YOUR SUMMARY PLAN DESCRIPTION

Wake Forest University

Class 1: All full-time regular faculty (budgeted to work between 1,096 and 1,462 hours per year)

Class 2: All full-time regular staff and administrators (budgeted to work between 1,560 and 2,080 hours per year)

Class 3: All part-time regular faculty (budgeted to work at least 1,000 hours per year but less than 1,096 hours per year) and all part-time regular staff and administrators (budgeted to work at least 1,000 hours per year but less than 1,560 hours per year)

Class 4: All Retirees as defined in the policies of Wake Forest University

Class 5: All Widows, widowers and/or dependents of deceased retirees or employees

Class 6: All Disabled employees

Class 7: All Phased Retirement Program Employees

High Plan

Classic PDP Plan

Dental Benefits for You and Your Dependents

Effective January 1, 2024

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Summary Plan Description is merely a draft specimen, which You should review with Your own tax or legal advisors to ensure compliance with ERISA and any other applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with ERISA or any other applicable laws. Changes may be necessary to assure compliance with ERISA and to assure consistency with Your specific plan provisions and plan administration.

YOUR SUMMARY PLAN DESCRIPTION

INTRODUCTION

This Summary Plan Description describes the benefits available to you under the benefits plan of Wake Forest University. Please read this booklet carefully to become familiar with your benefits. This plan is effective as of January 1, 2019.

This is a self-funded Dental Benefits Plan provided by the Employer. Metropolitan Life Insurance Company ("MetLife") does not insure the benefits described in this booklet.

Claims are administered on behalf of This Plan by MetLife as the Claim Administrator pursuant to the terms of an administrative service agreement.

Please note that the terms "You" and "Your" throughout this booklet refer to the employee, except where otherwise indicated. Many of the terms that are important in understanding your benefits are explained in the DEFINITIONS section.

Wake Forest University

TABLE OF CONTENTS

Section **Page**

TABLE OF CONTENTS (continued)

Section **Page**

BENEFITS AT A GLANCE

This section provides You and Your Dependents with a description of Your benefits. Certain limitations and exclusions may apply to any benefit or benefit amount. It is important that You and Your Dependents refer to the provisions contained in this Summary Plan Description for details about Your benefits.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Benefits 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	100%	100%
Type B Services	80%	80%
Type C Services	50%	50%
Orthodontic Covered Services	50%	50%
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	$150 for the following Covered Services Combined: Type B; Type C	$150 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$1,500 for the following Covered Services: Type A; Type B; Type C	$1,500 for the following Covered Services: Type A; Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$1,500	$1,500

DEFINITIONS

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

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a place to which the Employer's business requires You to travel.

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

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

Your natural child; Your adopted child or child placed for adoption; Your stepchild; Your foster child; or a child for whom You are the legally appointed guardian who resides with and is fully supported by You; and who, in each case, is under age 26.

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 This Plan notice, a Child also includes a child for whom You must provide Dental Benefits 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 benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Plan as an employee.

Claim Administrator means Metropolitan Life Insurance Company ("MetLife"), New York, New York. The Claim Administrator does not insure the benefits described in this Summary Plan Description.

Contributory Coverage means coverage for which the Employer requires You to pay any part of the cost of coverage.

Contributory Coverage includes: Dental Benefits.

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that This Plan 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 This Plan will pay for such services after any required Deductible is satisfied.

DEFINITIONS (continued)

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 covered for Dental Benefits;
- Dentally Necessary to treat the condition; and
- described in the section entitled BENEFITS AT A GLANCE or DENTAL BENEFITS sections of this Summary Plan Description.

Deductible means the amount You or Your Dependents must pay before This Plan 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 the Claim Administrator, 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 This Plan. 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 Benefits, 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 Your Spouse and/or Child.

Employer means Wake Forest University.

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

Maximum Allowed Charge means the lesser of:

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

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

DEFINITIONS (continued)

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 benefits. 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 the Claim Administrator that a person has satisfied the conditions and requirements for any benefit described in this Summary Plan Description. When a claim is made for any benefit described in this Summary Plan Description, Proof must establish:

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

Proof must be provided at the claimant's expense.

Reasonable and Customary Charge is the lowest of:

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

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

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 the Claim Administrator, and consistent with applicable law.

Spouse means Your lawful spouse.

For the purposes of determining who may become covered for benefits, the term does not include any person who:

- is in the military of any country or subdivision of any country; or
- is covered under This Plan as an employee.

This Plan means the self-funded Dental Benefits plan of the Employer.

DEFINITIONS (continued)

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

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

You and **Your** mean an employee who is eligible for the benefits described in this Summary Plan Description.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOU

ELIGIBLE CLASS(ES)

Class 1: All full-time regular faculty (budgeted to work between 1,096 and 1,462 hours per year).

Class 2: All full-time regular staff and administrators (budgeted to work between 1,560 and 2,080 hours per year).

Class 3: All part-time regular faculty (budgeted to work at least 1,000 hours per year but less than 1,096 hours per year) and all part-time regular staff and administrators (budgeted to work at least 1,000 hours per year but less than 1,560 hours per year).

Class 4: All Retirees as defined in the policies of Wake Forest University.

Class 5: All Widows, widowers and/or dependents of deceased retirees or employees.

Class 6: All Disabled employees.

Class 7: All Phased Retirement Program Employees.

You are eligible for coverage if You were Actively at Work and covered for coverage on the day immediately preceding the date of Your retirement and have retired in accord with the Employer's retirement plan. Please be aware that:

- references to Active Work and Actively at Work will not apply; and
- end of employment will mean the end of the person's status as a retiree, as stated in the Employer's retirement plan.

DATE YOU ARE ELIGIBLE FOR COVERAGE

You may only become eligible for the coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

If You are in an eligible class on January 1, 2019, You will be eligible for the coverage described in this Summary Plan Description on that date.

If You enter an eligible class after January 1, 2019, You will be eligible for coverage on the first day of the calendar month coincident with or next following the date You enter that class.

ENROLLMENT PROCESS

If You are eligible for coverage, You may enroll for such coverage by completing the required form. If You enroll for Contributory Coverage, You must also give the Employer permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

The Dental Benefits have a regular enrollment period established by the Employer. Subject to the rules of This Plan, You may enroll for Dental Benefits only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE YOUR COVERAGE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 30 days of becoming eligible for coverage, such coverage will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 30 days of becoming eligible, You will not be able to enroll for coverage until the next annual enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Employer, You may enroll for coverage for which You are eligible or choose a different option than the one for which You are currently enrolled. The changes to Your coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 30 days from the date of that change (with the exception of the birth of a newborn, you will have 60 days from the date of birth) to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event will take effect for marriage (including the acquiring of a stepchild), birth and adoption, divorce, legal separation or annulment, death of a dependent and change in employee or dependent spouse's employment status on the date of the Qualifying Event, and for all other Qualifying Events such coverage will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- obtaining custody of a foster child;
- acquiring a step-child by marriage;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- You previously did not enroll for Dental Benefits for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of employer contributions for the other group coverage; or
    3. COBRA Continuation of the other group coverage was exhausted; or

- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

DATE YOUR COVERAGE ENDS

Your coverage will end on the earliest of:

1. the date This Plan ends;
2. the date coverage ends for Your class;
3. the date You cease to be in an eligible class;
4. the end of the period for which the last contribution has been paid for You;
5. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT COVERAGE

Class 1: All full-time regular faculty (budgeted to work between 1,096 and 1,462 hours per year).

Class 2: All full-time regular staff and administrators (budgeted to work between 1,560 and 2,080 hours per year).

Class 3: All part-time regular faculty (budgeted to work at least 1,000 hours per year but less than 1,096 hours per year) and all part-time regular staff and administrators (budgeted to work at least 1,000 hours per year but less than 1,560 hours per year).

Class 4: All Retirees as defined in the policies of Wake Forest University.

Class 5: All Widows, widowers and/or dependents of deceased retirees or employees.

Class 6: All Disabled employees.

Class 7: All Phased Retirement Program Employees.

DATE YOU ARE ELIGIBLE FOR DEPENDENT COVERAGE

You may only become eligible for the Dependent coverage available for Your eligible class as shown in the section entitled BENEFITS AT A GLANCE.

You will be eligible for Dependent coverage described in this Summary Plan Description on the latest of:

1. January 1, 2019; and
2. the first day of the calendar month coincident with or next following the date You enter a class eligible for coverage; and
3. the date You obtain a Dependent.

No person may be covered as a Dependent of more than one employee.

ENROLLMENT PROCESS

If You are eligible for Dependent coverage, You may enroll for such coverage by completing the required form for each Dependent to be covered. If You enroll for Contributory Coverage, You must also give the Employer permission to deduct contributions from Your pay for such coverage. You will be notified by the Employer how much You will be required to contribute.

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

The Dental Benefits have a regular enrollment period established by the Employer. Subject to the rules of This Plan, You may enroll for Dependent coverage only when You are first eligible, during an annual enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the flexible benefits plan.

DATE COVERAGE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 30 days of becoming eligible for Dependent coverage, such coverage will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

If You Do Not Enroll When First Eligible

If You do not complete the enrollment process within 30 days of becoming eligible, You will not be able to enroll for Dependent coverage until the next annual enrollment period for Dental Benefits, as determined by the Employer, following the date You first become eligible. At that time You will be able to enroll for coverage for which You are then eligible.

Enrollment During an Annual Enrollment Period

During any annual enrollment period as determined by the Employer, You may enroll for Dependent coverage for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The changes to Your Dependent coverage made during an enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that date.

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 30 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The coverage enrolled for, or changes to Your coverage made as a result of a Qualifying Event will take effect for marriage (including the acquiring of a stepchild), birth and adoption, divorce, legal separation or annulment, death of a dependent and change in employee or dependent spouse's employment status on the date of the Qualifying Event, and for all other Qualifying Events such coverage will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- obtaining custody of a foster child;
- acquiring a step-child by marriage;
- divorce, legal separation or annulment;
- the death of a dependent;
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage;
- You previously did not enroll for Dental Coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    1. loss of eligibility for the other group coverage;
    2. termination of employer contributions for the other group coverage;
    3. COBRA Continuation of the other group coverage was exhausted; or

ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS (continued)

- Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Once You have enrolled one Child for Dependent Coverage, each succeeding Child will automatically be covered for such coverage on the date the Child qualifies as a Dependent.

DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Benefits for You ends;
3. the date You cease to be in an eligible class;
4. the date This Plan ends;
5. the date coverage for Your Dependents ends under This Plan;
6. the date coverage for Your Dependents ends for Your class;
7. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF COVERAGE;
8. the end of the period for which the last contribution has been paid; or
9. the last day of the calendar month the person ceases to be a Dependent.

In certain cases, coverage may be continued as stated in the section entitled CONTINUATION OF COVERAGE.

CONTINUATION OF COVERAGE

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Coverage 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 This Plan within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE COVERAGE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS, coverage 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.

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL BENEFITS

If Dental Benefits for You or a Dependent ends, You or Your Dependent may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of this Summary Plan Description entitled NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE or contact the Employer for information regarding continuation of coverage under COBRA.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue coverage by paying contributions for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your coverage is continued, coverage for Your Dependents may also be continued.

Coverage will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence, up to 12 months;
2. for the period You cease Active Work in an eligible class due to layoff, up to 12 months;
3. for the period You cease Active Work in an eligible class due to injury or sickness, up to 12 months.

At the end of any of the continuation periods listed above, Your coverage will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be covered under This Plan;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your coverage will end in accordance with the DATE YOUR COVERAGE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOU.

If Your coverage ends, Your Dependents' coverage will also end in accordance with the DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: COVERAGE FOR YOUR DEPENDENTS.

DENTAL BENEFITS

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to the Claim Administrator. When the Claim Administrator receives such Proof, the Claim Administrator will review the claim and if the Claim Administrator approves it, This Plan will pay the Dental Benefits in effect on the date that service was completed.

These Dental Benefits give 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, This Plan pays 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 MetLife to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from This Plan 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, the Claim Administrator will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, it is recommended that You:

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

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

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

BENEFIT AMOUNTS

This Plan 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 section entitled BENEFITS AT A GLANCE, subject to the conditions set forth in this Summary Plan Description.

In-Network

If a Covered Service is performed by an In-Network Dentist, This Plan 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 This Plan does not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, This Plan 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 This Plan does not pay benefits; and
- any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

The section entitled BENEFITS AT A GLANCE sets forth Maximum Benefit Amounts This Plan will pay for Covered Services received In-Network and Out-of-Network. This Plan 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 section entitled BENEFITS AT A GLANCE.

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 This Plan will pay benefits for such Covered Services.

This Plan applies 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 This Plan applies toward satisfaction of a Deductible for a Covered Service is the amount the Claim Administrator uses 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 the Claim Administrator determines that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, This Plan will pay benefits based upon the less costly service if such service:

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

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Claim Administrator may base the benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claim Administrator may base the 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, the Claim Administrator may base the 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, the Claim Administrator may base the benefit determination upon the partial denture which is the less costly service.

If This Plan pays 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 Summary Plan Description, 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 multiple sessions, they all constitute root canal therapy. Therefore, This Plan will only pay benefits for the root canal therapy.

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 33% of the Lifetime Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins.

The benefit payable for the periodic follow-up visits will also be based on the Lifetime Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins. It will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claim Administrator that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to these Dental Benefits

If the initial placement was made prior to these Dental Benefits being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

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

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before these Dental Benefits were in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

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 the Claim Administrator receives this information, the Claim Administrator will provide You with an estimate of the Dental Benefits available for the service. The estimate is not a guarantee of the amount This Plan 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 This Plan 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.

DENTAL BENEFITS (continued)

Benefits This Plan Will Pay After Coverage Ends

This Plan will pay benefits for a 2 month period after Your coverage ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your coverage ends; and
- the device is installed within 2 month(s) after the date the coverage ends.

This Plan will pay benefits for a 2 month period after Your coverage ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your coverage ends; and
- the Cast Restoration is installed within 2 month(s) after the date the coverage ends.

This Plan will pay benefits for a 2 month period after Your coverage ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your coverage ends; and
- the treatment is finished within 2 month(s) after the date the coverage ends.

DENTAL BENEFITS: 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. Full mouth or panoramic x-rays once every 36 months.
5. Bitewing x-rays 2 sets in a Year.
6. Diagnostic casts.
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. Topical fluoride treatment for a Child under age 19 twice in a Year.
9. Space maintainers for a Child under age 16 once per lifetime per tooth area.
10. Sealants or sealant repairs for a Child under age 16 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.
11. Photographic images.

Type B Covered Services

1. Problem-focused exams.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
5. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
6. Emergency palliative treatment to relieve tooth pain.
7. Amalgam fillings.
8. Resin-based composite fillings.
9. Protective (sedative) fillings.
10. Biopsies of hard or soft oral tissue.
11. Oral surgery, except as mentioned elsewhere in this Summary Plan Description.
12. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.
13. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
14. Periodontal scaling and root planing.
15. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
16. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
17. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed.
18. Pulp capping (excluding final restoration).
19. Therapeutic pulpotomy (excluding final restoration).
20. Pulp therapy.

21. Apexification/recalcification.
22. Pulpal regeneration, but not more than once per lifetime.
23. Injections of therapeutic drugs.
24. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
25. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
26. Fixed and removable appliances for correction of harmful habits.
27. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
28. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
29. Repair/reline and adjustments of occlusal guards and night guards.

Type C Covered Services

1. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claim Administrator determines 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 5 Years prior to replacement.
6. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 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. 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.
9. Re-cementing of Cast Restorations or Dentures.
10. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
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 a 5 Year period 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. Prefabricated crown.
14. Core buildup, but no more than once per tooth in a period of 5 Years.
15. Posts and cores, but no more than once per tooth in a period of 5 Years.
16. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
17. Other consultations, but not more than twice in a 12 month period.

18. Full mouth debridements, but not more than once in any 36 month period.
19. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery.
20. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation).
21. Repair of implants, but no more than once in a 12 month period.
22. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5 Year period**.**
23. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5 Year period**.**
24. Implant supported removable Dentures, but no more than once for the same tooth position in a 5 Year period**.**
25. Tissue conditioning, but not more than once in a 36 month period.
26. Simple repair of Cast Restorations or Dentures other than recementing.
27. Occlusal adjustments, but not more than once in a 12 month period.
28. Cleaning and inspection of a removable appliance once every 6 months.
29. Provisional splinting.

Orthodontic Covered Services

Orthodontia for You, Your Spouse and Your Children up to age 26.

DENTAL BENEFITS: EXCLUSIONS

This Plan will not pay Dental 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 Benefits;
3. services or supplies received by You or Your Dependent before the Dental Benefits start 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 Employer, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Employer;
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. labial veneers;
23. modification of removable prosthodontic and other removable prosthetic services;
24. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
25. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
26. duplicate prosthetic devices or appliances;
27. replacement of a lost or stolen appliance, Cast Restoration or Denture;

DENTAL BENEFITS: EXCLUSIONS (continued)

28. 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. other fixed Denture prosthetic services not described elsewhere.

DENTAL BENEFITS: 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, This Plan may reduce what This Plan pays based on what the other Plans pay. This Coordination of Benefits section explains how and when This Plan does 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, This Plan treats 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.

This Plan 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.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

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

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

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

The term does not include any of the following:

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

The provisions of This Plan, which limit benefits based on benefits or services provided under plans which the Employer (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 Summary Plan Description, except for any provisions in this Summary Plan Description that limit coverage based on benefits for services provided under plans which the Employer (or an affiliate) contributes to or sponsors.

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

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

DENTAL BENEFITS: 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, the Claim Administrator determines 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 the Claim Administrator to determine which Plan is Primary, is the rule that the Claim Administrator 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 BENEFITS: 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.

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 This Plan 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

The Claim Administrator needs certain information to apply the Coordination of Benefits rules. The Claim Administrator has the right to decide which facts The Claim Administrator needs. The Claim Administrator may get facts from or give them to any other organization or person. The Claim Administrator does 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 the Claim Administrator any facts This Plan needs 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, This Plan 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. This Plan will not have to pay that amount again. The term “payment made” includes benefits provided in the form of services, in which case This Plan may pay the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

- the person This Plan has paid or for whom This Plan has paid;
- insurance companies; or
- other organizations.

DENTAL BENEFITS: COORDINATION OF BENEFITS (continued)

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

GENERAL PROVISIONS

Assignment

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

Dental Benefits: Who This Plan Will Pay

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

Conformity with Law

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

Overpayments

Recovery of Dental Benefit Overpayments

This Plan has the right to recover any amount that the Claim Administrator determines to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if the Claim Administrator determines that:

- the total amount paid by This Plan on a claim for Dental Benefits is more than the total of the benefits due to You under this Summary Plan Description; or
- payment This Plan made should have been made by another group plan.

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

How This Plan Recovers Overpayments

This Plan may recover the overpayment from You by:

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

If the overpayment results from This Plan having made a payment to You that should have been made under another group plan, This Plan 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.

ADMINISTRATIVE DETAILS ABOUT THIS PLAN

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE WAKE FOREST UNIVERSITY DENTAL COVERAGE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Wake Forest University
2598 Reynolda Road
Winston-Salem, NC 27106

EMPLOYER IDENTIFICATION NUMBER: 56-0532138

PLAN NUMBER	COVERAGE	PLAN NAME
501	Dental Benefits	Wake Forest University Health and Welfare Benefit Plan

TYPE OF PLAN

This is a self-funded Dental Benefits Plan provided by the Employer. Metropolitan Life Insurance Company ("MetLife") does not insure any of the benefits described in the Summary Plan Description.

CLAIM ADMINISTRATOR FOR BENEFITS:

MetLife

TYPE OF ADMINISTRATION:

MetLife is the Claim Administrator pursuant to the terms of an administrative service agreement and has been given authority under This Plan to conduct a full and fair review of any claims on behalf of This Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under This Plan, service of legal process may be made upon the Plan Administrator at the above address.

ELIGIBILITY FOR COVERAGE; DESCRIPTION OR SUMMARY OF BENEFITS

This Summary Plan Description describes the eligibility requirements for coverage. It also includes a detailed description of the coverage.

PLAN TERMINATION OR CHANGES

This Plan sets forth those situations in which the Employer has the rights to end This Plan.

The Employer reserves the right to change or terminate This Plan at any time. Therefore, there is no guarantee that You will be eligible for the coverage described herein for the duration of Your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of Your beneficiary is not required to terminate, modify, amend, or change This Plan.

In the event Your coverage ends in accordance with the DATE YOUR COVERAGE ENDS and DATE YOUR COVERAGE FOR YOUR DEPENDENTS ENDS subsections of Your Summary Plan Description, You may still be eligible to receive benefits. The circumstances under which benefits are available are described in this Summary Plan Description.

CONTRIBUTIONS

If you enroll for Dental Benefits coverage, you are required to make contributions.

PLAN YEAR

This Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

CLAIMS INFORMATION

Dental Benefits Claims

Procedures for Presenting Claims for Dental Benefits

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

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Claim Administrator by dialing 1-800-942-0854.

Claim Submission

For claims for Dental Benefits, the claimant must complete the appropriate claim form and submit the required Proof as described below:

Step 1

A claimant may request a claim form, by calling the Claim Administrator at 1-800-942-0854.

Step 2

The Claim Administrator will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of requesting it.

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.

If the claimant does not receive a claim form within 15 days, Proof may be sent using any form sufficient to provide the Claim Administrator with the required Proof.

Step 4

The claimant must give the Claim Administrator Proof no later than 6 months after the date of the loss.

If 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 Proof is given as soon as is reasonably possible.

Initial Determination

After You submit a claim for Dental Benefits to the Claim Administrator, the Claim Administrator 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 This Plan. If the Claim Administrator needs such an extension, the Claim Administrator 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 the Claim Administrator's notice requesting further information and an extension until the Claim Administrator receives the requested information does not count toward the time period the Claim Administrator 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 the Claim Administrator.

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

- Name of Employee
- Name of This 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 the Claim Administrator receives Your written request appealing the initial determination or determination on the first appeal, the Claim Administrator will conduct a full and fair review of Your claim. Deference will not be given to initial denials, and the Claim Administrator'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, the Claim Administrator 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.

The Claim Administrator will notify You in writing of its final decision within 30 days after the Claim Administrator's receipt of Your written request for review, except that under special circumstances the Claim Administrator may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, the Claim Administrator 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 the Claim Administrator denies the claim on appeal, the Claim Administrator 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 criteria 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, the Claim Administrator will provide You free of charge with copies of documents, records and other information relevant to Your claim.

When the claim has been processed, You will be notified of the benefits paid. If any benefits have been denied, You will receive a written explanation.

Urgent Care Claim Submission

A small number of claims for Dental Benefits may be urgent care claims. Urgent care claims for Dental Benefits are claims for reimbursement of dental expenses for services which a Dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However Your Dentist may also submit such a claim to the Claim Administrator by telephoning the Claim Administrator and informing the Claim Administrator 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, the Claim Administrator will notify You of the determination on the claim as soon as possible, but no later than 72 hours after the claim was filed. If You or Your covered Dependent does not provide the Claim Administrator with enough information to decide the claim, the Claim Administrator 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, the Claim Administrator will then notify You of the claim decision within 48 hours after the Claim Administrator received the information. If the needed information is not provided, the Claim Administrator 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. The Claim Administrator will provide You any necessary information to assist You in Your appeal. The Claim Administrator will then notify You of its decision within 72 hours of Your request in writing. However, the Claim Administrator may notify You by phone within the time frames above and then mail You a written notice.

Discretionary Authority of Plan Administrator, Claim Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under This Plan, the Plan Administrator, Claim Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of This Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of This Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT TO COBRA CONTINUATION COVERAGE

COBRA is a federal law that requires most group health plans to give their employees and their dependents the opportunity to continue coverage when coverage is terminated due to certain specific events. If 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 be able to continue coverage under This Plan for a period of up to 18 months. If it is determined under the terms of the Social Security Act that you or your covered dependent is disabled within the first 60 days of COBRA coverage, you and your covered dependents may be able to continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents may be able to continue coverage under This Plan for up to 36 months. Also, your covered children may be able to continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan. Group health plans for employers with fewer than 20 employees, church plans, and plans established and maintained by the federal government are not subject to COBRA continuation requirements.

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:

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

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

c. the date, after you or your covered dependent elects to continue coverage, that you or your covered dependent first becomes covered under another group health plan as long as the new plan does not contain any exclusion or limitation with respect to your or your covered dependent’s preexisting condition;

d. the date your employer ceases to provide any group health plan for its employees.

Notice will be given when you or your covered dependent becomes entitled to continue coverage under This Plan. You or your covered dependent will then have 60 days to elect to continue coverage. If you or your covered dependent do not notify your Employer within the 60-day election period, you will lose the option to elect continuation coverage.

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. Thus, a covered spouse (as defined by federal law) or dependent child (or parent on their behalf) is entitled to elect COBRA coverage even if the covered Employee does not make that election. However, covered Employees may elect COBRA coverage on behalf of their covered dependents. Any person who elects to continue coverage under This 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.

If you do not elect COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day election period, you may change your election by sending the completed election form to the Plan Administrator and postmarking it no later than the last day of the 60-day election period.

If You Elect COBRA

If you choose COBRA coverage and pay the required contributions, you are entitled to coverage which, as of the time coverage is being provided, is identical to the coverage provided by the Employer to similarly situated active Employees, spouses or dependent children. This means that if the coverage for similarly situated Employees, spouses or dependent children changes, coverage will change for those who elected COBRA coverage.

Duration Of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered Employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However, the 18-month coverage period may be extended under the following circumstances:

Disability. If any person entitled to COBRA coverage (the covered Employee, covered spouse or covered dependent child) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage period and the disability lasts at least until the end of the 18 month period of continuation coverage, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered Employee, covered spouse or covered dependent child must notify the Employer's COBRA Administrator within 60 days of the **latest** of: (1) the Social Security Administration's determination of disability; (2) the date of the qualifying event; (3) the date on which the covered Employee's coverage initially was or will be lost; or (4) the date a person entitled to COBRA coverage is informed of this obligation by being provided the initial COBRA notice for the applicable group health plan. Written notice to the COBRA Administrator must be received before the end of the initial 18-month coverage period. A copy of the Social Security Administration's determination must be provided to the COBRA Administrator. **If these procedures are not followed, there will be no disability extension of COBRA.**

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.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of:

- The first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or

- The last day of the 29th month of total coverage.

A person entitled to COBRA coverage must notify the COBRA Administrator within 30 days if the Social Security Administration determines that the disabled person is no longer disabled. This Plan reserves the right to retroactively cancel COBRA coverage, and will require reimbursement of all benefits paid for claims incurred after coverage terminates.

Subsequent Qualifying Events. If, during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension), the covered Employee and the spouse divorce, the covered Employee dies, the covered Employee becomes entitled to Medicare, or a dependent ceases to be an eligible dependent under the terms of This Plan, then the covered spouse and/or covered dependent child(ren) (as applicable) may be able to extend COBRA coverage for up to 36 months from the date of the termination of employment or reduction in hours.

A person entitled to COBRA coverage must notify the Employer's COBRA Administrator of the subsequent event no later than 60 days after its occurrence. If such notification is not given, the covered spouse and/or covered dependent child will not be entitled to the additional COBRA coverage.

Contributions For COBRA Coverage

A person entitled to COBRA coverage is entirely responsible for paying the contributions for COBRA coverage. The required payment for each continuation coverage period for each option will be described in the notice that is sent when an individual experiences a qualifying event.

Initial Contribution Payment

If continuation of coverage is elected, payment for continuation coverage must be made no later than 45 days after the date of such election. (This is the date the election notice is post-marked, if mailed.) If the first payment for continuation coverage is not made in full by the 45th day after the date of election, continuation coverage under This Plan will end. A person entitled to COBRA coverage is responsible for making sure that the amount of the first payment is correct.

After the first payment for continuation coverage, the amount due for each coverage period for each qualified beneficiary will be provided when coverage is elected.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in This Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at This Plan Administrator's office and at other specified locations, all Plan documents governing This Plan and a copy of the latest annual report (Form 5500 Series) filed by This Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of This Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of This Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Benefits

Continue Dental Benefits for You, Your Spouse or Your Dependents if there is a loss of coverage under This Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing This Plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate Your Plan, called "fiduciaries" of This Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries.

No one, including Your Employer or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from This Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the plan Administrator to provide the materials and pay You up to $110.00 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse This Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees.

If You lose, the court may order You to pay these costs and fees; for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about This Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Wake Forest University reserves the right to change or terminate This Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Wake Forest University shall be empowered to amend or terminate This Plan or any benefit under This Plan at any time.

Please note that Metropolitan Life Insurance Company and its agents are not in the business of practicing law or providing legal services to group customers. This Summary Plan Description is merely a specimen, which You should review with Your own tax or legal advisors to ensure compliance with ERISA and any other applicable laws prior to use. MetLife and its agents do not make any representations as to this document's compliance with ERISA or any other applicable laws. Changes may be necessary to assure compliance with ERISA and to assure consistency with Your specific plan provisions and plan administration.