

YOUR BENEFIT PLAN

National Wellness and Fitness Association, Inc.

All Active Members

Essentials Plan

Dental Insurance for You and Your Dependents

Certificate Date: October 1, 2022

National Wellness and Fitness Association, Inc.
706 North 129 Street, Suite #100
Omaha, NE 68154

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
New York, New York

CERTIFICATE RIDER

Group Policy No.: 243215-1-G

Policyholder: National Wellness and Fitness Association, Inc.

Effective Date: October 1, 2022

The certificate is changed as shown below:

DOMESTIC PARTNER CERTIFICATE RIDER

The definition of Domestic Partner is added as follows:

Domestic Partner means each of two people, one of whom is a Member 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 Member.

This rider is to be attached to and made a part of the Certificate

A handwritten signature in blue ink, appearing to read 'Michel Khalaf', written in a cursive style.

Michel Khalaf
President



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: 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 CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

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

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance 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	100%	100%
Type B Services	65%	65%
Type C Services	10%	10%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$2,000 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	80%	80%
Type C Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$2,000 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	90%	90%
Type C Services	60%	60%
Deductibles for:		
Yearly Individual Deductible	\$50 for the following Covered Services Combined: Type B; Type C	\$50 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$2,000 for the following Covered Services: Type A; Type B; Type C

DEFINITIONS

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

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

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 an Employee'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 covered for insurance, the term does not include any person who:

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

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

Insurance will continue if such Child:

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

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

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

DEFINITIONS

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.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or DENTAL INSURANCE sections of this certificate.

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services.

Dental Hygienist means a person trained to:

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

DEFINITIONS (continued)

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:

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

Dentist means:

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

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

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

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

Domestic Partner - For the Domestic Partner Definition, please refer to the Domestic Partner Definition Rider in the front of this certificate.

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 he performs the service and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

DEFINITIONS (continued)

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.

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Members

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on October 1, 2022, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after October 1, 2022, You will be eligible for insurance the same day as the date You officially enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing 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;
- the date You enroll; and
- the selected effective date.

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 date You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
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 CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Active Members

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

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

1. October 1, 2022; 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 DENTAL INSURANCE

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.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

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

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

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

NEWBORN CHILDREN

A Dependent Child born to You while insurance is in effect under this Certificate will be covered for 31 days from the moment of such Dependent Child's birth. To continue coverage beyond the first 31 days You must notify Us of the child's birth and agree to pay any contributions that are required for the newborn child.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date You cease to be in an eligible class;
4. the date the Group Policy ends;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the end of the period for which the last premium has been paid 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 CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

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

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

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

DENTAL INSURANCE

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

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program (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.

BENEFIT AMOUNTS

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

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.

DENTAL INSURANCE (continued)

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

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

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

Alternate Benefit

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

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

For example:

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

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

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

DENTAL INSURANCE (continued)

Pretreatment Estimate of Benefits

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

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

Benefits We Will Pay After Insurance Ends

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

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

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

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 31 days after the date the insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than three exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than three times in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than three times in a Year.
4. Bitewing x-rays 1 set every 12 months.
5. Diagnostic casts.
6. 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) three times in a Year.
7. Topical fluoride treatment for a Child under age 14 once in 12 months.

Type B Covered Services

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
5. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
6. Emergency palliative treatment to relieve tooth pain.
7. Initial placement of amalgam fillings.
8. 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.
9. Initial placement of resin-based composite fillings.
10. 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.
11. Protective (sedative) fillings.
12. Full mouth debridements, but not more than once per lifetime.
13. 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 three times in any Year less the number of teeth cleanings received during such 1 Year period.
14. Pulp capping (excluding final restoration).
15. Pulp therapy.
16. Local chemotherapeutic agents.
17. Injections of therapeutic drugs.
18. Space maintainers for a Child under age 14 once per lifetime per tooth area.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

19. 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.
20. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
21. Interim caries arresting medicament application applied to permanent bicuspid and 1st and 2nd molar teeth, once per tooth every 60 months.
22. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C Covered Services

1. Therapeutic pulpotomy (excluding final restoration).
2. Apexification/recalcification.
3. Pulpal regeneration, but not more than once per lifetime.
4. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
5. 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.
6. 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.
7. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
8. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
9. 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.
10. 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.
11. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
12. 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.
13. Initial installation of Cast Restorations (except implant supported Cast Restorations).
14. 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.
15. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.
16. Core buildup, but no more than once per tooth in a period of 10 Years.
17. Posts and cores, but no more than once per tooth in a period of 10 Years.
18. Labial veneers, but no more than once per tooth in a period of 10 Years.
19. Oral surgery, except as mentioned elsewhere in this certificate.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

20. 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.
21. Other consultations, but not more than once in a 12 month period.
22. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
23. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
24. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
25. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
26. Simple extractions.
27. Surgical extractions.
28. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period:
 - 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.
29. Repair of implants, but no more than once in a 12 month period.
30. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period:
 - 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.
31. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period:
 - 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.
32. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period:
 - 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.
33. Tissue conditioning, but not more than once in a 36 month period.
34. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
35. Occlusal adjustments, but not more than once in a 12 month period.
36. Cleaning and inspection of a removable appliance once every 6 months.

DENTAL INSURANCE: EXCLUSIONS

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

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic, (For residents of Texas, see notice page section);
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. modification of removable prosthodontic and other removable prosthetic services;
24. fixed and removable appliances for correction of harmful habits;
25. appliances or treatment for bruxism (grinding teeth);
26. initial installation of a Denture or implant or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;

DENTAL INSURANCE: EXCLUSIONS (continued)

27. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
28. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
29. duplicate prosthetic devices or appliances;
30. replacement of a lost or stolen appliance, Cast Restoration or Denture;
31. orthodontic services or appliances;
32. repair or replacement of an orthodontic device;
33. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
34. intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, We may reduce what We pay based on what the other Plans pay. This Coordination of Benefits section explains how and when We do this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a dental expense, including coinsurance or copayments and without reduction for any applicable deductible for which both of the following are true:

- a covered person must pay it, and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, We treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

Basis of Benefit Payment

If the Primary Plan calculates its benefits or services on the basis of **negotiated fees**, the Allowable Expense for all plans will be based on those negotiated fees. However, if the Dentist has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary Plan's negotiated fee and if the Dentist's contract permits, the Secondary Plan's negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

If the Primary Plan calculates its benefits or services on the basis of **reasonable and customary charges or relative value schedule reimbursement methodology or other similar reimbursement methodology**, that will be the Allowable Expense for all Plans. However, if the Dentist has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different from the Primary Plan's payment arrangement and if the Dentist's contract permits, the Secondary Plan's negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

The term Allowable Expense does not include:

- an expense or portion of an expense that is not covered by any of the Plans;
- an expense that a provider by law or in accordance with a contractual agreement is prohibited from charging;
- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees or similar method;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
 - second surgical opinions;
 - pre-certification of services;
 - use of providers in a Plan's network of providers; or
 - any other similar provisions.

We won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

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

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

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

The term does not include any of the following:

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

The provisions of This Plan, which limit benefits based on benefits or services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under plans which the Policyholder (or an affiliate) contributes to or sponsors.

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

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, We determine which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below, which will allow Us to determine which Plan is Primary, is the rule that We will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

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

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary, if the Plan has actual knowledge of those terms.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married or are living together (whether or not they have been married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced or are not living together (whether or not they have been married), the Primary Plan is:

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

Child Covered Under More than One Plan of Individuals Who are not the Parents of the Child: When This Plan and another Plan cover the same Child as the Dependent of two or more individuals who are not the Parents of the Child, the order of benefits will be determined on the same basis as if those individuals were Parents.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person's Dependent). If the other Plan does not have this rule and, if as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then We will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We need certain information to apply the Coordination of Benefits rules. We have the right to decide which facts We need. We may get facts from or give them to any other organization or person. We do not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

- the person We have paid or for whom We have paid;
- insurance companies; or
- other organizations.

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

FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-438-6388. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, We will pay the claim immediately, subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

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

Step 1

A claimant can request a claim form by calling Us at 1-800-438-6388.

Step 2

We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. If the claimant has requested claim forms from Us and does not get them within 15 days after the request, the claimant shall be deemed to have complied with the requirements of this policy as to Proof of loss upon submitting, within 90 days after the loss, Written Proof covering the occurrence, the character and the extent of the loss for which claim is made.

Step 3

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

Step 4

The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, You (or the Dentist if You assigned the benefits to the Dentist) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from 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 1-800-438-6388.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate.

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

Initial Determination

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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 15 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 15 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 15 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.

GENERAL PROVISIONS

Assignment

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

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

Overpayments

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if We determine that:

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

If such overpayment occurs, We will deduct it from the payment of a claim or from any premium then due and unpaid.

Payment of a benefit will not be stopped unless the amount of overpayment exceeds the claim amount.



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

CERTIFICATE RIDER

Group Policy No.: 243215-1-G

Policyholder: National Wellness and Fitness Association, Inc.

Effective Date: February 1, 2024

The certificate is changed as follows:

Applicable to Dental Insurance for all Active Members - Essentials Plan

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, add the following under **Type B Covered Services**:
"23. Simple extractions."
2. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete the following under **Type C Covered Services**:
"26. Simple extractions."

This rider is to be attached to and made part of the certificate.



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

CERTIFICATE RIDER

Group Policy No.: 243215-1-G

Policyholder: National Wellness and Fitness Association, Inc.

Effective Date: February 1, 2024

The certificate is changed as follows:

Applicable to Dental Insurance for all Active Members - Essentials Plan

1. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete the following from **Type C Covered Services**:

“28. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period:

- 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.

29. Repair of implants, but no more than once in a 12 month period.

30. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period:

- 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.

31. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period:

- 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.

32. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period:

- 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.

36. Cleaning and inspection of a removable appliance once every 6 months.”

2. In **SCHEDULE OF BENEFITS**, add the following items to **Exclusions**:

“implant supported Cast Restorations;

implants including, but not limited to any related surgery, placement, maintenance, and removal;

implant supported Dentures;

repair of implants;”

This rider is to be attached to and made part of the certificate.



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

CERTIFICATE RIDER

Group Policy No.: 243215-1-G

Policyholder: National Wellness and Fitness Association, Inc.

Effective Date: January 1, 2025

The certificate is changed as follows:

Applicable to Dental Insurance for all Active Members residing in Pennsylvania.

In the **ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE** section, the following provision **ENROLLMENT PROCESS FOR DEPENDENT COVERAGE** is replaced with the following:

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; for a Dependent Child who is 2 years of age or younger, You may enroll for Dental insurance. Coverage will become effective the first of the month following the receipt of the request;
- 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.

This rider is to be attached to and made part of the certificate.

CR2024-NWFA-QLE-PA