YOUR EMPLOYEE DENTAL BENEFIT PLAN

METROPOLITAN TRANSPORTATION AUTHORITY

NEW YORK CITY TRANSIT

Applies to Active and Retired Employees in the following groups:

- **Non-Represented Operating Supervisory-Maintenance Supervisors Level II [also known as MS II and Console Train Dispatchers]**
- **Subway Surface Supervisory Association [also known as the SSSA (Retired on or after January 1, 2001)]**
- **Transport Workers Union-Local 106, Transit Supervisors Organization (Operating and Queens Division) [also known as TSO Operating (Retired on or after January 1, 2001)]**
- **TSO-Station Supervisory Level II [also known as SS II (Retired on or after June 1, 2001)]**

Effective January 1, 2008

Exhibit Number 26

Metropolitan Transportation Authority

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Benefits are provided through a group policy issued to Metropolitan Transportation Authority by Metropolitan Life Insurance Company.

Metropolitan Transportation Authority

MetLife®

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

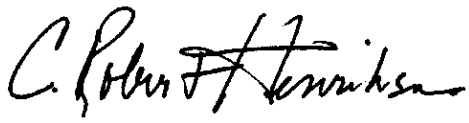
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Policyholder, coverage is provided for each Employee as defined herein.

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

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

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

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



C. Robert Henrikson
President and Chief Operating Officer

Policyholder: **Metropolitan Transportation Authority**

Group Policy No.: **94072-G**

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

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

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

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-638-5433

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

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

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

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

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-638-5433

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

1-800-252-3439

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

Web: http://www.tdi.state.tx.us

Email: ConsumerProtection@tdi.state.tx.us

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

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

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

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

1-800-638-5433

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

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

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

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

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

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

Georgia residents please be advised of the following:

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF PENNSYLVANIA

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

Benefits will continue if such Dependent child:

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

Subject to the When Benefits Ends section entitled this continuation will continue until the earliest of the date:

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

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

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

PEOPLE ENTITLED TO COVERAGE

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

POLICIES COVERED

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

EXCLUSIONS AND LIMITATIONS

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

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

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

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

DISCLAIMER

PLEASE READ CAREFULLY:

- **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**
- **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**
- **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**
- **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**
- **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

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

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

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

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

1-800-638-5433

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-877-310-6560 - toll-free
1-804-371-9032 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

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

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE AND DEPENDENT)	In-Network	Out-of-Network	AMOUNT
DENTAL EXPENSE BENEFITS			
MAXIMUM ALLOWABLE	See DENTAL EXPENSE BENEFITS Section J, SCHEDULE OF DENTAL SERVICES AND MAXIMUM ALLOWABLE		
MAXIMUMS			
Applicable to Active and Retired Employees			
For Orthodontic Treatment			
Aggregate Maximum Benefit			
(For All Dental Expense Periods)			$1,000
Applicable to Active Employees			
For Other Covered Dental Expenses			
Maximum Benefit			
(For One Dental Expense Period)			$1,500
Applicable to Retired Employees			
For Other Covered Dental Expenses			
Maximum Benefit			
(For One Dental Expense Period)			$1,250
(For All Dental Expense Periods)			$10,000

NOTE(S)

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

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

If a dental bill is expected to be $150 or more, see DENTAL EXPENSE BENEFITS, section F. PRE-DETERMINATION OF BENEFITS.

COORDINATION OF BENEFITS

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

WHEN YOU RETIRE

Dental Expense Benefits are provided under This Plan on and after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

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

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

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

2. to reduce the benefits;

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

a. The statement must be contained in a written application which has been signed by you.

b. A copy of the application has been furnished to you.

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

B. Assignment

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

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

C. Refund to Us for Overpayment of Benefits

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

1. all or some of those expenses were not paid for by the Covered Persons in your Family; or

2. any Covered Person in your Family was repaid for all or some of those expenses by a source other than from:

a. an insurer under a policy of insurance issued to you in your name; and

b. an insurer under a policy of insurance issued to a Covered Person in your Family who ordinarily lives in your home; and

c. us;

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

1. the amount of Dental Expense Benefits paid by us for those expenses; and

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

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

D. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.

2. No agent has the authority:

a. to accept or to waive the required proof of a claim; nor

b. to extend the time within which a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;

2. provided you are not disabled.

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

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

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

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

3. a child who:

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

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

c. is 25 years of age or older.

However, if you reside in Texas, the limiting age for children and grandchildren will not be less than 25 regardless of student status or military service status. Grandchildren must be living with you and dependent on you for financial support.

Please note, if you reside in New Mexico, the limiting age for children will not be less than 25 regardless

of student status.

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

a. that child is and remains unable to work in self-sustaining employment because of:

i. physical handicap; or

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

b. that child is and remains chiefly dependent upon you for support; and

c. that child is and remains a Dependent, as defined, except for the age limit; and

d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us.

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

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

b. a child who is legally adopted; and

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

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

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

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

2. the service performed by the practitioner is within the scope of his or her license.

"Employee" means a person who is employed and paid for services by the Employer on a full-time basis and who is either active or retired from one of the following groups:

- Non-Represented Operating Supervisory-Maintenance Supervisors Level II
  [also known as MS II and Console Train Dispatchers]
- Subway Surface Supervisory Association
  [also known as the SSSA (Retired on or after January 1, 2001)]
- Transport Workers Union-Local 106, Transit Supervisors Organization
  (Operating and Queens Division) [also known as TSO Operating
  (Retired on or after January 1, 2001)]
- TSO-Station Supervisory Level II
  [also known as SS II (Retired on or after June 1, 2001)]

"**Employer**" means New York City Transit, an employer participating in the MTA Consolidated Managerial Plan, which provides Dental Expense Benefits for Employees.

"Family" means you and your Dependents.

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

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

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

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

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

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

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

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are an Employee on January 1, 2008, that is your Personal Benefits Eligibility Date.

If you become an Employee after January 1, 2008, your Personal Benefits Eligibility Date is the first day of the month following the date you become an Employee of the Employer.

Dependent Benefits Eligibility Date

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

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

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

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Effective Date

Your Dependent Benefits will become effective on the later of:

1. your Dependent Benefits Eligibility Date; and

2. the effective date of your Personal Benefits.

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

B. New Dependents

Dependent Benefits with respect to a person who becomes your Dependent while you are insured for Dependent Benefits will be effective on the first day of the calendar month following the date such person becomes your Dependent.

Form G.23000-D2

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

"Covered Dental Expense" means:

For Both In-Network and Out-of-Network Benefits

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

1. performed or prescribed by a Dentist who is:

a. a Participating Provider; or

b. a Non-Participating Provider; and

2. necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards.

Any part of a charge for a type of dental service which is more than the Maximum Allowable for that service as determined in accordance with section J will not be a Covered Dental Expense.

With respect to In-Network Benefits and Out-of-Network Benefits, there may be more than one way to treat a dental problem. If, in our view, an adequate method or material which costs less could have been used, the Dental Expense Benefits will be based on the method or material which costs less. The rest of the cost will not be a Covered Dental Expense.

"Dental Expense Period" means a period which starts on any January 1 and ends on the next December 31.

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

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

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

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

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

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

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

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

1. are located in the Covered Person's area; and

2. have been selected by us to be Participating Providers and part of the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

The list will be periodically updated.

B. COVERAGE

1. When Benefits May Be Payable

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

a. for a Covered Person during a Dental Expense Period; and

b. while you are covered for the Dental Expense Benefits for that Covered Person.

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

a. for a Covered Person during a Dental Expense Period; and

b. while you are covered for the Dental Expense Benefits for that Covered Person.

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

2. How Benefits Are Determined

Benefits will be equal to not more than the maximum allowable amount shown in section J for those Covered Dental Expenses. However:

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

b. **Orthodontic Covered Services** - Orthodontic treatment generally consists of initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist. Orthodontic treatment also includes other services required for the orthodontic treatment such as transseptal fibrotomy and extractions of certain teeth.

Upon the initial placement of the appliance, which may include other services such as the initial workup, we will pay an amount not to exceed 20% of the Covered Expense times the Covered Percentage for Orthodontic Treatment.

After the initial placement of the orthodontic appliance we will pay any remaining benefit during the course of the orthodontic treatment (including periodic follow-up visits) as follows:

i. The amount payable during the scheduled course of the orthodontic treatment will be the lower of:

(a) the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia; and

(b) the remaining amount of the Aggregate Maximum Benefit for Orthodontic Treatment (For All Dental Expense Periods).

ii. We will divide the benefit payable for the course of the orthodontic treatment by the number of months in the scheduled course of the orthodontic treatment (but no more than 24 months). We will use 3 times the resulting amount as the most we will pay for each 3-month period during the scheduled course of the orthodontic treatment.

Benefits will only be payable during the scheduled course of the orthodontic treatment if:

i. Dental Expense Benefits are in effect for the person receiving the orthodontic treatment; and

ii. proof is given to us that the orthodontic treatment is continuing.

For minor orthodontia services that are performed in one visit and do not require follow-up visits, we will pay the amount of the Covered Dental Expense times the Covered Percentage for Orthodontia.

The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment, will not be more than the applicable Aggregate Maximum Benefit for Orthodontic Treatment as shown in the SCHEDULE OF BENEFITS. This includes any services required for orthodontia received prior or related to the initial placement of an orthodontia appliance.

Benefits For Orthodontic Services Begun Prior To This Dental Insurance - If the initial placement of the appliance was made prior to these Dental Expense Benefits being in effect, no benefits will be payable under these Dental Expense Benefits for the initial placement of the appliance.

If periodic follow-up visits commenced prior to these Dental Expense Benefits being in effect:

i. the number of months for which benefits are payable based on the scheduled course of orthodontic treatment will be reduced by the number of months of treatment performed before these Dental Expense Benefits were in effect; and

ii. the total amount of the benefit payable that we would have normally provided for treatment which was started while these Dental Expense Benefits were in effect will be reduced proportionately.

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

3. How the Preferred Dentist Program Works

Free Choice Of A Dentist:

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

a. a Participating Provider; or

b. a Non-Participating Provider.

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

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

a. Oral exams but not more than twice in a Dental Expense Period.

b. Full mouth or panoramic X-rays once every 36 months.

c. Bitewing X-rays but not more than twice in a Dental Expense Period for all Covered Persons.

d. Intraoral-periapical X-rays and other X-rays not specified above.

e. Cleaning of teeth (oral prophylaxis) but not more than twice in a Dental Expense Period.

f. Pulp vitality tests, diagnostic casts, and bacteriological studies for determination of pathologic agents.

g. Topical fluoride treatment for a Dependent child up to 19 years of age but not more than once in a Dental Expense Period.

h. Emergency palliative treatment to relieve tooth pain.

i. Space maintainers for a Dependent child up to 19 years of age.

j. For a Dependent child up to 14 years of age, sealants which are applied to non-restored, non-decayed, first and second permanent molars, once per tooth for all Dental Expense Periods.

2. Type B Expenses

a. Initial placement of amalgam or composite fillings.

b. Replacement of an existing amalgam or composite fillings.

c. Sedative fillings.

d. Repair or re-cementing of Cast Restorations.

e. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).

f. Pulp therapy and apexification/recalcification.

g. Periodontal maintenance but limited to 4 times in a Dental Expense Period less the number of teeth cleanings received during such year.

h. Treatment of periodontal disease (other than by periodontal maintenance) and treatment of other diseases of the gums and tissues of the mouth.

i. Oral surgery.

j. Extractions of unimpacted teeth and removal of exposed roots.

k. Extractions of impacted teeth.

l. Root canal treatment but not more than once for the same tooth in a Dental Expense Period.

m. 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.

n. Consultations.

o. Injections of therapeutic drugs.

p. Local chemotherapeutic agents.

q. Repair of Dentures.

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

r. Relinings and rebasings of existing removable Dentures:

i. if at least 6 months have passed since the installation of the existing removable Denture; and

ii. not more than once in any 36 month period.

s. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture.

3. Type C Expenses

a. Initial installation of Cast Restorations.

Cast Restoration means an inlay, onlay, or crown.

b. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but not more than one replacement for the same tooth within 60 months.

c. Prefabricated stainless steel crown or prefabricated resin crown, in either case, only for primary teeth but not more than once in any 60 month period.

d. Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of 60 months.

e. Initial installation of full or removable Dentures when needed to replace natural teeth that are lost while the Covered Person receiving such benefits was insured for Dental Expense Benefits under this certificate.

f. Replacement of a non-serviceable Denture if such Denture was installed more than 60 months prior to replacement.

g. 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.

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

4. Type D Expenses

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

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

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

1. Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.

2. Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:

a. scaling and polishing of teeth; or

b. fluoride treatments.

3. Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:

a. it otherwise is a Covered Dental Expense; and

b. it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or

c. it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.

4. Repair or replacement of an orthodontic appliance.

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

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

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

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

9. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.

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

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

12. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.

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

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

15. Periodontal splinting.

16. Temporary or provisional restorations.

17. Temporary or provisional appliances.

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

19. Myofunctional therapy or correction of harmful habits.

20. Implantology.

21. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

22. Charges for broken appointments.

23. Charges by the Dentist for completing dental forms.

24. Sterilization supplies.

25. Services or supplies furnished by a family member.

26. Treatment of temporomandibular joint disorders.

E. ALTERNATE BENEFITS

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

F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be $150 or more, before the Dentist starts the treatment, a Covered Person can find out what Dental Expense Benefits will be paid under This Plan. To do this, the Covered Person should send a claim form to us in which the Dentist tells us:

1. the work to be done; and

2. what the cost will be.

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

This method should not be used for:

1. emergency treatment; or

2. routine oral exams; or

3. X-rays, scaling and polishing, and fluoride treatments; or

4. dental services which cost less than $150.

G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

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

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

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

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

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

H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

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

1. For a prosthetic device if:

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

b. the device is installed within 90 days after the date the Dental Expense Benefits end; or

2. For a crown if:

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

b. the crown is installed within 90 days after the date the Dental Expense Benefits end; or

3. For root canal therapy if:

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

b. the treatment is finished within 90 days after the date the Dental Expense Benefits end.

I. PAYMENT OF BENEFITS

Dental Expense Benefits will be paid to:

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

2. you, in all other cases.

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

J. SCHEDULE OF DENTAL SERVICES AND MAXIMUMS ALLOWABLE

DENTAL SERVICE	**MAXIMUM ALLOWABLE**
DIAGNOSTIC	
Periodic oral examination (after regular office hours)	$13.80
Office visit for treatment and observation of injuries to teeth and supporting structures	
Adult Prophylaxis (including oral examination)	5.75
Special consultation (by specialist for case presentation when diagnostic procedures	
have been performed by primary Dentist)	13.80
Prophylaxis – up to age 14	8.05
Prophylaxis – age 14 and over, treatment includes scaling and polishing	12.65
Prophylaxis – one treatment	
with topical application of sodium fluoride	16.68
with topical application of stannous fluoride	19.55
Emergency palliative treatment, each visit	6.90

FILM ALLOWANCES

Complete intraoral series of 14 periapical films and at least 2 bitewing films	$23.58
Intraoral periapical (single film)	5.75
Each additional single film (up to a total of 12)	1.15
Intraoral, occlusal view, maxillary or mandibular, each	5.75
Superior or inferior maxillary, extra-oral	
One film	13.80
Two films	20.70
Bitewing X-ray films	
Two films	6.90
Four films	9.78
Each additional film	1.15
Panographic survey (including bitewings, if necessary)	23.58
Biopsy of oral tissue	10.93
Microscopic examination	20.10

PREVENTIVE

Oral prophylaxis (limited to two services in any calendar year)	
child under age 14	8.05
age 14 and over (includes scaling and polishing)	12.65
Topical sodium fluoride treatment following prophylaxis	16.68
One treatment – Stannous Fluoride	19.55
Biopsy of oral tissue	10.93
Microscopic examination	20.10

OPERATIVE (RESTORATIVE) SERVICES

Amalgam Restorations:	
Primary teeth:	
Silver amalgam - 1 Surface – Primary	8.05
Silver amalgam - 2 Surfaces – Primary	12.65
Silver amalgam - 3 Surfaces – Primary	16.68
Permanent teeth:	
Silver amalgam - 1 Surface - Permanent	10.93
Silver amalgam - 2 Surfaces - Permanent	14.95
Silver amalgam - 3 Surfaces - Permanent	20.70
Gold Restorations:	
Cast Gold 1 Surface	48.30
Cast Gold 2 Surfaces	55.20
Cast Gold 3 or more Surfaces	69.00
Onlays, extra, each tooth	13.80
Silicate, Acrylic & Plastic Restorations:	
Silicate cement filling	12.65
Acrylic or plastic filling	14.95
Composite filling	14.95

ORAL SURGERY

Extractions and Impacted Teeth:	
Extraction – Uncomplicated single or first removal of tooth, including routine post operative visits	$ 10.93
Extraction - Each additional tooth, per tooth	8.05
Surgical removal of erupted tooth	23.58
Post-operative visit (for sutures and complications)	4.03
Removal of impacted tooth	
Soft tissue	23.58
Partially bony	34.50
Completely bony	55.20
Alveolar or Gingival Reconstruction:	
Alveolectomy (edentulous), each quadrant	34.50
Alveolectomy (in addition to removal of teeth), each quadrant	13.80
Alveoplasty with ridge extension, each arch	58.08
Removal of palatal forus	48.30
Removal of mandibular tori, each quadrant	48.30
Excision of hyperplastic tissue, each arch	44.28
Cysts and Neoplasms:	
Incision and drainage of abscess	
Intra-oral	13.80
Extra-oral	20.70
Excision pericoronal gingiva	13.80
Sialolithotomy: removal of salivary calculus	
Intra-orally	45.43
Extra-orally	138.00
Closure of salivary fistula	82.50
Dilation of salivary duct	23.58
Resection of benign tumor of soft tissue (2.5 cm or larger)	34.50
Transplantation of tooth or tooth bud	96.60
Maxillary sinusotomy for removal of tooth fragment or foreign body	89.70
Closure of oral fistula of maxillary sinus	55.20
Excision of cyst	
Small	34.50
Large (2.5 cm or larger)	103.50
Sequestrectomy for osteomyelitis or bone abscess, superficial	27.50
Condylectomy of temporomandibular joint	414.00
Meniscectomy of temporomandibular joint	345.00

ANESTHESIA

General anesthesia	20.70

ENDODONTICS (INCLUDING RADIOGRAPHS BUT EXCLUSIVE OF RESTORATION)

Pulp capping	8.05
Therapeutic pulpotomy (in addition to restoration), each treatment	8.05
Vital pulpotomy	16.68
Remineralization (Calcium Hydroxide, temporary restoration), each tooth	13.80

Root Canals:

Culturing Canal	9.78
Root Canal filling (single canal)	62.10
Root Canal filling (two canal)	82.80
Root Canal filling (three canal)	103.50
Apicoectomy	
including filling of root canal	$ 69.00
separate procedure	48.30

Miscellaneous:

Incision and removal of foreign body from soft tissue	13.80
Frenectomy	34.50
Crown exposure for orthodontia	20.70
Injection of sclerosing agent into temporomandibular joint	41.40
Treatment of trigeminal neuralgia by injection into second and third divisions	47.15

PERIODONTICS

Emergency treatment (periodontal abscess, acute periodontitis)	13.80
Subgingival curettage, root planing, each quadrant	16.68
Correction of occlusion, each quadrant	16.68
Gingivectomy - each quadrant (including post-surgical visits)	69.00
Gingivectomy, osseous or muco-gingival surgery, each quadrant (including post-surgical visits)	82.80
Gingivectomy treatment, (fewer than six teeth), each tooth	13.80

CROWNS AND FIXED BRIDGES

Acrylic	82.80
Acrylic with metal	103.50
Porcelain	103.50
Porcelain with metal	138.00
Cast gold full crown	89.70
Cast gold three-quarter	82.80
Stainless steel (primary teeth)	23.58
Stainless steel (permanent teeth)	27.60
Gold dowel pin	13.80

PROSTHETICS

Pontics:	
Cast gold (sanitary)	55.20
Steele's facing	62.10
Tru-Pontic type	75.90
Porcelain baked to gold	110.40
Plastic processed to gold	75.90
Removal (Unilateral) Bridges:	
One piece casting chrome cobalt alloy clasp attachment (all types), each unit including pontics	27.60
Recementation:	
Inlay	6.90
Crown	6.90
Bridge	13.80
Dentures:	
(Allowances for dentures, partial dentures and relines include adjustments for the six-month period following installation)	
Complete upper acrylic denture including necessary adjustments	$213.90
Complete lower acrylic denture including necessary adjustments	213.90
Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base fee	103.50
Each extra tooth or clasp	6.90
Partial upper or lower with chrome cobalt alloy lingual or palatal bar acrylic saddles, base fee	207.00
Each extra tooth or clasp	6.90
Each additional stress breaker	19.55
Stay plate, base fee	41.40
Each additional tooth or clasp	4.03
Denture adjustment	5.75
Office reline - cold cure acrylic	20.70
Denture reline	48.30
Special tissue condition, each denture in addition to reline (not more than two per denture)	20.70
Denture duplication (jump case), each denture	75.90
Repairs, Dentures, Acrylic:	
Broken denture, repairing, base fee	16.68
Replacement of missing or broken teeth, each tooth	4.03
First tooth	34.50
with clasp	41.80
each additional tooth and clasp	6.90

Space Maintainers:	
(Allowance includes all adjustments within six months following installation)	
Fixed space maintainer, band type	48.30
Removable acrylic space maintainers with stainless steel round wire rest only, base fee	55.20
Each stainless steel clasp or activation wire (attached to space maintainer)	6.90
Study models	6.90
Removable inhibiting appliance to correct thumbsucking	55.20
Office visit for observation, adjustment and activation, each visit	5.75
Fixed or cemented inhibiting appliance to correct thumbsucking	55.20
Fractures and Dislocations:	
Treatment of simple fracture of the maxilla	
Open reduction	276.00
Closed reduction	172.00
Treatment of simple fracture of the mandible	
Open reduction	317.40
Closed reduction	172.00
Treatment of compound or comminuted fracture of the maxilla	
Open reduction	414.00
Closed reduction	276.00
Treatment of compound or comminuted fracture of the mandible	
Open reduction	414.00
Closed reduction	276.00
Treatment of luxation (dislocation) of the mandible, uncomplicated	10.93
Treatment of condylar fracture	
Open reduction	483.00
Closed reduction	207.00
Reduction of dislocation of temporomandibular joint	48.30
Treatment of malar fracture, simple, closed reduction	138.00
Treatment of malar fracture, simple or compound depressed, open reduction	276.00

The amounts shown as Maximums Allowable for Non-Participating Providers include the cost of:

1. local anesthesia; and

2. postoperative care; and

3. adjustments to a denture for up to 6 months after installation.

The Maximum Allowable for Non-Participating Providers for a dental service:

a. which is not listed above; and

b. which is not excluded in section D;

will be an amount which is consistent with the amounts for the dental services listed above.

Form G.23000-13E

WHEN BENEFITS END

A. All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

C. Your Dependent Benefits will end on the earlier of:

1. the date that the Dependent ceases to be your Dependent; or

2. the date of your death.

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

The Dental Expense Benefits for a Covered Person may be continued in accordance with the Federal law called COBRA. See the pages entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS.

Form G.23000-F

CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE

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

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

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or

2. the end of the last period for which the Employer has paid premiums to us for your benefits.

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

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

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

CONTINUATION OF DENTAL EXPENSE BENEFITS FOR YOUR DEPENDENTS DURING A MEDICAL LEAVE OF ABSENCE FROM SCHOOL

You may continue Dental Expense Benefits for a child who ceases to be a full-time student if such child is required because of illness, to take a medical leave of absence from school. Dental Expense Benefits may be continued during the medical leave of absence for a period of up to 12 months. During this period you must continue to pay any premiums you were required to pay for such Dental Expense Benefits. This continuation will end upon the earliest of:

1. 12 months after the date the leave of absence begins;

2. the date you fail to pay any required premium when due;

3. the date the medical leave of absence ends;

4. the date the child fails to satisfy the definition of Dependent for any reason other than status as a full-time student; or

5. the date your Dental Expense Benefits end.

You must send us Proof documenting the illness and medical necessity of the leave of absence. Proof includes furnishing us with a Physician's statement certifying the medical necessity of the leave.

Form G.23000-L

COORDINATION OF BENEFITS

A. Definitions

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

1. a group insurance plan; or

2. a group blanket plan, but not including school accident-type coverages covering students in:

a. a grammar school;

b. a high school; or

c. a college;

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

3. a group practice plan; or

4. a group service plan; or

5. a group prepayment plan; or

6. any other plan which covers people as a group; or

7. a governmental program or coverage required or provided by any law, except Medicaid, but including any motor vehicle No Fault coverage which is required by law.

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

"This Plan" means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or

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

will not be affected by these Coordination of Benefits provisions.

For the purpose of applying these provisions, if both spouses are covered as Employees under This Plan, each spouse will be considered as covered under separate Plans.

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

1. before those of the other Plan; and

2. without considering the other Plan's benefits.

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

1. are determined after those of the other Plan; and

2. may be reduced because of the other Plan's benefits.

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

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

1. it is a charge for an item of necessary dental expense; and

2. it is an expense which a Covered Person must pay; and

3. it is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

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

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

However, Allowable Expenses do not include:

a. expenses for services rendered because of:

1. an Occupational Sickness; or

2. an Occupational Injury.

b. any amount of benefits reduced under a Primary Plan because the Covered Person does not comply with the Plan provisions. Examples of such provisions are those related to:

1. second surgical opinions;

2. precertification of admissions or services; and

3. preferred provider arrangements.

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

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

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

B. Effect on Benefits

1. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

a. the other Plan has rules coordinating its benefits with those of This Plan; and

b. both those rules and This Plan's rules in subsection 3 of this Section B require that This Plan's benefits be determined before those of the other Plan.

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

a. the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and

b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

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

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

3. Rules for Determining the Order in which Plans Determine Benefits. When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:

a. Non-dependent/Dependent. The Plan which covers that person other than as a dependent (for example, as an employee, member, subscriber or retiree) determines its benefits before the Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. Secondary to the Plan covering the person as a dependent; and

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

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

b. Child Covered under More than One Plan. When This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

i. the Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

1. the parents are married;

2. the parents are not separated (whether or not they ever have been married); or

3. a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

For example, if one parent's birthday were January 8 and the other parent's birthday were March 3, then the Plan covering the parent with the January 8 birthday would determine its benefits before the Plan covering the parent with the March 3 birthday.

ii. if both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.

iii. if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that Plan has that actual knowledge of the terms of the court decree.

iv. if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

1. the Plan of the Custodial Parent;

2. the Plan of the spouse of the Custodial Parent;

3. the Plan of the Non-Custodial Parent;

4. the Plan of the spouse of the Non-Custodial Parent.

c. Active/Laid-off or Retired Employee. The Plan which covers that person as an active employee (or as that employee's dependent) is Primary to a Plan which covers that person as a laid-off

or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

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

e. Longer/Shorter Time Covered. If none of the above rules determines the order of benefits, the Plan which has covered the Employee for the longer time determines its benefits before the Plan which covered that person for the shorter time.

C. Right to Receive and Release Needed Information

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

D. Facility of Payment

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

E. Right of Recovery

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

1. the persons we have paid or for whom we have paid;

2. insurance companies; or

3. other organizations.

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

Form G.23000-N7

NOTICES

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

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

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

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

1. that the dental service will be deemed to be necessary; or

2. that benefits under This Plan will be paid for the expenses of the dental service.

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

1. is necessary in terms of generally accepted dental standards; and

2. is qualified for benefits under This Plan.

PROCEDURES FOR CLAIM REVIEW

INTERNAL PROCEDURES FOR CLAIM REVIEW BY METLIFE

First Level of Review

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

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

Second Level of Review

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

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

EXTERNAL PROCEDURES FOR CLAIM REVIEW OUTSIDE OF METLIFE

New York state law gives you the right to an external appeal when payment of benefits for dental services have been denied on the basis that the services are not dentally necessary or that the services are experimental or investigational.

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

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

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

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

Eligibility for an External Appeal

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

- you must have received a Final Adverse Determination as a result of our internal utilization review appeal process; or

- you and MetLife must have agreed to waive that appeal process.

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

If services are denied as experimental or investigational, you must have a life-threatening or disabling condition or disease to be eligible for an external appeal and your Dentist must complete the Attending Physician Attestation form and send the form to the New York Insurance Department. The Attending Physician Attestation form is included as part of the application form.

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

Eligibility for an Expedited External Appeal

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

Time Periods for External Appeals

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

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

The Cost to You for an External Appeal

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

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

Submission of Information

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

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

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

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

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

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

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

Notification of a Decision

When the external appeal agent has made the decision:

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

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

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

Form G.23000-E

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

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL BENEFITS

When your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may continue coverage under This Plan for a period of up to 18 months. However, if it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within 60 days after your termination of employment or reduction of hours, you and your covered dependents may continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may continue coverage under This Plan for up to 36 months. Also, your covered children may continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan.

During the continuation period, a child of yours that is (1) born; (2) adopted by you; or (3) placed with you for adoption, will be treated as if the child were a covered dependent at the time coverage was lost due to an event described above.

This continuation will terminate on the earliest of:

1. the end of the 18, 29 or 36 month continuation period, as the case may be;

2. the date of expiration of the last period for which the required payment was made;

3. the date, after a Covered Person elects to continue coverage, that the Covered Person first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to any preexisting condition on the Covered Person;

4. the date This Plan is cancelled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within 60 days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan.

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

PRIVACY OF YOUR MEDICAL INFORMATION

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

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

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

- Not use or further disclose PHI other than as permitted or required by the plan documents in Section I and II above;
- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

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

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

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

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

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

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

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

  Human Resources Personnel, as designated by the appropriate MTA agency

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

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

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the plan documents have been amended to incorporate the provisions in this section titled "Sharing of PHI With the Plan Sponsor".

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

DISCLOSURE STATEMENT - (NEW YORK)

METROPOLITAN LIFE INSURANCE COMPANY

Required Disclosure Statement

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