YOUR BENEFIT PLAN

National Wellness and Fitness Association, Inc.

All Active Members Residing in Colorado

Bright Plan 1000

Dental Insurance for You and Your Dependents

Certificate Date: May 1, 2025

National Wellness and Fitness Association, Inc.
4201 Spring Valley Road
Dallas, TX 75244

TO OUR MEMBERS:

All of us appreciate the protection and security insurance provides.

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

National Wellness and Fitness Association, Inc.

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

CERTIFICATE OF INSURANCE

1. SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Please refer to the Schedule of Benefits issued with this certificate for a list of Covered Services and exclusions.

2. TITLE PAGE (COVER PAGE)

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

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

Policyholder:	National Wellness and Fitness Association, Inc.
Group Policy Number:	243215-1-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s): For Claim Information	FOR DENTAL CLAIMS: 1-800-438-6388

THIS IS A LIMITED BENEFIT HEALTH COVERAGE CERTIFICATE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THIS CERTIFICATE DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE ACA. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO AND CAN BE PURCHASED AS A STAND-ALONE PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

WE ARE REQUIRED BY LAW TO INCLUDE THE NOTICES SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

3. CONTACT US

If you have questions about your insurance coverage you may contact MetLife at 1-800-275-4638.

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166-0188
www.metlife.com/dental

Or call MetLife at 1-800-275-4638

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5. ELIGIBILITY

Eligible Class

All Active Members residing in Colorado.

Date You Are Eligible For Insurance

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS (WHO PAYS WHAT).

If You are in an eligible class on May 1, 2025, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after May 1, 2025, You will be eligible for insurance the same day as the date You officially enter that class.

Enrollment Process

If You are eligible for insurance, You may enroll for such insurance by completing an enrollment form or by enrolling over the phone. If You enroll for Contributory Insurance, You will be notified how much You will be required to contribute.

DATE YOUR INSURANCE TAKES EFFECT

If You complete the enrollment process for Contributory Dental Insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the date You enroll; and
- the selected effective date.

5. ELIGIBILITY (Continued)

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Active Members residing in Colorado.

Date You Are Eligible For Dependent Insurance

You may only become eligible for the Dependent insurance shown available for Your eligible class as shown in the SCHEDULE OF BENEFITS (WHO PAYS WHAT).

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. May 1, 2025; and
2. the same day as the date You officially enter that class; and
3. the date You obtain a Dependent.

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

ENROLLMENT PROCESS FOR DEPENDENT COVERAGE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing or by enrolling over the phone for each Dependent to be insured. If You enroll for Contributory Insurance, You will be notified how much You will be required to contribute.

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

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with the information that We require for each Dependent to be insured within 30 days after: (i) the date Your insurance set forth in this certificate takes effect, or (ii) a Change in Status.

Change in Status means:

- Changing Your enrollment in Dental Insurance from the plan set forth in this certificate to a different plan of Dental Insurance offered by the Policyholder under the group policy;
- Your marriage;
- Your divorce, annulment or legal separation;
- the dissolution of Your domestic partnership;
- the death of Your Spouse or Domestic Partner;
- Your Spouse or Domestic Partner starting or leaving a job;
- the birth of a child to You;
- Your adoption of a child;
- Your Spouse or Your Domestic Partner taking an unpaid leave of absence;
- Your loss of existing dental insurance for You or Your Dependents;
- Your move to a different ZIP code or county;
- Your move to or from a shelter or other transitional housing;
- Your Child Dependent moving to or from the place where they attend school;
- Your or Your Spouse or Domestic Partner gaining membership in a federally recognized tribe, status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder, or Northwest Arctic Native Association shareholder;
- You or Your Dependent beginning or ending service with AmeriCorps; or
- You or Your Dependent being released from incarceration.

5. ELIGIBILITY (Continued)

Date Insurance on Your Dependents Takes Effect

Rules for Contributory Insurance

If You complete the enrollment process for Contributory Dental Insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the date You enroll;
- the selected effective date.

6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

If a Covered Person incurs a charge for a Covered Service, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the PDP, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from Us to choose a Dentist.

The PDP does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, We will determine the extent to which benefits, if any, are payable.

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

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

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

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting Our website at www.metlife.com/dental.

7. BENEFITS / COVERAGE (WHAT IS COVERED)

The PDP does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, We will determine the extent to which benefits, if any, are payable.

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

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

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

The payment or reimbursement for an Out-Of-Network Dentist shall be the same as the payment or reimbursement for an In-Network Dentist who charges the same amount.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-438-6388 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

In-Network

If a Covered Service is performed by an In-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying:

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

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

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

- the Deductible;
- any other part of the Maximum Allowed Charge for which We do not pay benefits; and
- any amount in excess of the Maximum Allowed Charge charged by the Out-of-Network Dentist.

Maximum Benefit Amounts

The SCHEDULE OF BENEFITS sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

For example, if a Covered Service is received Out-of-Network and We pay $300 in benefits for such service, $300 will be applied toward both the In-Network and the Out-of-Network Maximum Benefit Amounts applicable to such service.

7. BENEFITS / COVERAGE (WHAT IS COVERED) (Continued)

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service. The Deductible Amount will be applied based on when Dental Insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is "incurred". When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

Alternate Benefit

If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

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

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base Our benefit determination upon the amalgam filling which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge the Covered Person for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

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

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 90 day period after Your insurance ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your insurance ends; and
- the device is installed within 90 days after the date the insurance ends.

We will pay benefits for a 90 day period after Your insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 90 days after the date the insurance ends.

We will pay benefits for a 90 day period after Your insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 90 days after the date the insurance ends.

8. LIMITATIONS / EXCLUSIONS (WHAT IS NOT COVERED AND PRE-EXISTING CONDITIONS)

Please refer to the SCHEDULE OF BENEFITS (WHO PAYS WHAT) for a list of exclusions and limitations for the insurance described in this certificate.

9. PAYMENT RESPONSIBILITY

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to dental treatment are the responsibility of You and the Dentist. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Dental Insurance sections of this certificate for more details.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a written response from MetLife to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Dentist. If the dentist agrees to accept part of the payment directly from MetLife, You are responsible for prompt payment of the remaining part of the dentist's charge.
- You should consult with the Dentist about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Dentist the most current, complete and accurate information about Your medical and dental history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Dentist.

10. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

When a claimant files a claim for Life Insurance benefits, Proof should be sent to Us after the death of an insured. Within 45 days of the date We receive Proof, We will deny the claim, approve the claim, or request additional information to determine whether the claim is payable. If the claim is denied or if additional information is needed, We will tell You why the claim is being investigated or denied. If the cause of the denial of the claim or need for additional information is based upon a reasonable belief that the contents of the claim constitute probable cause for fraud, Our notice to the claimant will not be required to contain the specific reason for the denial or the need for additional information.

If We approve the claim without making a request for additional information, and We do not pay the claim within 60 days of the date We receive Proof, the claim will then become overdue.

An overdue claim which is or becomes payable will accrue interest from the date it becomes overdue until the date We pay it. Such interest will accrue at a rate equal to the average rate of return of the State of New Jersey Cash Management Fund for the preceding fiscal year, rounded to the nearest one-half percent.

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Policyholder who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-275-4638.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof to Us within 90 days after the date of any loss covered under this policy. Failure to furnish such Proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give Proof within such time, provided such Proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time Proof is otherwise required.

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

Initial Determination

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

If Your claim is a Clean Claim and it is approved by Us, benefits will be paid within 30 calendar days after We receive due written Proof of a covered loss in electronic format, or within 45 calendar days after receipt of due written Proof of a covered loss in any other format. Due written Proof includes, but is not limited to, information needed for Us to administer coordination of benefits.

"**Clean Claim**" means a claim that:

- is submitted on the appropriate form (the American Dental Association Dental Claim Form);
- does not require further information, adjustment or alteration by You or the provider of the services in order for Us to process and pay it;
- does not have any defects or impropriety, including any lack of supporting documentation; and
- does not involve a circumstance requiring special treatment that prevents timely payments from being made on the claim.

10. CLAIMS PROCEDURE (HOW TO FILE A CLAIM) (Continued)

If We are unable to pay a claim for Dental Insurance benefits because We need additional information or documentation, or there is a circumstance requiring special treatment, We will send You notice of what supporting documentation or information We need within 30 calendar days after the date We receive such claim. We must receive the requested documentation or information within 30 calendar days after the request is received. The claim will remain open until the requested documentation or information needed to resolve the claim is received or for at least 30 calendar days after a request for additional information is sent, whichever occurs first.

In any case, absent fraud, all claims except Clean Claims received on a timely basis shall be paid, denied, or settled within 90 calendar days after Our receipt of such claim.

If We do not pay, deny, or settle a Clean Claim or request additional information or documentation within the time periods noted above, We will pay interest at the rate of 10 percent annually on the total benefit amount ultimately allowed on the claim, accruing from the last day of the periods noted above.

If We do not pay, deny, or settle a claim within 90 calendar days, We will pay a penalty at the rate of 20 percent of the total benefit amount ultimately allowed on the claim. Such penalty shall be imposed on the 91st day following our receipt of the claim.

If We deny 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 based on a service not being Dentally Necessary or experimental in nature, the notification of the claims decision will state the scientific or clinical basis for the determination. If the claim is denied because We 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.

11. GENERAL POLICY PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

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

Who We Will Pay

If You assign payment of Dental Insurance benefits to the Covered Person's Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay Dental Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, including the certificate(s) attached to the Group Policy as Exhibits;
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by Covered Person

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

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

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

Conformity with Law

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

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment for services received by a Covered Person.

An overpayment occurs if We determine that:

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

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

11. GENERAL POLICY PROVISIONS (continued)

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

11. GENERAL POLICY PROVISIONS (Continued)

Coordination Of The Group Policy's Benefits With Other Benefits

The Coordination of Benefits (COB) provision applies when a Covered Person has dental care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

A. A "**Plan**" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   (1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); dental care components of long-term care contracts; dental benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   (2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-dental components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. "**This Plan"** means, in a COB provision, the part of the contract providing the dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as orthodontic benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the covered person.
   When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. **"Allowable Expense**" is a dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the covered person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the covered person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

Coordination Of The Group Policy's Benefits With Other Benefits (continued)

The following are examples of expenses that are not Allowable Expenses:

(1) If a covered person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(2) If a covered person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(3) If a covered person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(4) The amount of any benefit reduction by the Primary Plan because a person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second opinions and preferred provider arrangements.

(5) If the Primary Plan is a Closed Panel Plan with no out-of-network benefits and the secondary plan is not a Closed Panel Plan, the secondary Plan shall pay or provide benefits as if it were primary when no benefits are available from the Primary Plan because the covered person uses a non-panel provider, except for emergency services that are paid or provided by the primary.

E. "**Claim Determination Period**" is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person is covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during the Claim Determination Period. However, it does not include any part of a year during which a person has no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. "**Closed Panel Plan**" is a Plan that provides dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

Order-Of-Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

Coordination Of The Group Policy's Benefits With Other Benefits (continued)

B. Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. An example of this type of situation is insurance type coverage that is written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule to use.

(1) **Non-Dependent or Dependent**. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

(2) **Dependent Child Covered Under More Than One Plan**. Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
  (i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
  (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

  (i) If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
  (ii) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
  (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

Coordination Of The Group Policy's Benefits With Other Benefits (continued)

(iv) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the Child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a Dependent Child covered under more than one Plan of individuals who are not the parents of the Child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the Child.

(3) **Active Employee or Retired or Laid-off Employee**. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) **Longer or Shorter Length of Coverage**. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect On The Benefits Of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

B. If the Primary Plan is a Closed Panel Plan, and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary provider.

Coordination Of The Group Policy's Benefits With Other Benefits (continued)

C. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right To Receive And Release Needed Information

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility Of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that 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.

Right Of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

12. TERMINATION / NONRENEWAL / CONTINUATION

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the date You cease to be in an eligible class;
5. the date You cease to be a Member of the National Wellness and Fitness Association, Inc.

In certain cases, insurance may be continued as stated in the section entitled TERMINATION / NONRENEWAL / CONTINUATION.

DATE INSURANCE ON YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Insurance On You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date Insurance for Your Dependents ends under the Group Policy;
6. the date Insurance for Your Dependents ends for Your class;
7. the end of the period for which the last premium has been paid for the Dependent;
8. the last day of the calendar month the person ceases to be a Dependent; or
9. the date You cease to be a Member of the National Wellness and Fitness Association, Inc.

In certain cases insurance may be continued as stated in the section entitled TERMINATION / NONRENEWAL / CONTINUATION.

12. TERMINATION / NONRENEWAL / CONTINUATION(Continued)

Other Continuation Options

For Mentally or Physically Disabled Children

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of A mental or physical disability as defined by applicable law. Proof of such disability must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the date insurance on Your Dependents ends in the section entitled TERMINATION / NONRENEWAL / CONTINUATION, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical disability; and
- continues to qualify as a Child, except for the age limit.

13. APPEALS AND COMPLAINTS

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.

External Appeals

If You receive an adverse determination on the first internal appeal, or the voluntary second appeal if applicable, You have the right to request an independent external appeal. You will also have the right to an external appeal in the event We fail to comply with the internal appeal provisions cited above.
You must submit Your appeal to Us at the address indicated on the claim form within:

- 4 months after the date of an adverse determination on the first internal appeal; or
- 60 days after the date of an adverse determination of the second voluntary appeal, if applicable.

Appeals must be in writing and must include a completed external review request form specified by the Colorado Division of Insurance. If We deny Your request for an external review, we will do so in writing and include procedures for You to appeal the denial of the request with the Colorado Division of Insurance.

13. APPEALS AND COMPLAINTS (continued)

The Colorado Division of Insurance will assign an independent external review entity, whose claims review decision is final and binding. The independent entity will make a final determination within 45 days after the date of receipt of the request for external review. If the review entity overturns our claims determination, We will pay the claim within 5 business days of such determination.

Policies and Procedures for Urgent Care Claims

All In-Network Dentists are required to have 24-hour emergency coverage or have alternate arrangements for emergency care for their patients. Since the MetLife Preferred Dentist Program is a freedom-of-choice PPO program, there is no primary care physician or primary dentist. No authorization of a service is necessary by a primary care physician or primary dentist, nor is it necessary to obtain a preauthorization for services. The Covered Person is free to use the Dentist of his or her choice.

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

The benefit amount will be consistent with the terms of the Group Policy.

Urgent Care Claim Submission

A small number of claims for Dental Insurance may be urgent care claims. “Urgent Care Claims” for Dental Insurance 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 Us by telephoning and informing Us 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, We will notify You of the determination on the claim as soon as possible, but no later than 72 hours after the claim is filed. If You do not provide Us with enough information to decide the claim, We will notify You within 24 hours after We receive the claim of the further information that is needed**.**

We will provide You with a reasonable period of time to submit the necessary information, but in no event less than 48 hours. We will notify You of the claim decision within 48 hours after the earlier of:

- Our receipt of the requested information; and
- The end of the specified period of time in which You have to provide Us the requested information.

If We deny Your Urgent Care 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 based on a service not being Dentally Necessary or experimental in nature, the notification of the claims decision will state the scientific or clinical basis for the determination, and how such determination applies to the plan. If the claim is denied because We 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.
We may notify You of an Urgent Claim denial orally or in Writing. If denied orally, We will provide You with a Written denial within 3 days of the oral denial.

13. APPEALS AND COMPLAINTS (continued)

Time Limit on Legal Actions for Dental Insurance

A legal action on a claim for Dental Insurance benefits may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

Complaints

To make a complaint to MetLife, please see “3. Contact Us”.

14. INFORMATION ON POLICY AND RATE CHANGES

You will be notified by the Policyholder how much You will be required to contribute to the cost of the insurance described in this certificate.

Information on policy and rate changes is set forth in the Group Policy.

15. DEFINITIONS

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

Cast Restoration means an inlay, onlay, or crown.

Certificateholder means an employee of the Policyholder who is a Covered Person or has a Dependent who is a Covered Person. Unless otherwise specified, a Certificateholder is entitled to exercise the rights and benefits granted under this certificate.

Child means the following: (for residents of Connecticut, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

The definition of Child includes newborns.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide Us notice, a Child also includes a child for whom You must provide Dental Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term includes a Member's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

For the purposes of determining who may become a Covered Person, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as a Member.

Colorado Statutory Designated Beneficiary means, for the purpose of this insurance, the person named by You as Your Designated Beneficiary in a Designated Beneficiary Agreement that has been properly executed and recorded with a County Clerk and Recorder in Colorado, pursuant to the Colorado Designated Beneficiary Agreement Act (Article 22, Title 15, of the Colorado Revised Statutes) provided that:

1. the Designated Beneficiary Agreement establishes that the Designated Beneficiary has the right to be covered as Your Dependent under this policy; and

2. there is no Superseding Legal Document as defined under Colorado law which supersedes the agreement as it pertains to this insurance.

The term Colorado Statutory Designated Beneficiary refers to an individual who may qualify for coverage under this Group Policy as a Dependent and does not necessarily mean that You have designated, or intend to designate, that person as Your beneficiary under this Group Policy.

15. DEFINITIONS (continued)

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

Contributory Insurance includes: Dental Insurance.

Covered Percentage means the percentage of the Maximum Allowed Charge that We will pay for a Covered Service performed by an In-Network Dentist or an Out-of-Network Dentist after any required Deductible is satisfied.

Co-Payment means the dollar amount that You pay to Your Dentist for Covered Services performed by an In-Network Dentist. These amounts are shown in the Co-Payment Schedule.

Covered Person means a Member of the Policyholder or a Dependent of such employee whose life or person is the subject of insurance under this certificate.

Covered Service means a dental service used to treat a Covered Person's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS (WHO PAYS WHAT) or BENEFITS/COVERAGE (WHAT IS COVERED) section of this certificate.

Deductible means the amount a Covered Person must pay before We will pay for Covered Services.

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dentally Necessary means that a dental service or treatment is performed generally is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

- a person licensed to practice dentistry in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Dentist’s services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

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

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

Dependent(s) means Your Spouse and/or Your Child(ren).

15. DEFINITIONS (continued)

Domestic Partner means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

    1. 18 years of age or older;
    2. unmarried;
    3. the sole domestic partner of the other;
    4. sharing a primary residence with the other; and
    5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

  A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

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

Maximum Allowed Charge means:

1. with respect to In-Network Dentists, the lesser of:

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

2. with respect to Out-of-Network Dentists, the lesser of:

    a. the amount charged by the Out-of-Network Dentist; or
    b. the Out-of-Network scheduled amount for the state where the dental service is performed.

Member means a member in good standing with the National Wellness and Fitness Association, Inc.

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

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

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

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

15. DEFINITIONS (continued)

Spouse means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner. For all provisions, other than the section entitled "GENERAL PROVISIONS", the term also includes Your Colorado Statutory Designated Beneficiary.

For the purposes of determining who may become a Covered Person, the term does not include any person who:

- is on active duty in the military of any country or international authority. However, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as a Member.

We, Us and **Our** mean MetLife.

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

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

You or **Your** means prior to the date insurance takes effect under this certificate, a Member of the Policyholder who is a member of an eligible class described in the in the section entitled ELIGIBILITY; and after the date insurance takes effect under this certificate, the Certificateholder.

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

SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. Covered Person are only covered for insurance:

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

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance On You and Your Dependents: Year 1		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	90%	90%
Type B Services	50%	50%
Type C Services	10%	10%
Deductibles for:		
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type B; Type C	$100 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$1,000 for the following Covered Services: Type A; Type B; Type C	$1,000 for the following Covered Services: Type A; Type B; Type C

SCHEDULE OF BENEFITS (continued)

Dental Insurance On You and Your Dependents: Year 2

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	60%	60%
Type C Services	20%	20%
Deductibles for:		
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type B; Type C	$100 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$1,000 for the following Covered Services: Type A; Type B; Type C	$1,000 for the following Covered Services: Type A; Type B; Type C

SCHEDULE OF BENEFITS (continued)

Dental Insurance On You and Your Dependents: Year 3 and Later

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Maximum Allowed Charge
Type A Services	100%	100%
Type B Services	70%	70%
Type C Services	20%	20%
Deductibles for:		
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type B; Type C	$100 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$1,000 for the following Covered Services: Type A; Type B; Type C	$1,000 for the following Covered Services: Type A; Type B; Type C

Exclusions

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. implant supported Cast Restorations;
24. modification of removable prosthodontic and other removable prosthetic services;

Exclusions (Continued)

25. implants including, but not limited to any related surgery, placement, maintenance, and removal;
26. implant supported Dentures;
27. repair of implants;
28. fixed and removable appliances for correction of harmful habits;
29. appliances or treatment for bruxism (grinding teeth);
30. initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
31. precision attachments associated with fixed and removable prostheses;
32. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
33. duplicate prosthetic devices or appliances;
34. replacement of a lost or stolen appliance, Cast Restoration or Denture;
35. orthodontic services or appliances;
36. repair or replacement of an orthodontic device;
37. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
38. intra and extraoral photographic images.

Description of Covered Services

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months.
4. Diagnostic casts.
5. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) once every 6 months.

Type B Covered Services

1. Bitewing x-rays 1 set every 12 months.
2. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
3. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
4. Emergency palliative treatment to relieve tooth pain.
5. Topical fluoride treatment for a Child under age 14 once in 12 months.
6. Initial placement of amalgam fillings.
7. Replacement of an existing amalgam filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
8. Initial placement of resin-based composite fillings.
9. Replacement of an existing resin-based composite filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
10. Protective (sedative) fillings.
11. Injections of therapeutic drugs.
12. Space maintainers for a Child under age 14 once per lifetime per tooth area.
13. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
14. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
15. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
16. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Description of Covered Services (continued)

Type C (Major) Covered Services

1. Intraoral-periapical x-rays
2. X-rays, except as mentioned elsewhere.
3. Pulp capping (excluding final restoration).
4. Therapeutic pulpotomy (excluding final restoration).
5. Pulp therapy.
6. Apexification/recalcification.
7. Pulpal regeneration, but not more than once per lifetime.
8. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
9. Local chemotherapeutic agents.
10. Initial installation of full or partial Dentures (other than implant supported prosthetics):
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
11. Addition of teeth to a partial removable Denture to replace teeth removed while this Dental Insurance was in effect for the person receiving such services.
12. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
13. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
14. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
15. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
16. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
17. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
18. Initial installation of Cast Restorations (except implant supported Cast Restorations).
19. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
20. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.
21. Core buildup, but no more than once per tooth in a period of 10 Years.
22. Posts and cores, but no more than once per tooth in a period of 10 Years.
23. Labial veneers, but no more than once per tooth in a period of 10 Years.

Description of Covered Services (continued)

24. Oral surgery, except as mentioned elsewhere in this certificate.
25. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
26. Other consultations, but not more than once in a 12 month period.
27. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
28. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
29. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
30. Full mouth debridements, but not more than once per lifetime.
31. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
32. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such 1 Year period.
33. Simple extractions.
34. Surgical extractions.
35. Tissue conditioning, but not more than once in a 36 month period.
36. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
37. Occlusal adjustments, but not more than once in a 12 month period.
38. Full mouth or panoramic x-rays once every 60 months.

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. “Personal information” as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don’t control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a “consumer report” about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, LLC (“MIB”). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB’s

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices for Protected 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 Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes 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 Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI 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 PHI 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, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

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

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI 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.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI 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 PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organizations, e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- **Where Required by Law or for Public Health Activities:** We disclose PHI 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 PHI to a governmental agency or regulator with health care oversight responsibilities.

- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI 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 your PHI 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. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI 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 PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals:** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI 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 PHI 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 or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI 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 PHI. 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 PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. 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 PHI that:

  - is accurate and complete;
  - was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
  - is not part of the PHI kept by or for us; or
  - is not part of the PHI 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 your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). 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 you incur any cost.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on PHI 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. 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 PHI 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 PHI 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 and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

- **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 U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@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 PHI we already have about you, as well as any PHI 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, 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 e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

Effective Date: 02012019

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PLAN PRIVACY INFORMATION

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

The term "Plan Sponsor" means National Wellness and Fitness Association, Inc..

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

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

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

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

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

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

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

III. Sharing of PHI With the Plan Sponsor

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

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

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

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

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

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

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

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

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

  Director of Operations,Business Associate

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

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

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

IV. Participants Rights

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

V. Privacy Complaints/Issues

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

VI. Security

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

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

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

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

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

Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Dental Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your dental insurance coverage under your employer's group dental insurance policy ends, you may elect to continue dental insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for dental insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total dental insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have dental insurance coverage under your employer's group dental insurance policy pursuant to USERRA. Contact your employer for more information.

The following addenda apply to residents of New Hampshire.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

These notices are being provided to you pursuant to New Hampshire law.

Patient's Bill of Rights

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. Also, because the patient has the right to receive information from the facility and to discuss the benefits, risks, and costs of appropriate treatment alternatives, except for emergency admissions, every uninsured patient and prospective patient shall be fully informed in writing, upon his or her request, of the expected list price for services. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE

This notice is being provided to you pursuant to New Hampshire law.

CONTINUATION OF DENTAL INSURANCE ON YOU

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it would otherwise end for any reason except solely due to Your employment ending on account of gross misconduct.

Metropolitan Life Insurance Company ("MetLife") will give You written notice of:

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

The written notice will be mailed to Your last known address, as provided by the Policyholder.

The premium that You must pay for Your continued Dental Insurance may include:
- any amount that You contributed for Your Dental Insurance before it ended;
- any amount the Policyholder paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

You will have 45 days after the date of the notice to elect to continue Your Dental Insurance. If You elect to continue Your Dental Insurance, You must provide a copy of this written notice to the Policyholder when the election is made.

To continue Your Dental Insurance, You must, within 45 days after the date of the notice:
- send a written request to MetLife to continue Your Dental Insurance; and
- pay the first premium.

If Dental Insurance ends because the Group Policy ends, the maximum continuation period will be 39 weeks.

If Dental Insurance ends for any other reason, the maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the Policyholder files for bankruptcy protection under Title 11 of the United States Code;

- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date You cease to be a member of an eligible class; or

- 18 months in all other cases.

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

- the end of the maximum continuation period;

- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;

- if You are eligible for Medicare, the date of the first Medicare open enrollment period following the date You become ineligible for continued coverage under the Policyholder's plan;

- the date You become eligible for coverage under any other group dental coverage; or

- if You do not pay the required premium to continue Your Dental Insurance. If You do not pay the required premium, You will be given a 31 day grace period before Your Dental Insurance terminates. You will be provided with a notice within 15 days of the date of termination that Your Dental Insurance will be cancelled if the required premium is not paid.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS

If You are a resident of New Hampshire, Your Dental Insurance on Your Dependents may be continued if it would otherwise end for any reason except solely due to Your employment ending on account of gross misconduct.

MetLife will give written notice of the right to elect continuation coverage to Your former Spouse if You have died or Your marriage has ended, or to You in all other circumstances.

Notices

If Dental Insurance on Your Dependents ends because Your marriage ends in divorce or legal separation, You must notify the Policyholder, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred.

MetLife will give Your former Spouse if You have died or Your marriage has ended, written notice of:

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

Premium Contributions

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

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

To continue Dental Insurance if Your marriage has ended, You or Your former Spouse must, within 45 days after the date of the notice:

- send a written request to MetLife to continue Dental Insurance on Your Dependents; and
- pay the first premium.

You must notify MetLife and the Policyholder of the mailing address of your former Spouse. MetLife will provide Your former Spouse with a separate notice of the right to continue insurance.

Your right to continue Dental Insurance on Your Dependents will be deemed waived if MetLife has made reasonable efforts in good faith to contact You or Your former Spouse, if applicable; such notice complies with applicable New Hampshire law; and such person:

- fails to provide any required notification; or
- fails to request to continue Dental Insurance on Your Dependents and pay the first premium within the time limits stated in this section.

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Divorce Decree or Legal Separation Decree

Unless your divorce decree or legal separation decree provides otherwise, Your former Spouse shall remain as a covered person under Your insurance under this Policy if your marriage ends in divorce or legal separation.

You must notify MetLife within 30 days of the date of the final decree of divorce or legal separation of the right to continue coverage as an eligible person.

Your former Spouse's coverage under Your insurance under this subsection shall end on the first of the following:

(1) The 3-year anniversary of the final decree of divorce or legal separation, unless the decree specifies an earlier ending;

(2) The date of remarriage of Your former Spouse;

(3) The date of Your remarriage;

(4) Your death; or

(5) Such earlier time as provided by the final decree of divorce or legal separation.

If Your former Spouse's coverage under your insurance ends due to (2) Your former spouse's remarriage, there shall be no further continuation. However, if Your former Spouse's coverage under your insurance ends due to (1), (3), (4), or (5), Your former Spouse will be able to continue coverage under their own insurance under this policy in accordance with the subsection below entitled Maximum Continuation Period

Maximum Continuation Period

If Dental Insurance on Your Dependents ends because the Group Policy ends, the maximum continuation period will be 39 weeks.

If Dental Insurance on Your Dependents ends for any other reason, the maximum continuation period will be the longest of the following that applies:

- for a former spouse whose coverage was continued under the above section "Divorce Decree or Legal Separation Decree", an additional 36 months beyond the date such continued coverage ends, unless that coverage ended due to remarriage of the former Spouse; however, for a Spouse who is 55 or older on the date of the final decree of divorce or legal separation, coverage will continue until the earlier of the date on which the former Spouse is eligible for Medicare or coverage under another employer's group policy;

- 36 months if Dental Insurance on Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;

NOTICE FOR RESIDENTS OF NEW HAMPSHIRE (continued)

CONTINUATION OF DENTAL INSURANCE ON YOUR DEPENDENTS (continued)

Maximum Continuation Period (Continued)

- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;

- 36 months if Your employment ends because You retire, and within 12 months of retirement You or Your Dependents have a substantial loss of coverage because the Policyholder files for bankruptcy protection under Title 11 of the United States Code;

- 29 months if the Covered Person becomes entitled to disability benefits under Social Security within 60 days of the date the Covered Person's coverage under the Group Policy would otherwise end; or

- 18 months in all other cases.

Cessation of Dental Insurance on Your Dependents

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

- the end of the maximum continuation period;

- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of employees to which You belong;

- if the Dependent is eligible for Medicare, the date of the first Medicare open enrollment period following the date the Dependent becomes ineligible for continued coverage under the Policyholder's plan;

- the date the Dependent becomes eligible for coverage under any other group dental coverage; or

- if You do not pay a required premium to continue Dental Insurance on Your Dependents. If You do not pay the required premium, You will be given a 31 day grace period before Dental Insurance on Your Dependents terminates. You will be provided with a notice within 15 days of the date of termination that Dental Insurance on Your Dependents will be cancelled if the required premium is not paid.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

CONSUMER GUIDE TO EXTERNAL APPEAL

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- The completed External Review Application Form - signed and dated on page 6.
- ** The Department cannot process this application without the required signature(s) **
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.
- If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department's mailing address.

What is the Standard External Appeal Process and Time Frame for receiving a Decision?
It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

- Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.
  - If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.
- If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.
- Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.
- If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.
  - To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.
- By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW
Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services
Officer.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- The enclosed, completed application form - signed and dated on page 6.
- ** The Department cannot process this application without the required signature(s) **
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service
- at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its
- review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____State:_____Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize_____to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City:_____State:_____Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name: _____ Relationship to Patient: _____

Member's Insurance ID #: _____ Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes ____ No ____

- Name of employer: _____
- Employer's Phone Number: (_____) _____
- Is the employer's insurance plan self-funded? Yes* ____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes_____No _____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _____

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

PCP's Phone Number: (_____) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Treating Provider's Phone Number: (_____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

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Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes ____ No ____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes ____ No ____

My reason for requesting a phone conference is:

_____

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VIII – Authorization and Release of Medical Records

I, _____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

Sign Here

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____) _____.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date