits section and compare them with the rules of any other plan that covers you or your family. In no case does this plan require that you use specific dentists.

For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that You have health insurance coverage. If You do not have other health insurance coverage, You may be subject to a federal tax penalty.

For New Hampshire Residents: 30 Day Right to Examine Certificate.

Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

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 ALASKA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

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

For Alaska Residents (Dental Insurance):

The term also includes newborns.

For Minnesota Residents (Dental Insurance):

The term also includes:

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

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For New Hampshire Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

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

For Utah Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

For Washington Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

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.

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

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

Reasonable Access to an In-Network Dentist

If You do not have an In-Network Dentist within 50 miles of Your legal residence, We will reimburse You for the cost of Covered Services and materials provided by an Out-of-Network Dentist at the same benefit level as an In-Network Dentist.

Exclusions

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

Coordination of Benefits or Non-Duplication of Benefits with a Secondary Plan:

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

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

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. 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 1-888-262-4874.

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.

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

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 MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because You did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify You as to its claim decision. You will have 45 days to provide the requested information from the date You receive the notice requesting further information from MetLife.

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

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

Appealing the Initial Determination

If MetLife denies Your claim, You may appeal the denial. Upon Your written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim. You must submit Your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision, or as soon as reasonably possible for situations in which You cannot reasonably meet the deadline. Appeals must be in writing and must include at least the following information:

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

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

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

After MetLife receives Your written request, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. Your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. MetLife will notify You in writing of its final decision within 18 days after MetLife's receipt of Your written request for review.

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

Second Level Appeal

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

External Appeal

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

Overpayments

Recovery of Overpayments

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

An overpayment occurs if it is determined that:

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

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

NOTICE FOR RESIDENTS OF ALASKA

Overpayments (Continued)

How We Recover Overpayments

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

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

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

NOTICE FOR RESIDENTS OF 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 Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

**METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904**

1-888-262-4874

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 DEPARTMENT OF INSURANCE DEPARTMENT AT:

**DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013**

WEBSITE: <http://www.insurance.ca.gov/>

**1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for dental insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

"Domestic Partner means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

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

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

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

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 IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. 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:

Idaho Department of Insurance

Consumer Affairs

700 West State Street, 3rd Floor

PO Box 83720

Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-888-262-4874**

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

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

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

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

NOTICE FOR RESIDENTS OF MAINE

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

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DENTAL INSURANCE

1. If Your Dental Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Dental Insurance ends because:
 - You cease to be in an Eligible Class; or
 - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Dental Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Dental Insurance for Your former Spouse that would otherwise end may be continued.

To continue Dental insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Dental Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- 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 date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If Your former Spouse is eligible to continue Dental Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it ends because Your employment ends unless:

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

The Employer must give You written notice of:

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

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

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

To continue Your Dental Insurance, You must:

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

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

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

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Dental Insurance; or
- the date You become eligible for coverage under any other group Dental coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

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

If Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Dental Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Dental Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

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

The premium that You or Your former Spouse must pay for continued Dental Insurance for Your Dependents may include:

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

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

- send a written request to continue Dental Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Dental Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Dental Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Dental Insurance will end on the earliest of the following to occur:

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

NOTICE FOR NEW HAMPSHIRE RESIDENTS

The following service will be a Covered Service for New Hampshire residents whether or not general anesthesia or intravenous sedation is already specified elsewhere as covered:

General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when

- the covered person is a Child under the age of 6 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition;
- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or
- We determine such anesthesia is necessary in accordance with generally accepted dental standards.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Dental Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

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

NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

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

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

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE TO 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 Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-888-262-4874

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.

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

Or:

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

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.

NOTICE TO RESIDENTS OF VIRGINIA (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 Employee;
- Name of the Plan;
- Reference to the initial decision;
- Whether the appeal is the first or second appeal of the initial determination;
- An explanation why You are appealing the initial determination.

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

After MetLife receives Your written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that You submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review Your appeal will not be the same person as the person who made the initial decision to deny Your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny Your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of dentistry involved in the judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination. MetLife will notify You in writing of its final determination within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, MetLife will notify You prior to the expiration of the 30 day period, state the reason(s) why an extension is needed, and state when it will make its determination.

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

Policies and Procedures for Emergency and Urgent Care

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

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

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

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Urgent Care Submission:

A small number of claims for dental expense benefits may be urgent care claims. Urgent care claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted MetLife will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim is filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. MetLife will provide you any necessary information to assist you in your appeal. MetLife will then notify you of its decision within 72 hours of your request in writing. However, MetLife may notify you by phone within the same time frames above and then mail you a written notice.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

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

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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, New York 10166
1-888-262-4874

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.

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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;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services Palliative Treatment	100%	100%
Type A Services All other Type A	100%	80%
Type B Services	60%	50%
Type C Services	25%	25%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	\$100 for the following Covered Services Combined: Type B; Type C	\$100 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$1,250 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.

Benefit or Benefits means: For purposes of this certificate, and the dental coverage offered to Participants under Group Dental Insurance Policy number 128809-G, Benefits shall refer only to the dental coverage so offered. Benefits shall not refer to or include the pension benefits offered to eligible retirees, disability recipients and/or survivors pursuant to Chapter 145 of the Ohio Revised Code.

Cast Restoration means an inlay, onlay, or crown.

Child means the following: (for residents of ALASKA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case, is:

- under age 26 and;
- supported by You; and
- not employed on a full-time basis.

The definition of Child includes newborns.

An adopted child includes a child placed in Your physical custody for purpose of 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.

For the purposes of determining who may become covered for insurance, 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 Participant.

Coinsurance means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that You are responsible for paying 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 You are responsible for paying for such services after any required Deductible is satisfied.

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

Contributory Insurance includes: Dental Insurance.

GCERT2000

Def as amended by GCSCR10-11

DEFINITIONS (continued)

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 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.

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.

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

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

Dependent(s) means:

- for a Participant who is an Ohio Public Employees Retirement System retiree, or disability recipient, Your Spouse and/or Child;
- for a Participant who is an Ohio Public Employee Retirement System surviving spouse, Your Child who qualified as Your Child on the date You became a surviving spouse; and
- a Participant who is an Ohio Public Employee Retirement System survivor who is not a surviving spouse, so long as the survivor meets the definition of a child.

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.

GCERT2000

Def as amended by GCSCR10-11

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.

Participant means an Ohio Public Employee Retirement System retiree, disability recipient, survivor and his or her eligible dependent.

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

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 he performs the service and must act within the scope of that license. He 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.

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.

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) (the 'Actual Charge'); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the 'Usual Charge'); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 70th 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.

DEFINITIONS (continued)

An example of how the 70th 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 70th percentile of charges is the charge that is equal to the charge numbered 70.

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.

For the purposes of determining who may become covered for insurance, 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 Participant.

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** a Participant who is insured under the Group Policy for the insurance described in this certificate and who is an Ohio Public Employees Retirement System retiree, disability recipient or survivor. With respect to the exercising of rights and receipt of money for a survivor who is a minor, such exercise or receipt by the minor's guardian or parent will be considered to be the action of the minor.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

The insurance for residents of Louisiana, Mississippi, Montana and Texas is provided for under other certificates. Therefore, for purposes of this certificate, residents of Louisiana, Mississippi, Montana and Texas are not deemed to be members of the Eligible Class set forth below:

All Participants of the Ohio Public Employees Retirement System who are retirees or disability recipients and surviving spouses of retiree or disability recipient Participants of the Ohio Public Employees Retirement System.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on January 1, 2019, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2019, You will be eligible for insurance on 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 the OPERS Open Enrollment Packet. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your monthly pension check. You will be notified by the Policyholder how much You will be required to contribute.

The Dental Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dental Insurance only when You are first eligible, during the annual open enrollment period or if You have a Qualifying Event.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible.

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 annual enrollment period for Dental Insurance, as determined by the Policyholder, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

Enrollment During an Annual Open Enrollment Period

During any annual open enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. If You are not currently enrolled for Dental Insurance but You enroll during an enrollment period, the Dental Insurance takes effect on the first day of the calendar year following the enrollment period.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment Due to a Qualifying Event

You may enroll for insurance, for which You are eligible, or change the amount of Your insurance between annual open enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event, will take effect on the first day of the month following the date of Your request.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment; or
- the death of a dependent.

YOUR IDENTIFICATION CARD

You will receive identification cards. These cards have Your name, Group Policy Number and ID number on them. It is recommended that Your identification card be presented when receiving Benefits under this coverage because it contains information You or Your Dentist will need when submitting a claim or making an inquiry. Your receipt or possession of an identification card does not mean you are automatically entitled to Benefits.

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; or
4. the date Your membership in the Eligible Class ends.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

The insurance for residents of Alaska, Louisiana, Mississippi, Montana and Texas is provided for under other certificates. Therefore, for purposes of this certificate, residents of Louisiana, Mississippi, Montana and Texas are not deemed to be members of the Eligible Class set forth below:

All Participants of the Ohio Public Employees Retirement System who are retirees or disability recipients and surviving spouses of retiree or disability recipient Participants of the Ohio Public Employees Retirement System.

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.

If You are in an eligible class on January 1, 2019, You will be eligible for Dependent insurance on the later of:

1. January 1, 2019; and
2. the date You obtain a Dependent.

If You enter an eligible class after January 1, 2019, You will be eligible for Dependent insurance on the later of:

1. the date You enter a class eligible for insurance; and
2. the date You obtain a Dependent.

No person may be insured as a Dependent of more than one Participant.

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 must also give the Policyholder Written permission to deduct premiums from Your monthly pension check. You will be notified by the Policyholder 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.

The Dental Insurance has a regular enrollment period established by the Policyholder. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance only when You are first eligible, during an enrollment period or if You have a Qualifying Event.

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the date You become eligible.

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 Dependent Insurance until the next annual 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.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During an Annual Open Enrollment Period

During any annual open enrollment period as determined by the Policyholder, You may enroll for Dependent Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. If You are not currently enrolled for Dependent Insurance but You enroll during an enrollment period, the Dependent Insurance takes effect on the first day of the calendar year following the enrollment period.

Enrollment Due to a Qualifying Event

You may enroll for Dependent Insurance for which You are eligible or change the amount of Your Dependent Insurance between annual open enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request.

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment; or
- the death of a dependent.

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the end of the period for which the last premium has been paid; or
8. the date the person ceases to be a Dependent, or the last day of the calendar month in which a Dependent Child reaches the age of 26.

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

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 child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR 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 because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

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. Dentists participating in the MetLife Preferred Dentist Program have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the MetLife Preferred Dentist Program, 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 MetLife Preferred Dentist Program 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 1-888-262-4874 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.

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.

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.

DENTAL INSURANCE (continued)

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 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.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in

DENTAL INSURANCE (continued)

multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

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 for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your insurance ends; and
- the device is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 31 days after the date the 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. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), twice in a Year.
4. Problem-focused exams once in a Year.
5. Full mouth or panoramic x-rays once every 60 months.
6. Bitewing x-rays 1 set in a Year.
7. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
8. Emergency palliative treatment to relieve tooth pain.
9. Topical fluoride treatment for a Child under age 16 once in a Year.
10. Space maintainers for a Child under age 14 once per lifetime per tooth area.
11. Sealants or sealant repairs for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
12. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
13. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.

Type B Covered Services

1. Intraoral-periapical x-rays.
2. X-rays, except as mentioned elsewhere.
3. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
4. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
5. Diagnostic casts.
6. Amalgam fillings.
7. resin-based composite fillings.
8. Protective (sedative) fillings.
9. Biopsies of hard or soft oral tissue and histopathologic exams .
10. Oral surgery, except as mentioned elsewhere in this certificate.
11. Root canal treatment except for molars.
12. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
13. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period
14. Full mouth debridements.
15. Simple extractions.
16. Extraction of Erupted teeth.
17. Extraction of impact soft tissue tooth.
18. Removal of residual tooth roots.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

19. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such year.
20. Pulp capping (excluding final restoration).
21. Therapeutic pulpotomy (excluding final restoration).
22. Pulp therapy.
23. Apexification/recalcification.
24. Pulpal regeneration, but not more than once per lifetime.
25. Injections of therapeutic drugs.
26. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
27. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.
28. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
29. Occlusal adjustments, but not more than once in a 12 month period.
30. After hours office visit.

Type C Covered Services

1. 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.
2. Local chemotherapeutic agents.
3. Initial installation of full or partial Dentures (other than implant supported prosthetics).
4. Addition of teeth to a partial removable Denture.
5. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
6. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
7. 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.
8. Other removable prosthetic services not described elsewhere.
9. 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.
10. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.
11. Initial installation of Cast Restorations (except implant supported Cast Restorations).
12. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:
 - a Cast Restoration was installed for the same tooth; or
 - a Cast Restoration for the same tooth was replaced.
13. Core buildup, but no more than once per tooth in a period of 10 Years.
14. Posts and cores, but no more than once per tooth in a period of 10 Years.
15. Labial veneers, but no more than once per tooth in a period of 10 Years.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

16. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
17. Other consultations, but not more than once in a 12 month period.
18. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 3 Year period.
19. Surgical extractions of impacted partial and complete teeth.
20. Coronectomy.
21. 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 10 Year period.
22. Repair of implants, but no more than once in a 10 year period.
23. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period.
24. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period.
25. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period.
26. Tissue conditioning, but not more than once in a 36 month period.
27. Simple repair of Cast Restorations or Dentures other than recementing.
28. Cleaning and inspection of a removable appliance twice in a Year.
29. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, 1 in 24 months.
30. Repair/Reline and adjustments of occlusal guards and night guards, 1 in 24 months.
31. Root canals on molars.

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
 - 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. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. 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 required to pay; or
 - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
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. 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;
21. caries susceptibility tests;
22. fixed and removable appliances for correction of harmful habits;
23. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
24. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
25. duplicate prosthetic devices or appliances;
26. replacement of a lost or stolen appliance, Cast Restoration or Denture;
27. orthodontic services or appliances;

DENTAL INSURANCE: EXCLUSIONS (continued)

28. repair or replacement of an orthodontic device;
29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
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 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.

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

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

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

- 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.

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;
- 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, which limit benefits based on benefits or services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors 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.

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 plans which the Policyholder (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.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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).

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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.

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

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.

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.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

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

- 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

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-888-262-4874. 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 90 days of the date of a loss.

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

Step 1

A claimant can request a claim form by calling Us at 1-888-262-4874.

Step 2

We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3

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

Step 4

The claimant must give Us Proof not later than 90 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 may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

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 MetLife who can also answer questions about the insurance benefits and to assist You or, if applicable, Your Dentist 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 1-888-262-4874.

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

Such notification will be provided to You within a 24 day period from the date We received the completed 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 24 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 the claim in whole or in part, the notification of the claims decision will state the reason why the 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 the claim, You or Your Dentist may take two appeals of the initial determination. Upon written request, MetLife will provide You or your Dentist free of charge with copies of documents, records and other information relevant to the claim. You or Your Dentist must submit the 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
- An explanation why You or Your Dentist are appealing the initial determination.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

After MetLife receives the written request appealing the initial determination or determination on the first appeal, MetLife will conduct a full and fair review of the 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 or Your Dentist submit relating to Your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review the appeal will not be the same person as the person who made the initial decision to deny the 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 the 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 the 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 the claim.

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. 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 Group 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 Law

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

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.

GENERAL PROVISIONS (continued)

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