MetLife®

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

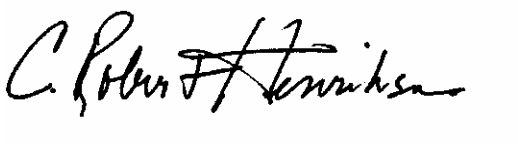
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

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
Chairman of the Board, President and Chief Executive Officer

Employer: **Trinity Health Care Staffing Group**

Group Policy Number: **TM 05710202-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

All Active Full Time Non Per Diem Employees
NB 03/01/2007
October 2005 version

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

1-800-275-4638

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

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

1-800-275-4638

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

1-800-252-3439

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

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:

1-800-275-4638

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 72204-1904

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
1-800-275-4638

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.

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:

1-800-275-4638

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

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

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.

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
Customer Service
18210 Crane Nest Drive
Tampa, FL 33647
1-800-275-4638

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) **AMOUNT**
For:
All Active Full Time Non Per Diem Employees

DENTAL EXPENSE BENEFITS

	In-Network	Out-of-Network
ANNUAL DEDUCTIBLE AMOUNT		
Individual Type A Expenses……	$0	$0
Individual Type B and C Expenses Combined…….	$50	$50
Type D Expenses……..	$0	$0
Family Type A Expenses…….	$0	$0
Family Type B and C Expenses Combined……..	$150	$150

	In-Network	Out-of-Network
COVERED PERCENTAGE		
Type A Expenses……..	100%	100%
Type B Expenses……..	80%	80%
Type C Expenses……..	50%	50%
Type D Expenses……..	50%	50%

MAXIMUMS

For Orthodontic Treatment Aggregate Maximum Benefit (For All Dental Expense Periods)	$1,250
For Other Covered Dental Expenses Maximum Benefit (For One Dental Expense Period)	$1,000

Waiting Periods for Timely Entrants

Preventive Services..... No waiting period

Basic Services .....No waiting period

Major Services..... 12 month waiting period

Orthodontic Services ..... 12 month waiting period

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 $300 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

No Dental Expense Benefits are provided under This Plan on or 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. Time Limit on Certain Defenses

After This Plan has been in force 2 years from the date of its issue, no statement of the Employer shall be used to void This Plan.

C. 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.

D. 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.

E. 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 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 is covered under This Plan as an Employee;

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

4. 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 your for financial support.

with respect to dental benefits for **residents of Utah**:

a. a child who is employed on a full-time basis; or

b. a child who is 26 years of age or older.

with respect to dental benefits for **residents of New Mexico**:

a. a child who is employed on a full-time basis; or

b. a child who is 25 years of age or older.

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 retardation; 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; and

e. you make any payment which is required by the Employer.

Child 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; and

d. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree).

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

"**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. "Full-time" means an Employee is regularly scheduled to work at least 30 hours per week for the Employer.

"Employer" means the individual, firm, or other organization in whose name the Group Policy is issued. Subsidiaries and/or affiliates of the Employer are not covered under This Plan unless they are specified or approved in writing by us.

"**Enrollment Form**" means the form used by you to request Personal and Dependent Benefits.

"**Family**" means you and your Dependents.

"**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.

"Qualifying Events" means a change in your family status which would affect your Benefits under This Plan due to one or more of the following:

1. marriage;

2. birth, adoption or placement for adoption of a dependent child;

3. divorce, legal separation or annulment;

4. death of a dependent spouse*;*

5. termination of spouse's employment; or

6. a change in a spouse's class of employment or status or a change in the group policy which applies to a spouse's class of Employees and which results in a change in dental benefits under the spouse's insurance.

"**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

For All Active Full Time Non Per Diem Employees

Personal Benefits Eligibility Date

If you are an Employee on February 01, 2007, that is your Personal Benefits Eligibility Date.

If you become an Employee after February 01, 2007, your Personal Benefits Eligibility Date is 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 date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

APPLICABLE TO NON-CONTRIBUTORY BENEFITS

A. Request and Enrollment Forms

You must make a written request to the Employer for Personal Benefits. In order to become insured for Personal Benefits, you must complete the Enrollment Form. The Enrollment Form will be given to the Employer by us.

B. Effective Date

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.

APPLICABLE TO CONTRIBUTORY BENEFITS

A. Request and Enrollment Forms

You must make a written request to the Employer for Personal Benefits. In order to become insured for Personal Benefits, you must complete the Enrollment Form. These forms will be given to the Employer by us.

B. If Timely Request Is Made

A timely request for Personal Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Personal Benefits Eligibility Date. If you are not Actively at Work as an Employee on your Personal Benefits Eligibility Date, a request will be timely for Personal Dental Expense Benefits if it is made on or prior to the date thirty-one days after the date you return to Active Work as an Employee.

If you make a timely request for Personal Benefits, your Personal Benefits will become effective on the later of:

1. your Personal Benefits Eligibility Date; and

2. the date of your request;

provided you are Actively at Work on that date, otherwise on the date you return to Active Work as an Employee.

If you make a timely request for Personal Dental Expense Benefits, your Personal Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on your Personal Benefits Eligibility Date.

Preventive Services ..... No waiting period

Basic Services ..... No waiting period

Major Services ..... 12 month waiting period

C. If Late Request Is Made

If a request is not a timely request, it is a late request.

If you make a late request for Personal Dental Expense Benefits, your Personal Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

Preventive Services ..... No waiting period

Basic Restorative Services (Fillings) ..... 6 month waiting period

Basic – All Other Services ..... 12 month waiting period

Major Services ..... 24 month waiting period

D. Request to be covered, or to change your coverage, upon a Qualifying Event

If there is a Qualifying Event you may request to be covered, or to change your coverage, for Personal Dental Expense Benefits only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under This Plan because of a loss of the prior dental coverage.

If you make a request to be covered for Personal Dental Expense Benefits or a request for change(s) in Personal Dental Expense Benefits within thirty-one days of a Qualifying Event, your Personal Dental Expense Benefits or the change(s) in Personal Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

E. Active Work Requirement

You must be Actively at Work as an Employee in order for your Personal Benefits to become effective. If you are not Actively at Work as an Employee on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

F. Reinstatement of Benefits

If your Personal Benefits end because you or your Employer do not make a required contribution to their cost, you may make a request to reinstate them. Such a request will be treated as if it were a late request in order to determine the effective date of your Personal Benefits.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

APPLICABLE TO NON-CONTRIBUTORY BENEFITS

A. Request and Enrollment Forms

You must make a written request to the Employer for Dependent Benefits. In order to become insured for Dependent Benefits, you must complete the Enrollment Form. The Enrollment Form will be given to the Employer by us.

B. Effective Date

Your Dependent Benefits will become effective on your Dependent 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 Dependent Benefits will become effective on the date of your return to Active Work as an Employee.

C. 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 date such person becomes your Dependent.

APPLICABLE TO CONTRIBUTORY BENEFITS

A. Request and Enrollment Forms

You must make a written request to the Employer for Dependent Benefits. In order to become insured for Dependent Benefits, you must complete the Enrollment Form. These forms will be given to the Employer by us.

B. If Timely Request Is Made

A timely request for Dependent Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Dependent Benefits Eligibility Date. If you are not Actively at Work as an Employee on your Dependent Benefits Eligibility Date, a request will be timely for Dependent Dental Expense Benefits if it is made on or prior to the date thirty-one days after the date you return to Active Work as an Employee.

If you make a timely request for Dependent Benefits, your Dependent Benefits will become effective on the later of:

1. your Dependent Benefits Eligibility Date; and

2. the date of your request;

provided you are Actively at Work on that date, otherwise on the date you return to Active Work as an Employee.

If you make a timely request for Dependent Dental Expense Benefits, your Dependent Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on your Dependent Benefits Eligibility Date.

Preventive Services	No waiting period
Basic Services	No waiting period
Major Services	12 month waiting period
Orthodontic Services	12 month waiting period

C. If Late Request Is Made

If a request is not a timely request, it is a late request.

If you make a late request for Dependent Dental Expense Benefits, your Dependent Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

Preventive Services	No waiting period
Basic Restorative Services (Fillings)	6 month waiting period
Basic – All Other Services	12 month waiting period
Major Services	24 month waiting period

Orthodontic Services..... 24 month waiting period

D. Request to be covered, or to change your coverage, upon a Qualifying Event

If there is a Qualifying Event you may request to be covered, or to change your coverage, for Dependent Dental Expense Benefits only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under This Plan because of a loss of the prior dental coverage.

If you make a request to be covered for Dependent Dental Expense Benefits or a request for change(s) in Dependent Dental Expense Benefits within thirty-one days of a Qualifying Event, your Dependent Dental Expense Benefits or the change(s) in Dependent Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

E. Active Work Requirement

You must be Actively at Work as an Employee in order for your Dependent Benefits to become effective. If you are not Actively at Work as an Employee on the date when your Dependent Benefits would otherwise become effective, your Dependent Benefits will become effective on the date of your return to Active Work as an Employee.

F. Reinstatement of Benefits

If your Dependent Benefits end because you or your Employer do not make a required contribution to their cost, you may make a request to reinstate them. Such a request will be treated as if it were a late request in order to determine the effective date of your Dependent Benefits.

G. New Dependents

Dependent Dental Expense Benefits with respect to a person who becomes your Dependent while you are insured for Dependent Dental Expense Benefits will be effective on the date of your request.

Form G.23000-D2

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

"Covered Dental Expense" means:

1. For In-Network Benefits

The charges based on the Preferred Dentist Program Table of Maximum Allowed Charges for the types of dental services shown in section C. These services must be:

a. performed or prescribed by a Dentist who is a Participating Provider; and

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

No more than the Maximum Allowed Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Maximum Allowed Charge is the lower of:

a. the amount charged by the Participating Provider for the service or supply; and

b. the maximum amount that the Participating Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

2. For Out-of-Network Benefits

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

a. performed or prescribed by a Dentist who is not a Participating Provider; and

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

No more than the Reasonable and Customary Charge for dental services or supplies will be covered by the Dental Expense Benefits. The Reasonable and Customary Charge is the lower of:

a. 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

b. 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

c. the usual charge of most other Dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies (the 'Customary Charge').

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. See section E for examples that show how this works.

"Deductible Amount" means the amount shown in the SCHEDULE OF BENEFITS. The Deductible Amount is an annual amount.

The In-Network Deductibles during any one Dental Expense Period will not apply to In-Network Benefits for Covered Dental Expenses for your Family after In-Network Covered Dental Expenses have been incurred for Covered Persons in your Family and those Covered Dental Expenses equal the In-Network Family Deductible Amount.

The Out-of-Network Deductibles during any one Dental Expense Period will not apply to Out-of-Network Covered Dental Expenses for your Family after Covered Dental Expenses have been incurred for Covered Persons in your Family and the sum of In-Network Covered Dental Expenses and Out-of-Network Covered Dental Expenses equal the Out-of-Network Family Deductible Amount.

"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.

"Covered Percentage" means the percentage or percentages shown in the SCHEDULE OF BENEFITS.

"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; and

c. the Covered Dental Expenses are more than the Deductible Amount.

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 the Covered Percentage of those Covered Dental Expenses which are more than the Deductible Amount. 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; and

b. The sum of all benefits for all Covered Dental Expenses incurred for a Covered Person for orthodontic treatment during all Dental Expense Periods will not be more than the applicable Aggregate Maximum Benefit For All Dental Expense Periods as shown in the SCHEDULE OF BENEFITS.

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 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 once every 6 months.

b. Full mouth X-rays but not more than once every 60 months.

c. Bitewing X-rays but not more than:

i. once every 6 months for Dependent children under 19 years of age; and

ii. once every 12 months for all other Covered Persons

d. Preventive treatment:

i. scaling and polishing of teeth (oral prophylaxis) but not more than once every 6 months and

ii. topical fluoride treatment for a Dependent child under 19 years of age but not more than once every 6 months.

e. Space maintainers for a Dependent under 16 years of age.

f. Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for a Dependent child up to 16 years of age every 36 months.

g. Fixed and removable appliances for correction of harmful habit.

2. Type B Expenses

a. Periapical X-rays and other X-rays not specified above.

b. Consultations, but not more than 2 in any 12 month period.

c. Periodontal maintenance but limited to 2 times in a year less the number of teeth cleanings received during such year.

d. Pulp vitality tests, diagnostic casts, and bacteriological studies for determination of pathological agents, genetic test for susceptibility to oral diseases and caries susceptibility tests.

e. Emergency palliative treatment.

f. Injections of antibiotic drugs.

g. Administration of general anesthesia, when dentally necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.

h. Pulpal therapy, pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).

i. Apexification/recalcification.

j. Root canal treatment but not more often than once every 24 months for the same tooth.

k. Amalgam Fillings.

l. Resin – based composite fillings (See Section E for an example of how and when a resin-based composite filling is used, we may nevertheless base Dental Expense Benefits on an amalgam filling).

m. Relining and Rebasing of existing removable dentures but not more than once in 36 months.

n. Repair or re-cementing of

i. crowns; or

ii. inlays or onlays; or

iii. dentures or bridgework.

o. Extractions.

p. Oral surgery (other than as described elsewhere is this certificate).

3. Type C Expenses

a. Periodontal scaling and root planing but not more than once per quadrant or area every 24 months.

b. Treatment of periodontal disease and other diseases of the gums and tissues of the mouth not otherwise specifically mentioned in this section.

c. Periodontal surgery including gingivectomy or gingivoplasty, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant or area every 36 months.

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

e. Initial installation of Cast Restorations.

Cast Restoration means an inlay, onlay, or crown.

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.

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.

f. Those services needed to replace one or more natural teeth which are lost while Dental Expense Benefits for the Covered Person are in effect for:

i. installation of fixed bridgework done for the first time.

ii. installation for the first time of:

1. a partial removable denture; or
2. a full removable denture.

g. Replacing an existing removable denture or fixed bridgework if:

i. it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or

ii. it is needed because the existing denture or bridgework can no longer be used and was installed more than 60 months prior to its replacement.

h. Replacing an existing immediate temporary full denture by a new permanent full denture when:

i. the existing denture cannot be made permanent; and

ii. the permanent denture is installed within 12 months after the existing denture was installed.

i. 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.

j. Implants but no more than once for the same tooth position in a 60 month period.

k. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders.

4. Type D Expenses

Orthodontia, including diagnostic work up, appliance therapy, transseptal fibrotomy, and necessary extractions 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. Replacement of a lost, missing or stolen crown, bridge or denture.

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. Repair or replacement of an orthodontic appliance.

10. 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.

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

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

13. 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.

14. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.

15. Any duplicate appliance or prosthetic device.

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

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

18. Periodontal splinting.

19. Temporary or provisional restorations.

20. Temporary or provisional appliances.

21. 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.

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

23. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.

24. Charges for broken appointments.

25. Charges by the Dentist for completing dental forms.

26. Sterilization supplies.

27. Services or supplies furnished by a family member.

28. Treatment of temporomandibular joint disorders. This exclusion does not apply to residents of Minnesota.

E. EXAMPLES OF 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.

1. Amalgam and Composite Fillings

When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, we will base our benefit determination upon the amalgam filling which is the less costly service.

2. Inlays, Onlays, Crowns and Gold Foil

If a tooth can be repaired to our satisfaction according to generally accepted dental standards by a less costly method than an inlay, onlay, crown or gold foil, Dental Expense Benefits will be based on the adequate method of repair which costs the least.

3. Crowns, Pontics, and Abutments

Veneer materials may be used for front teeth or bicuspids. However, Dental Expense Benefits will be based on the adequate veneer materials which cost the least.

4. Bridgework and Dentures

Dental Expense Benefits will be based on the adequate method of treating the dental arch which costs the least. In some cases removable dentures may serve as well as fixed bridgework. If dentures are replaced by fixed bridgework, the Dental Expense Benefits will be based on the cost of a replacement denture unless adequate results can only be achieved with fixed bridgework.

These are not the only examples of alternate benefits. To find out how much your Dental Expense Benefits will be, see section F.

F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be $300 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 will pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan will pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan will 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 $300.

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 the tooth 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.

Form G.23000-13A

NOTICE FOR RESIDENTS OF CALIFORNIA

NOTICE OF YOU AND YOUR DEPENDENTS' RIGHT TO CONTINUE DENTAL COVERAGE UNDER SECTION 10128.50 et seq. OF THE CALIFORNIA INSURANCE CODE (Known as Cal-Cobra)

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

Events that Allow Continuation, and Length of Continuation

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

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

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

Your Dependent may continue coverage under this plan for up to 36 months if Your Dependent's dental insurance would otherwise end because of:

1. Your divorce,
2. Your legal separation,
3. Your death or
4. Your becoming eligible for Medicare.

Also, Your Dependent Child may continue coverage under this plan for up to 36 months if such Child's insurance would otherwise end because that Child no longer qualifies as a Dependent under the terms of this plan.

New Dependents

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 Dependent at the time insurance was lost due to an event described above. To obtain insurance for the Child You must enroll the Child for coverage within 30 days of birth, adoption or placement for adoption.

Termination of Coverage

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

1. the end of the 36 month continuation period;

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

3. the date this plan or coverage for Your class is cancelled;

4. the date the person becomes entitled to Medicare;

5. the date a person becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;

6. the date a person becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);

7. the date a person becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;

8. The first day of the first month that begins more than 31 days after the date of final determination under Title I or Title XVI of the Social Security Act that the person is no longer disabled.

Notice and Election of Coverage

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

1. Your termination or
2. Your reduction of hours worked,

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

1. the date of the event that gives a right to continue coverage;

2. the date You are given notice of a right to continue coverage; and

3. the date coverage under this plan ends.

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

1. You or Your Dependent receipt of determination of disability under the terms of the Social Security Act,
2. Your Dependent Child's ceasing to qualify as a Dependent under this plan,
3. Your divorce,
4. Your legal separation,
5. Your death, or
6. Your becoming eligible for Medicare.

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

Cost of Continued Coverage

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

Premium Payment

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

Exceptions

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

1. to a person who is covered by or eligible to be covered by Medicare;

2. to a person who is covered or who becomes covered by another group benefit plan that does not have an exclusion or limitation for preexisting conditions that applies to the person;

3. to a person who is covered, or becomes covered or could become covered by Federal Cobra (Section 4980B of the United States Internal Revenue Code);

4. to a person who is covered, or becomes covered or could become covered under a plan governed by Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq., relating to Requirements for Certain Group Health Plans for Certain State and Local Employees;

5. to a person who fails to meet any one or more of the time limits set forth above for notice and election of coverage;

6. to a person who fails to submit the correct premium when or before it is due;

7. if at the time coverage under this plan ends the Employer has 20 or more employees; or

8. if the Employer fails to notify us of your termination or reduction in hours within 31 days.

Continuation under a New Plan

The Employer must notify each person who has continued insurance under this plan if this plan ends for any reason and is replaced by the Employer with a new group plan. The notice must be given 30 days before this plan ends. The notice will be sent to the last known address of the person who has continued coverage under this plan. If this plan ends, continued insurance under this plan will end. A person who has continued insurance under this plan may then elect similar coverage under the Employer's new group plan, if any, for the balance of the period that the person would have remained covered under This Plan. Continued insurance will end for that person if the person does not, within 30 days of receiving notice that this plan has ended, enroll in the new plan and pay premiums to the new plan. The Employer will provide benefit and premium information, enrollment forms and instructions for enrolling in the new plan. This information will be sent to the last known address of the person who has a right to continue insurance. If the Employer or any successor Employer or purchaser of the Employer ceases to provide a similar group benefit plan to active employees, the right to continue insurance ends.

Other Notifications

The Employer is required, within 30 days, to notify us in writing:

1. of any Employee who has a qualifying event; or

2. when the Employer becomes subject to Federal COBRA (Section 4980B of the U.S. Internal Revenue Code).

The Employer is required to notify any new plan that replaces this plan of persons who are entitled to elect continuing insurance under the new plan.

The Employer will also notify each person, who is entitled to continue insurance for 36 months of the date the insurance is to end. The written notice will be sent in writing to the person's last known address 180 days before the insurance is to end.

Form G.23000-Leg 4-9

WHEN BENEFITS END

A. All of your benefits will end on the date 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.

D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

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

The period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than nine months.

Your Leave of Absence and Lay Off

The period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than two months following the date the leave of absence or lay off begins.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

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 but not including a group blanket plan; or
2. a group practice plan; or
3. a group service plan; or
4. a group prepayment plan; or
5. any other plan which covers people as a group; or
6. 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.

"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 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 two sentences 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 an 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.

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 certain of 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:

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 (as the case may be) 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 This Plan is cancelled;

e. the date it would be legally permissible for This Plan to otherwise terminate your coverage during the continuation period.

Notice will be given when you or your covered dependents become entitled to continue coverage under This 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. If you do not notify the Employer within the 60-day 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 dependent children. 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.

When the Plan Administrator is notified that a qualifying event has occurred, the Plan Administrator will notify you that you have the right to choose COBRA coverage. Under the law, you have 60 days from the date you would lose coverage because of a qualifying event to inform the Plan Administrator that you want COBRA coverage. If you do not choose COBRA coverage, your dental coverage will end. However, if you initially waive COBRA continuation coverage before the end of the 60-day time 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 premiums, 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) is determined by the Social Security Administration to have been disabled at any time during the first 60 days of the COBRA coverage period, 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 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.**

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(s) (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 will not be entitled to the additional COBRA coverage.

PREMIUMS FOR COBRA COVERAGE

A person entitled to COBRA coverage is entirely responsible for paying the premiums 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 PREMIUM 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.

ERISA INFORMATION

NAME OF THE PLAN

Trinity Health Care Staffing Group Welfare Benefit Plan ("Plan")

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Trinity Health Care Staffing Group
1834 Sally Hill Farms Blvd
FLORENCE, SC 29501
(843) 656-0142

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

582467213 **501**

TYPE OF PLAN

Dental Expense Benefits

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

Written notice of termination must be given to the Employer at least 31 days prior to the date such insurance will be terminated.

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

Your Employer is liable to MetLife for payment of the pro-rata premium which accrues while any coverage remains in force.

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

Your Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits 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 the Plan.

In the event your coverage ends in accord with the "When Benefits End" provision of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

CONTRIBUTIONS

You must make a contribution to the cost of Personal Dental Expense Benefits.

You must make a contribution to the cost of Dependent Dental Expense Benefits.

The total premium rate for insurance under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 01 and ending on the following December 31.

QUALIFIED DOMESTIC RELATIONS ORDERS / QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Procedures for Presenting Claims for Dental Expense Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you in filing claims. Claim forms can also be downloaded from www.metlife.com/dental.

Routine Questions on Dental Expense Claims

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

Claim Submission

For claims for dental expense benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the "Payment of Benefits" section of the certificate.

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

Initial Determination

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

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

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

Appealing the Initial Determination

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

- Name of Employee
- Name of the Plan
- Reference to the initial decision

- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

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

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

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

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

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

Urgent Care Claim Submission

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

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

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the 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.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the 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 the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the 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 Insurance

Continue dental insurance for yourself or dependents if there is a loss under the 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 the 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 the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

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

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or you need assistance in obtaining documents from the Plan administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and InquiriesEmployee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Trinity Health Care Staffing Group reserves the right to change or terminate This Plan in the future. Any such action would be taken only after careful consideration.

CONTINUITY OF DENTAL EXPENSE COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

(not applicable to self-insured plans)

Coverage Under This Plan

In order to prevent loss of coverage due to a transfer of insurance carriers, This Plan will provide dental coverage for those who:

1. are eligible for Personal Benefits and/or for Dependent Benefits under This Plan; and

2. have made written request, if required, to the Employer for Personal Benefits and/or for Dependent Benefits under This Plan; and

3. were covered for similar Personal Benefits and/or Dependent Benefits under the prior plan of the Employer on the day before This Plan is effective.

However:

1. Employees who are not Actively at Work will receive full coverage under This Plan when they return to Active Work; and

2. Eligible Dependents who are confined in a Hospital or other treatment facility or at home will receive full coverage under This Plan when they are no longer confined.

Coverage provided as a result of the transfer of insurance carriers is subject to all of This Plan's provisions, except as set forth in the following sections.

Dental Expense Benefits

The dental coverage provided under This Plan will be subject to the following special rules:

A. Service Requirements: We will give credit for service requirements and late enrollment waiting periods which were met in part or in full under the prior carrier's plan at the time of transfer.

B. Deductibles: We will credit This Plan's Deductible requirements with amounts applied to similar requirements of the prior plan at the time of transfer. The credit given will not exceed This Plan's requirements.

C. Maximum Benefits: We will provide This Plan's Dental Expense Benefit at the time of transfer. However, we will reduce the maximum benefits available under This Plan by the amount of benefits that were:

1. provided for similar covered dental expenses under the prior carrier's plan; and

2. applied against a prior carrier's maximum; and

3. received during a period of time that corresponds to This Plan's maximum benefit period.

4. Interim Coverage During Disability: We will waive This Plan's Actively at Work and non-confinement rules in order to provide interim coverage for Employees and their eligible Dependents who are disabled at the time of transfer. Coverage so provided is subject to the provision of This Plan as set forth in WHEN BENEFITS END.

Coverage Continued Under Prior Plan

Persons who were covered under government-mandated continuance provisions of the prior plan at the time of transfer may continue coverage under This Plan. Benefits available under This Plan will be payable until the earlier of:

A. the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or

B. the date This Plan ends;

provided required payment is made for the cost of benefits so continued.

MetLife®

HIPAA Notice of Privacy Practices for Personal Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Dental Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company ("**MetLife**"). **Please read it carefully**. You have received this notice because of your Dental Insurance coverage with us. MetLife and each member of the MetLife family of companies (an "Affiliate") strongly believe in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Dental insurance coverage ("Personal Health Information"), and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898, Bridgewater, NJ 08807-6896.

We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Dental Insurance, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Dental Insurance coverage.

The main reasons for which we may **use** and may **disclose** your Personal Health Information are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

- **For Payment:** We may use and disclose Personal Health Information to pay for benefits under your Dental Insurance coverage. For example, we may review Personal Health Information contained on claims to reimburse providers for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.

- **For Health Care Operations:** We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Dental Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

- **Where Required by Law or for Public Health Activities:** We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a

governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services:** We may use Personal Health Information to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.

- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **Other Uses of Personal Health Information:** Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

- **Right to Inspect and Copy your Personal Health Information:** In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

    - is accurate and complete;

    - was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;

    - is not part of the Personal Health Information kept by or for us; or

    - is not part of the Personal Health Information which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel

or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282*. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to *MetLife P.O. Box 981282, El Paso, TX 79998-1282* and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to file a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896, Bridgewater, NJ 08807-6896. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as how to file a complaint please contact us at (908) 253-2706 or at HIPAAprivacyInst@MetLife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, but only if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact us at HIPAAprivacyInst@MetLife.com, (908) 253-2706 or write to us at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898, Bridgewater, NJ 08807-6896.

 Effective- {01012003}

Privacy Notice to Our Customers

This Privacy Notice is given to you on behalf of **METROPOLITAN LIFE INSURANCE COMPANY**.

TO PLAN SPONSORS AND GROUP INSURANCE CONTRACTHOLDERS: THIS NOTICE EXPLAINS HOW WE TREAT INFORMATION ABOUT ANYONE WHO APPLIES FOR OR OBTAINS OUR PRODUCTS AND SERVICES UNDER EMPLOYEE BENEFIT PLANS THAT WE INSURE OR GROUP INSURANCE CONTRACTS THAT WE ISSUE. PLEASE NOTE THAT WE REFER TO THESE INDIVIDUALS IN THIS NOTICE BY USING THE TERM "YOU", AS IF THIS NOTICE WERE BEING ADDRESSED TO THESE INDIVIDUALS.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others.

How We Protect What We Know About You: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that want we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with your, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. Please identify the specific product or service you are writing about.

The following applies to all ERISA governed groups:

VERMONT CIVIL UNION CERTIFICATE RIDER

Group Policy No.: **TM 05710202-G**

Policyholder: **Trinity Health Care Staffing Group**

Effective Date: **02/01/2007**

Your certificate (including any riders attached to your certificate) is changed as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.

"Dependent" means a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

"Child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

"Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions".

All references in this rider to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

Any person who meets the definition of "dependent" under this rider for purposes of dependent insurance, is required to meet all other applicable eligibility and enrollment requirements in order to qualify for such insurance.

If dependent insurance for a spouse and/or child is not provided under your certificate, such insurance is not added by virtue of this rider.

This rider does not limit any definitions or terms included in your certificate. It broadens definitions and terms only to the extent required by Vermont law.

This rider is subject to the terms and provisions of your certificate and is to be attached to and made a part of such certificate.

DISCLOSURE:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this rider and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine your rights under this rider and the certificate to which it is attached.