A770

MetLife

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

Metropolitan Life Insurance Company ("MetLife"), a stock company, will pay the benefits specified in the Exhibits of this policy subject to the terms and provisions of this policy.

Policyholder: City of Atlantic City

Group Policy No.: TM 05956668-G

EFFECTIVE DATE:

This policy will take effect on April 1, 2023.

POLICY ANNIVERSARIES

The first Policy Anniversary will be April 1, 2024. Subsequent Policy Anniversaries will be April 1, 2025 and each April 1st thereafter.

PREMIUM PAYMENTS

This policy, and the insurance provided under it, is issued in return for the payment of required Premiums.

Premiums are payable at the home office of MetLife or to its authorized agent. The first Premium is due on and must be paid on or before this policy's Effective Date. Any later Premiums are due monthly in advance on the first day of each Policy Month. These dates are the Premium Due Dates.

MetLife and the Policyholder may agree upon a different frequency for the payment of Premiums. In that case, Premium Due Dates will be adjusted to reflect the agreed upon frequency.

POLICY SITUS

This policy is issued for delivery in and governed by the laws of New Jersey.

Signed as of this policy's effective date at MetLife's home office in New York, New York.

Timothy J. Ring
Secretary

Michel Khalaf
President

GROUP DENTAL INSURANCE POLICY **NON-DIVIDEND PAYING**

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DEFINITIONS

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

Contribution means any amount an Employee is required to pay towards the total Premium that MetLife charges for the insurance provided by this policy.

Contributory Insurance means any insurance for which an Employee is required to make a Contribution.

Covered Person means an Employee or Dependent who is the subject of insurance under the certificates attached to the policy as Exhibits.

Dependent means any person who qualifies as a Dependent under the certificates attached to the policy as Exhibits.

Employee means any person who qualifies as an Employee under the certificates attached to the policy as Exhibits.

Employer means the Policyholder shown on the face page of this policy.

Exhibit means any attachment to this policy referred to in the Schedule of Exhibits. Exhibits to this policy include the certificates and any riders attached to such certificates; a Schedule of Initial Premium Rates; and such other attachments as agreed to by MetLife and the Policyholder.

Certificateholder means an Employee who is a Covered Person or has a Dependent who is a Covered Person. Unless otherwise specified, the Certificateholder is entitled to exercise the rights and benefits granted under the certificates attached to the policy as Exhibits.

Noncontributory Insurance means any insurance for which the Employee is not required to make a Contribution.

Policy Anniversary means each of the Policy Anniversary dates as set forth in the Policy Anniversaries provision on the policy face page. The Policy Anniversary is also the renewal date of the policy.

Policy Month means the one month period beginning on the Effective Date shown on the face page of this policy. Subsequent Policy Months will begin on the same day of each subsequent month.

Policyholder means the entity listed as the Policyholder on the face page of this policy.

Premium means the amount that must be paid to MetLife for all the insurance provided under this policy.

Premium Due Date is defined on the face page of this policy.

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

Written or **Writing** means a record which is on or transmitted by paper, electronic media, or other durable media and which is consistent with applicable law.

SCHEDULE OF INSURANCE

The schedules of insurance which apply under this policy are set forth in the Exhibits and certificates attached to this policy as Exhibits.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

The Eligibility and Effective Dates of Insurance provisions provided under this policy are set forth in the Exhibits to this policy and the appropriate records of MetLife and the Policyholder. Provisions setting forth the conditions, if any, under which MetLife requires a person to furnish evidence of good health satisfactory to MetLife to obtain coverage are also set forth in the Exhibit(s).

PREMIUM RATE(S)

Initial Rate(s)

The initial Premium rate(s) are shown in the Exhibits to this policy.

Computation of Premiums

The Premium due on any Premium Due Date is determined by the total number of Covered Persons, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

Computation of Premiums for Changes in Insurance

For insurance that takes effect on the first day of a Policy Month, Premium will be charged from the first day of that Policy Month. For insurance that takes effect after the first day of a Policy Month, Premium will be charged from the first day of the next Policy Month.

If insurance ends because this policy ends or because insurance for a class of persons ends, Premium for such insurance will be charged to the date it ends. If insurance ends for any other reason, Premium will be charged to the end of the Policy Month in which such insurance ends.

Right to Change Premium Rates

Except as may be required by any Rate Guarantee Period, MetLife may change Premium rates on any date on or after the first Policy Anniversary Date; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 31 days before such change.

In addition to the above and notwithstanding any Rate Guarantee Period, MetLife may change Premium rates at any time for changes which materially affect the risk or cost assumed for the insurance provided by this policy, as follows:

1. when this policy is amended;
2. when a class of eligible persons is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;
3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including organizational restructuring, acquisition, spin-off or similar situations;
4. when there is a significant change in the geographic distribution of either Certificateholders or Employees;
5. when applicable law requires a change in:
    a. the insurance provided by this policy; and/or
    b. the class of persons eligible for insurance under this policy; or

6. when a Premium Due Date coincides with or next follows:

   a. a change greater than 25% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or

   b. a change greater than 25% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.

7. on any other date agreed to by MetLife and the Employer.

New Premium rates will apply only to Premiums that become due on or after the date the rate change takes effect.

GRACE PERIOD

Each Premium due after the Effective Date of such insurance may be paid up to 31 days after its Premium Due Date. This period is known as the grace period. The insurance provided by this policy for which premium has not been paid will stay in effect during the grace period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, such insurance will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder by the end of the grace period, such insurance will continue in effect until the date notice is given.

Policyholder's intent to end this policy during the grace period

The Policyholder may notify MetLife in Writing prior to the end of a grace period of its intent to end this policy or insurance coverage provided under it before the end of such grace period. In this case, this policy or such insurance will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

The Written notice to be given by MetLife and required by the first paragraph of this provision will not be necessary if the Policyholder replaces the insurance provided by this policy for which premium has not been paid with other group insurance or the Policyholder notifies MetLife of its intent to end this policy or such insurance.

If more than one type of insurance coverage is provided under this policy then, to the extent there are different Premium Due Dates or different length grace periods for such coverages, this grace period provision will apply to each coverage independently of the others.

If more than one type of insurance coverage is provided under this policy, then to the extent such coverages have the same Premium Due Dates and the same length grace period, this grace period provision will apply to all such coverages simultaneously so that in the absence of written notice from the Policyholder of its intent to end a specific coverage, failure to pay the entire premium due by the end of the grace period will end all coverage under the policy.

Grace period extensions

MetLife may extend the grace period by giving Written notice to the Policyholder. Such notice will state the date insurance will end if the Premium remains unpaid.

Premiums must be paid for a grace period, any extension of such period and any period insurance was in effect for which Premium was not paid.

END OF INSURANCE PROVIDED BY THIS POLICY

The Policyholder can end this policy by giving 60 days advance Written notice to MetLife. The policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

MetLife can end this policy as follows:

1. for non-payment of Premium, as set forth in the Grace Period provisions;

2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if fewer than:

    a. for Dental Expense Benefits for Employees, 65% of Employees eligible for Contributory Insurance under this policy are insured for such insurance; or

    b. for Dental Expense Benefits for Dependents, if fewer than 25% of all Employees with Dependents are insured for Contributory Dependent Insurance;

c. 10 Employees are insured by this policy.

3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or

4. on any Policy Anniversary, except during a Rate Guarantee Period for insurance affected by the Rate Guarantee Period, by giving the Policyholder 31 days advance Written notice.

This policy will end on the date on which the last certificate in effect under this policy ends.

If this policy ends, all Premiums due must be paid. If MetLife accepts Premium after the date this policy ends, such acceptance will not act to reinstate the policy. MetLife will refund any unearned Premium.

GENERAL PROVISIONS

Entire Contract. The entire contract is made up of the following:

1. this policy and its Exhibits including the certificates attached to the policy as Exhibits;
2. the Policyholder's application; and
3. the amendments to this policy, if any.

Policy Changes or Waivers

The terms and provisions of this policy may be changed, either by amendment or endorsement.

1. The policy may be changed by amendment upon the mutual agreement of MetLife and the Policyholder. Such amendment must be in Writing and Signed by an officer of MetLife and by an authorized representative of the Policyholder.

2. The policy may be changed by an endorsement issued by MetLife without the consent of the Policyholder. Such endorsement must be in Writing and Signed by an officer of MetLife. The use of endorsements is limited to:

    a. changes made in response to :
        - applicable local, state or federal law or regulation;
        - a change in applicable local, state or federal law or regulation; or
        - the administration of applicable local, state or federal law or regulation;
    b. reflect changes in MetLife's administrative practices;
    c. reflect policy liberalizations to the extent that they do not increase Premiums;
    d. incorporate provisions agreed upon prior to issuance of this policy; and
    e. reflect the exercise of a right or rights set forth under the terms of the policy.

Changes to the policy may be made without the consent of the Certificateholders or anyone else with a beneficial interest in it. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement may be effective retroactively if such retroactivity is not prohibited by applicable law.

An officer of MetLife must approve in Writing any waiver of the terms and provisions of this policy.

A sales representative or other MetLife employee, who is not an officer of MetLife does not have MetLife's authority to approve changes or waivers. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to this policy.

Incontestability: Statements Made by Policyholder

Any statement made by the Policyholder will be considered a representation and not a warranty. MetLife will not use such a statement to contest insurance after such insurance has been in force for 2 years from its effective date. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application.

Incontestability: Statements Made by Covered Persons

Any statement made by a Covered Person or a Covered Person's legal representative will be considered a representation and not a warranty. MetLife will not use statements which relate to insurability to contest insurance after such insurance has been in force for 2 years during the Covered Person's life. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during the Covered Person's life.

MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. the Covered Person or the Covered Person's legal representative has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person, the Covered Person's legal representative or the Covered Person's beneficiary.

Certificates

MetLife will issue certificates to the Policyholder or the Policyholder's designee for delivery to each Certificateholder, as appropriate. Such certificate will describe the Certificateholder's benefits and rights under this policy and are Exhibits to the policy. The term "certificate" includes certificate riders.

Assignment

This policy is not assignable except and to the extent such assignment may be agreed to by MetLife.

The assignability of certificates attached as Exhibits to this policy and of the rights and benefits arising under such certificates, is described in the certificates.

Information Needed and Policy Administration

All information necessary to compute Premiums and carry out the terms of this policy will be provided by the Policyholder to MetLife. Such information:

- Must be provided in a timely manner and in a format as agreed to by MetLife and the Policyholder;
- Will be provided, maintained and administered as agreed to in writing by an officer of MetLife and the Policyholder; and
- If maintained by the Policyholder, may be examined by MetLife at any reasonable time.

If MetLife or the Policyholder makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

Any act undertaken by the Policyholder that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with MetLife's requirements; including but not limited to the eligibility requirements for coverage as set forth in the certificates to this policy.

Misstatement of Age

If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust the Premium and/or benefits.

Non-Dividend Paying

This policy does not pay dividends.

Conformity with Law

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

SCHEDULE OF EXHIBITS

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Premium Rates	All Covered Persons	April 1, 2023
2	Certificate Forms	All Covered Persons	April 1, 2023

Summary of Benefits
Dental Insurance - Sold Option

Employer Sponsored Dental		
Class Description	All Active Full Time Employees (30 Hours)	
	In-Network	**Out-of-Network‡**
Reimbursement	Negotiated Fee Schedule	R&C 99th Percentile
Type A – Preventive	100%	100%
Type B – Basic	100%	100%
Type C – Major	75%	75%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $0 $0 Aggregate	B & C $0 $0 Aggregate
Calendar Year Maximum *(applies to A,B,C services)*	$2,250	$2,250
Orthodontia	100%	100%
Orthodontia Calendar Maximum	$2,000	$2,000
Incentive Provisions	Criteria: 1 cleaning in prior year • Increase Maximum by $150 the following year; subject to a total Maximum increase of $450	Criteria: 1 cleaning in prior year • Increase Maximum by $150 the following year; subject to a total Maximum increase of $450

‡ Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), or (2) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Employer Sponsored Dental	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
▪ Employee Only	$52.02	287	$102,183	$1,226,190
▪ Employee + Spouse	$106.20	99		
▪ Employee + Child(ren)	$127.60	199		
▪ Employee + Family	$182.08	282		
▪ Total		867		
Rates are guaranteed from April 1, 2023 – March 31, 2025 (24 months)				
3rd year Rate Cap: The second year's renewal rates will not be increased by more than 5.0% above the current rates.				

Frequency & Allocations / Exclusions

(Custom Comprehensive (Flex) – Custom Standard (Flex))

Class Description: All Active Full Time Employees	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 12 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 12 months
▪ Sealants	▪ 1 per molar in lifetime for a child under age 16
▪ Space Maintainers	▪ 1 per lifetime for a child under age 14
▪ Fluoride	▪ 1 time in 1 calendar year for a dependent child under age 19
▪ Full Mouth X-Rays	▪ Once in 3 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 2 times in 1 calendar year ▪ Adult: 2 times in 1 calendar year
▪ Consultations	▪ 1 in 12 months
▪ Labs & Other Tests	
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Amalgam Fillings	▪ No Limit
▪ Root Canal	▪ 1 per tooth per lifetime
▪ Periodontal Maintenance	▪ 4 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 4)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 per tooth in 5 calendar years
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Emergency Palliative Treatment	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months

▪ Dentures	▪ 1 in 5 calendar years
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 60 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ General Anesthesia	
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions

All Active Full Time Employees

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature.
- Services for which a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- 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 or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic unless required for the treatment of a congenital defect or birth anomaly.
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- 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 natural teeth.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- 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.

- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Occlusal Adjustments.
- Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

EXHIBIT 1

SCHEDULE OF PREMIUM RATES

The initial monthly Premium rates for the insurance provided by this policy are as follows:

Rate Guarantee Period

Subject to the Right to Change Premium Rates provision on page 5, the Premium rates for Dental Benefits will be in effect from April 1, 2023 through March 31, 2025.

Dental Expense Benefits:

	Amount per unit for Dental Expense Benefits in force hereunder
Employee Only	$52.02
Employee and Spouse	$106.20
Employee and Child(ren)	$127.60
Employee and Family	$182.08

The premium renewal rates on April 1, 2025 will not increase more than 5% from the initial schedule of premium rates listed above.

EXHIBIT 2

CERTIFICATE FORMS

Certificate Number	Certificate Form	Applies To	Effective Date
1	GCERT2000	All Active Full-Time Employees	April 1, 2023

CIVIL UNION NOTICE FOR RESIDENTS OF NEW JERSEY

CIVIL UNIONS AND DOMESTIC PARTNERS

The New Jersey Civil Union Act grants Civil Union partners the same benefits, protections and responsibilities that flow from marriage under New Jersey state law. The New Jersey Domestic Partnership Act grants Domestic Partners some of the benefits, protections and responsibilities that flow from marriage under New Jersey state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to Civil Union Partners or to Domestic Partners. For example, a federal law, controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, Civil Union Partners, Domestic Partners and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

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, and
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

For All Active Full-Time Employees

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	100%	100%
Type C Services	75%	75%
Type D Services (Orthodontic)	100%	100%
Deductibles for:	In-Network	Out-of-Network
Yearly Individual Deductible	$0	$0
Maximum Benefit:	In-Network	Out-of-Network
Yearly Individual Maximum	$2,250 for the following Covered Services: Type A, Type B & Type C	$2,250 for the following Covered Services: Type A, Type B & Type C
Individual Maximum per calendar year Type D Covered Services (Orthodontic)	$2,000	$2,000

The Yearly Individual Maximum Benefit for a person covered under this certificate will increase in the next Year by $150.00, if such person receives at least 1 oral exam (other than a problem-focused exam) and cleaning (periodontal or regular) in the prior Year. This increase is limited to three increases per calendar year and will remain in effect for succeeding Years.

Benefit Waiting Periods for Late Entrants

Type A Services .....No waiting period

Type B (Fillings).....6 month waiting period

All Other Type B Services .....12 month waiting period

Type C Services .....24 month waiting period

Type D Services (Orthodontic).....24 month waiting period

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.

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

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

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

Cast Restoration means an inlay, onlay, or crown.

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

For Dental Insurance, Your natural child; Your 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.

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.

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 an employee.

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

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that We will pay for such services 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.

DEFINITIONS (continued)

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.

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.

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

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

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

- have registered as each other's domestic partner or reciprocal beneficiary with a government agency where such registration is available or who are in a same sex relationship from another jurisdiction which provides some, but not all of the rights and obligations of marriage; 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.

Full-Time means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours a week. Full-Time does not include temporary or seasonal employees.

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 the lesser of:

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

Noncontributory Insurance means insurance for which the Employer does not require You to pay any part of the premium.

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

DEFINITIONS (continued)

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group 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.

Reasonable and Customary Charge is the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) ; or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 99th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife's Reasonable and Customary Charge records (the 'Customary Charge'). Where MetLife determines that there is inadequate charge information maintained in MetLife's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

  An example of how the 99th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Reasonable and Customary charge records. These 100 hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 99th percentile of charges is the charge that is equal to the charge numbered 99.

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. The term also includes Your Domestic Partner.

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 an employee.

DEFINITIONS (continued)

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**, means the 12 month period that begins January 1.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

For All Active Full-Time Employees

You will be eligible for insurance on the later of:

1. April 1, 2023; and
2. the day after the date You complete the Waiting Period of 60 days.

If You enter an eligible class after April 1, 2023, You will be eligible for insurance on the day after the date You complete the Waiting Period of 60 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dental Insurance when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance you are a timely entrant, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the day after the enrollment period, if You are actively at Work on that date.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible. If You are not currently enrolled for Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

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

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the day after the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

If You complete the enrollment process more than 31 days after You are first eligible or not during an annual enrollment period or If You do not have a Qualifying Event or in the case of transferred business, if you did not elect coverage under the prior plan, you are a late entrant, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date and benefits will become effective after you satisfy the late entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS.

If You are not Actively at Work on the date the Insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work and benefits will become effective after you satisfy the late entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS.

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 last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

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 Full-Time Employees

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.

For All Active Full-Time Employees

You will be eligible for Dependent insurance on the later of:

1. April 1, 2023; and
2. the day after the date You complete the Waiting Period of 60 days.

If You enter an eligible class after April 1, 2023, You will be eligible for Dependent insurance on the day after the date You complete the Waiting Period of 60 days.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

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

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 for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer 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.

The Dental Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Dependent Dental Insurance when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process for Dependent Dental Insurance within 31 days of becoming eligible for Dependent Insurance you are a timely entrant, such insurance will take effect on the later of:

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

provided You are Actively at Work on that date. If You are not Actively at Work on that date, it will take effect on the day You return to Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

You will be able to enroll for Dependent Insurance during the first annual enrollment period. When You complete the enrollment process during the first annual enrollment period, such insurance will take effect on the day after the enrollment period, if You are actively at Work on that date.

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

Enrollment During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period for dental insurance as determined by the Employer, You may enroll for insurance for which You are eligible. If You are not currently enrolled for Dependent Dental Insurance but You enroll or make changes to Your insurance during a subsequent enrollment period, the Dependent Dental Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

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

If You complete the enrollment process more than 31 days after You are first eligible or not during an annual enrollment period or If You do not have a Qualifying Event, you are a late entrant or in the case of transferred business, if you did not elect coverage under the prior plan, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date and benefits will become effective after you satisfy the late entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS.

If You are not Actively at Work on the date the insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work and benefits will become effective after you satisfy the late entrant benefit waiting period(s) as shown in the SCHEDULE OF BENEFITS.

Enrollment Due to a Qualifying Event

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

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the day after the date of Your request, if You are Actively at Work on that date.

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

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for dental coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date Your Dental Insurance ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent except in the case of a Dependent Child who has reached the maximum age as defined in the DEFINITIONS section, Insurance will end on the last day of the calendar year;
9. for Utah residents, the last day of the calendar month the person ceases to be a Dependent;
10. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

The following rules will apply if this Dental Insurance replaces other group dental coverage provided to You by the Employer.

Prior Plan means the group dental coverage provided to You by the Employer on the day before the Replacement Date.

Replacement Date means the effective date of this Dental Insurance under the Group Policy.

Rules if You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;

2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:

    - the loss of a tooth; and
    - the accumulation of amounts toward:
        - Annual Maximum Benefits; and
        - Lifetime Maximum Benefits;

3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;

4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:

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

Rules if You and Your Dependents were <u>NOT</u> covered under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;

2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

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 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.

FOR FAMILY AND MEDICAL LEAVE

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

COBRA CONTINUATION FOR DENTAL INSURANCE

The following applies to employers with 20 or more employees that are not church or government plans:

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Employer for information regarding continuation of insurance under COBRA.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff up to 2 months.
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 9 months.
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence up to 2 months.

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

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

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

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

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 benefit amounts 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 Reasonable and Customary Charge.

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

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

Emergency Dental Condition

If You cannot reasonably reach an In-Network Dentist, benefits for an Emergency Dental Condition performed by an Out-of-Network Dentist for will paid as if the Covered Service had been performed by an In-Network

Dentist. You must confirm to Us in writing that the Covered Service was obtained from an Out-of-Network Dentist solely because You required treatment for an Emergency Dental Condition and an In-Network Dentist was not available.

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 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 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.

Orthodontic Covered Services

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

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be based on the lower of:
- the amount charged by the Dentist; and
- the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment if:
- Dental Insurance is in effect for the person receiving the orthodontic treatment; and
- proof is given to Us that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.
If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:
- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After 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 if:

- the Covered Service was performed by a Dentist while You are insured for Dental Insurance; and
- the Covered Service requires more than one visit to complete.

If You are Fully Disabled on the date Your Dental Insurance ends because this policy ends, We will pay benefits for Covered Services if:

- the Covered Service was recommended in Writing by a Dentist or Physician;
- the Covered Service was begun prior to the date Your Dental Insurance ended;
- the Covered Service was performed within 90 days after this Dental Insurance ends.

"Fully Disabled" for purposes of Dental Insurance means that because of a sickness or injury: You can not do Your job; or a Dependent can not do his or her usual activities.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

Type A Covered Services

1. Oral exams are limited to twice every 12 months less the number of problem-focused examinations received during such months.

2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, are limited to twice every 12 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), are limited to twice every 12 months.

4. Problem-focused examinations are limited to twice every 12 months less the number of oral exams received during such months.

5. Bitewing x-rays but not more than 2 sets every calendar year.

6. Full mouth or panoramic x-rays once every 3 calendar years.

7. Intraoral-periapical x-rays.

8. Dental x-rays except as mentioned elsewhere in this certificate.

9. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice every 12 months.

10. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.

11. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.

12. Diagnostic casts.

13. Topical fluoride treatment for a Child under age 19, but not more than once in a calendar year.

14. Sealants or sealant repairs for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth in a lifetime.

15. Preventive resin restorations, which are applied to non-restored first and second permanent molars, but not more than once per tooth in a lifetime.

16. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, but not more than once per tooth in a lifetime.

17. Space maintainers for a Child under age 14, once per lifetime per tooth area.

18. 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.

19. Other consultations, but not more than once in a 12 month period.

Type B Covered Services

1. Protective (sedative) fillings.

2. Initial placement of amalgam fillings.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

3. Replacement of an existing amalgam filling.

4. Initial placement of resin fillings.

5. Replacement of an existing resin filling.

6. Emergency palliative treatment to relieve tooth pain.

7. Simple extractions.

8. Surgical extractions.

9. Oral surgery except as mentioned elsewhere in this certificate.

10. Pulp capping (excluding final restoration).

11. Pulp therapy.

12. Apexification/recalcification.

13. Therapeutic pulpotomy (excluding final restoration).

14. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.

    Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.

15. 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 four times in any calendar year less the number of teeth cleanings received during such calendar year.

16. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period.

17. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.

18. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 36 month period.

19. Prefabricated crown, but no more than one replacement for the same tooth surface within 5 calendar years.

20. Labial veneers, but no more than once per tooth in a period of 5 years.

21. Initial installation of Cast Restorations (except an implant supported Cast Restoration).

22. Replacement of Cast Restorations (except an implant supported Cast Restoration), but only if at least 5 years have passed since the most recent time that:

    - a Cast Restoration was installed for the same tooth surface; or
    - a Cast Restoration for the same tooth surface was replaced.

23. Core buildup, but no more than once per tooth in a period of 5 calendar years.

24. Post and cores, but no more than once per tooth in a period of 5 calendar years.

25. Local chemotherapeutic agents.

26. Injections of therapeutic drugs.

27. 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. 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.

2. Tissue Conditioning, but not more than once in a 36 month period.

3. Simple Repairs of Cast Restorations but not more than once in a 12 month period.

4. Initial installation of fixed and permanent Dentures:

   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

5. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 calendar years prior to replacement.

6. Initial installation of full or removable Dentures:

   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

7. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture.

8. Replacement of a non-serviceable full or removable Denture if such Denture was installed more than 5 calendar years prior to replacement.

9. Adjustments of Dentures:

   - if at least 6 months have passed since the installation of the existing removable Denture; and
   - not more than once in any 12 month period.

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. Repair of Dentures but not more than once in a 12 month period.

12. Addition of teeth to fixed and permanent Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.

13. Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

14. Re-cementing of Cast Restorations or Dentures but not more than once in a 12 month period.

15. 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 60 month period:

- when needed to replace congenitally missing teeth; or
- when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

16. Cleaning and inspection of a removable appliance twice every 12 months.

17. Repair of implants, but not more than once in a 60 month period.

18. Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period:

- when needed to replace congenitally missing teeth; or
- when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance.

19. Repair of implant supported prosthetics but not more than once in a 12 month period.

20. With respect to residents of Minnesota, surgical and non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging, but cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period.

Type D Covered Services

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the benefit waiting period that applies.

Orthodontia, if the orthodontic appliance is initially installed while Dental Insurance is in effect for You, Your Spouse, and Your Children.

DENTAL INSURANCE: EXCLUSIONS

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

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
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 primarily cosmetic, unless required for the treatment of a congenital defect or birth anomaly (for residents of Texas, see notice page section).
5. 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.
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, personalization 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 not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.

Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.

The term does not include:

- any plan, program or coverage provided by a government as an employer; or
- Medicare.

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. Initial installation of a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
24. Other fixed Denture prosthetic services not described elsewhere in this certificate.
25. Precision attachments, except when the precision attachment is related to implant prosthetics.
26. Initial installation or replacement of a full or removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Addition of teeth to a partial removable Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
28. Addition of teeth to a fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
29. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
30. Implants to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Implants supported prosthetics to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
32. Occlusal adjustments.
33. Fixed and removable appliances for correction of harmful habits.
34. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
35. Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota.
36. Repair or replacement of an orthodontic device.

DENTAL INSURANCE: EXCLUSIONS (continued)

37. Duplicate prosthetic devices or appliances.

38. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.

39. Intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

You or Your Dependent may be covered for health benefits or services by more than one Plan. For instance, You may be covered by this Policy as an employee and by another Plan as a Dependent of Your spouse. If You or Your Dependent are, this provision allows Us to coordinate what We pay with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the covered person is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

"**Allowable Expense**" means the charge for any dental service, supply or other item of expense for which the covered person is liable when the dental service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

"**Claim Determination Period**" means a period, or portion of a period that starts on January 1 and ends on the next December 31, during which You or Your Dependent are covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

"**Plan**" means coverage with which coordination of benefits is allowed. Plan includes:

- group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice Plans, including insurance continued pursuant to a Federal or State continuation law;
- Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or nongovernmental Plan.

Plan does not include:

- individual or family insurance contracts or subscriber contracts;
- individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice Plans;
- group or group-type coverage where the cost of coverage is paid solely by the Covered person except when coverage is being continued pursuant to a Federal or State continuation law;
- school accident -- type coverage
- a State Plan under Medicaid

"**Primary Plan**" means a Plan whose benefits for a covered person's dental coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "1" or "2" below exist:

1. the Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
2. all Plans which cover the covered person use order of benefit determination rules consistent with those contained in the Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

"**Reasonable and Customary**" means, for the purposes of this Coordination of Benefits provision only, an amount that is not more than the usual or customary charge for the service or supply as determined by the Plan, based on a standard which is most often charged for a given service by a Dentist within the same geographic area.

"**Secondary Plan**" means a Plan which is not a Primary Plan. If a covered person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary And Secondary Plan

We consider each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan (s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

As is always true, we will not reduce Allowable Expenses for dentally necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules For The Order Of Benefit Determination

The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the covered person as a dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

1. The benefits of the Plan that covers the covered person as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the covered person as a laid off or retired employee, or as such a person's dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

2. The benefits of the Plan that covers the covered person as an employee, member, subscriber or retiree, or dependent of such person, shall be determined before those of the Plan that covers the covered person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

3. If a child is covered as a dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

    a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar year.
    b. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the parent for a shorter period of time.
    c. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.

d. If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

4. If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

   a. The benefits of the Plan of the parent with custody of the child shall be determined first.
   b. The benefits of the Plan of the spouse of the parent with custody shall be determined second.
   c. The benefits of the Plan of the parent without custody shall be determined last.
   d. If the terms of a court decree state that one of the parents is responsible for the dental expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding dental expenses, this portion of this provision shall be ignored.

5. If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow, it is necessary to consider:

- the basis on which the Primary Plan and the Secondary Plan pay benefits; and
- whether the Dentist who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan. For the purpose of applying the following provisions, if the Plan does not have a network, the Dentist will be considered on the same basis as an in-network Dentist.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the Dentist bills a charge and the covered person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a Dentist, called a network Dentist, bills a charge, the covered person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the covered person uses the services of a non-network Dentist, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the Dentist may be based on a capitation. This means that the health maintenance organization (HMO) pays the Dentist a fixed amount per covered person. The covered person is liable only for the applicable deductible, coinsurance or copayment. If the covered person uses the services of a non-network Dentist, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays Dentists based upon capitation is called a "Capitation Plan."

In the rules below, "Dentist" refers to the Dentist who provides or arranges the services or supplies and HMO refers to a health maintenance organization Plan.

The Primary Plan is an R&C Plan and the Secondary Plan is an R&C Plan: The Secondary Plan shall pay the lesser of:

- the difference between the amount of the billed charges and the amount paid by the Primary Plan; and
- b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

DENTAL INSURANCE: COORDINATION OF BENEFITS (CONTINUED)

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is a Fee Schedule Plan: If the Dentist is a network Dentist in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the Dentist receives from the Primary Plan, the Secondary Plan and the covered person shall not exceed the fee schedule of the Primary Plan. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

The Primary Plan is an R&C Plan and the Secondary Plan is a Fee Schedule Plan: If the Dentist is a network Dentist in the Secondary Plan, the Secondary Plan shall pay the lesser of:

- the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The covered person shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the covered person has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the Dentist's billed charges. In no event shall the covered person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is an R&C Plan: If the Dentist is a network Dentist in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

- the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
- the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Primary Plan is a Fee Schedule Plan and the Secondary Plan is an R&C Plan or Fee Schedule Plan: If the Primary Plan is an HMO Plan that does not allow for the use of non-network Dentists except in the event of urgent care or emergency care and the service or supply the covered person receives from a non-network Dentist is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

The Primary Plan is a Capitation Plan and the Secondary Plan is a Fee Schedule Plan or R&C Plan If the covered person receives services or supplies from a Dentist who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from or give them to any other organization or person. 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 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 providing benefits in the form of services, in which case "payment made" means reasonable monetary 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 it 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;
- insurance companies; or
- other organizations.

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

FILING A CLAIM

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 review the claim and, if We approve it, We will pay benefits 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 within 20 days of the date of the loss.

Step 2
We will send a claim form to the claimant within 15 days of the request. The person making such claim shall be deemed to have complied with the requirements of the policy as to Proof of loss upon submitting within the time fixed in the policy for filing Proof of loss, written Proof covering the occurrence, character and extent of the loss for which claim is made. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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.

However, failure to give notice and Proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such and notice and Proof and that notice and Proof was given as soon as was reasonably possible.

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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.

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer 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.

Under New Jersey law, we must require that Dentists file all claims for dental services, but You are permitted, at Your option to submit a claim on behalf of yourself or Your Dependent. Under New Jersey law, all claims shall be filed using the standard dental claim form applicable to this policy.

Acknowledgement of Receipt of Claims

We shall acknowledge receipt of all claims and include the date We received the claim.

If a claim is submitted by electronic means, an "Electronic Claim", the claim shall be acknowledged electronically no later than two working days following Our receipt of the claim. The acknowledgement of receipt shall go to the entity from which or from whom We received the claim.

If a claim is submitted by written notice, a "written claim", the claim shall be acknowledged no later than 15 working days following Our receipt of the claim.

If We pay benefits on the claim within two days of Our receipt of an Electronic Claim or within 15 days of Our receipt of a Written Claim, the payment shall include the date of our receipt of the claim and the payment shall be deemed to be the acknowledgement of Our receipt of the claim.

When Dentists are offered web-based access to the status of claims, the available information shall include the date of Our receipt of the claims. If provided on a timely basis under the time frames described above, such information shall be deemed to be the acknowledgement of Our receipt of the claim.

When Dentists are provided access to claims status via an automated telephone system and the available information includes the date of Our receipt of the claims and that information is made available on a timely basis under the time frames described above, the posting of that information shall be deemed to be the acknowledgement of receipt of those claims.

Claim Submission Requirements

We shall notify Participating Dentists at least annually and shall make available to You or Your Dependent upon request, a listing of the type of information and documentation that must be submitted with an Electronic Claim or a Written Claim, including a standard claim form and any other claim submission requirements. We may change the required information and documentation as long as Participating Dentists are given at least 30 days prior notice of the change in requirements. We shall also provide Participating Dentists with a street address where a claim submission can be delivered by hand or registered/certified mail.

Prompt payment of claims

A Clean Claim is a claim:

- which is an eligible claim for a Covered Service provided by a Dentist to a covered person under the policy;
- which has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;
- on which there is no dispute regarding the amount claimed;
- which We have no reason to believe that the claim has been submitted fraudulently; and

- which requires no special treatment that prevents timely payments from being made on the claim under the terms of the policy.

We shall pay benefits for Clean Electronic Claims within the earlier of:

- 30 calendar days after receipt of the claim or
- the time established for the Federal Medicare program.

We shall pay benefits for Electronic Claims that are disputed or denied because of missing information or documentation within 30 calendar days of receipt of the missing information or documentation.

We shall pay benefits for Clean Written Claims within 40 calendar days after Our receipt of the claim.

We shall pay benefits for Written Claims that are disputed or denied because of missing information or documentation within 40 calendar days of receipt of the missing information or documentation

Payment of a claim shall be considered to have been made:

- on the date a draft or other valid instrument equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope; or
- on the date of delivery of a draft or other valid instrument equivalent to payment.

Denied and disputed claims

If only a portion of a claim is disputed or denied, We shall pay benefits for the uncontested portion on the same basis as for a clean claim. The pending of a claim does not constitute a dispute or denial.

For a denied or disputed claim, within 30 or 40 calendar days of Our receipt of the claim, whichever applies, We shall notify You or the Dentist, as appropriate, of the basis for Our decision to deny or dispute the claim.

This notice will identify and explain all reasons why the claim was denied or disputed. If a claim is denied because it cannot be entered into the claims system, then the notice will include all reasons why the claim cannot be entered into the claims systems. Examples of reasons why a claim cannot be entered into the claims system include:

- the group is not covered on the date of service;
- You or Your dependent are not covered on the date of service;
- non-payment of premium;
- missing data fields;
- missing or incorrect data (for example, CDT code, date of service, Dentist name); and
- ineligible provider.

If the reasons why a claim cannot be entered into the claims system are subsequently cured and the claim is entered, Our first review after the claim is entered shall identify all applicable reasons why the claim is being denied or disputed.

We shall deny or dispute a claim only for:

- reasons identified in the first review after the claim is entered; or
- additional reasons which We were led to by information or documentation relevant to the claim where such information or documentation was received after the first review.

Where missing information or documentation is a reason to deny or dispute the claim, the notice shall specify the additional information or documentation that is required and We shall engage in a good faith effort to expeditiously obtain such additional information or document by, among other things, telephoning the Dentist.

If the amount of the claim is disputed, the notice will include an explanation of the reason for the dispute, including any change of coding performed by Us and the reasons for such change of coding. The notice will also include a toll free telephone number for the Dentist or claimant to call to discuss the claim with Us.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)

Under New Jersey law, if We do not provide the notice required above We waive our right to contest the claim for any reason other than the referral of the claim to the Office of Insurance Fraud Prosecutor in accordance with Our Fraud Prevention and Detection Plan.

If We fail to pay a clean claim within the time limits set forth above, We shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning 30 or 40 days, as applicable, from the date all information and documentation required to process the claim is received by Us. We may aggregate interest amounts up to $25.00, with the consent of the Dentist.

If We have reason to believe that the claim has been submitted fraudulently, We shall investigate the claim in accordance with Our fraud prevention plan established under New Jersey law or refer the claim to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety.

Unless otherwise provided by law, We shall pay the amount finally agreed upon in settlement of all or part of any claim not later than ten working days from either the receipt of such agreement by Us or the date of the performance by You or the Dentist of any conditions to payment set forth in the agreement, whichever is later.

We shall adjust claims previously paid only on the basis of actual identifiable error(s) in the submission, processing or payment of a particular claim(s). We shall not adjust previously paid claims based on extrapolation, with the following exceptions:

- Where the extrapolation, including the method, is non-binding;
- In judicial or quasi-judicial proceedings, including arbitration;
- In governmental administrative proceedings;
- Where relevant records required to be maintained by the Dentist have been improperly altered or reconstructed, or a material number of such records are unavailable; or
- Where there is clear evidence of claim fraud or abuse by the Dentist.

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.

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (CONTINUED)

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.

DENTAL INSURANCE: GRIEVANCE PROCEDURES

The following is a description of the MetLife Preferred Dentist Program's Grievance procedures that will apply in the event You wish to submit a Grievance regarding an adverse experience that may have occurred.

DEFINITIONS

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

Grievance means any verbal or written communication from You regarding an adverse experience or outcome related to an interaction with Our personnel or an encounter with a Dentist.

Explanation of Benefits means the written explanation of how dental benefits are paid after a claim has been submitted for benefits under this Dental Insurance.

Grievance Review Committee means a committee which operates within the Preferred Dentist Program, and consists of dental management personnel. The Grievance Review Committee is chaired by the National Dental Director.

SUBMISSION OF A GRIEVANCE

You can file a Grievance by:

- contacting the customer service unit at the telephone number shown on the Explanation of Benefits; or
- writing to the customer service unit at the address shown on the Explanation of Benefits.

A customer service representative will research the Grievance and, when possible, resolve it by telephone to Your satisfaction within three working days of the receipt of the Grievance.

If the Grievance is not so resolved, the customer service representative will forward the Grievance to the appropriate unit of MetLife to address the issue. Examples of these units are:

provider relation unit for network issues;
claim department or dental product area for claim review issues; and
claim department or account management for claim determination issues.

The appropriate unit will advise You and the customer service representative, in writing, of its review and any actions it has taken within 15 working days of receipt of the Grievance from the customer service representative. The appropriate unit may also, within the 15 working days, request added time to more fully consider the Grievance.

If the Grievance is not resolved to Your satisfaction, You can appeal the action of the particular unit to the Grievance Review Committee within 30 working days of the date You were notified of their decision. You will be given the information needed to make such an appeal at the time You are notified of the particular unit's decision.

The Grievance Review Committee will advise You and the customer service representative, in writing, of its review of the appeal and any actions it has taken on the appeal within 15 working days of receipt of the appeal from You. The Grievance Review Committee may also, within the 15 working days, request added time to more fully consider the Grievance.

Action of the Grievance Review Committee will be considered final.

DENTAL INSURANCE: GRIEVANCE PROCEDURES (CONTINUED)

ADDITIONAL ADDRESSES AND PHONE NUMBERS

MetLife Corporate Customer Relations
P.O. Box 789
Johnstown PA 15904
Telephone: 1-814-269-8371

New Jersey Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360
Telephone: 1-877-222-3737

New Jersey Department of Banking
Division of Insurance
Consumer Protection Services
P.O. Box 329
Trenton NJ 08625-0329
Telephone: 1-800-446-7467 (if calling from New Jersey) or 1-609-292-5316 (if calling from outside New Jersey)

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.

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 Employer. The entire contract with the Employer is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Employer's application, attached to the Group Policy; 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. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

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.

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.

ATTEST:

Paula Geletei

Paula Geletei, City Clerk

6/14/2023

CITY OF ATLANTIC CITY

BY: _____

Marty Small Sr., Mayor

Date: 6-13-23

BY: _____

Anthony A. Swan, Esq., CPM
Business Administrator

Date: 7 Jun 23

THE WITHIN AGREEMENT APPROVED AS TO FORM AND EXECUTION.

Date: 6/6/23

By: _____

Peter T. Sallata, Esq.
Assistant City Solicitor

Resolution of the City of Atlantic City

No. 97

Approved as to Form and Legality on Basis of Facts Set Forth

Assistant City Solicitor /s/ Karl Timbers

Factual contents certified to by

Director of Human Resources/s/ Shanece M. Jones

REVISED 2/15/2023

Prepared by City Solicitor's Office

Council Members SHABAZZ & RANDOLPH present the following Resolution:

RESOLUTION TO APPROVE AN AGREEMENT WITH METROPOLITAN LIFE INSURANCE COMPANY D/B/A MET LIFE FOR EMPLOYEE DENTAL COVERAGE IN AN AMOUNT NOT TO EXCEED TWO MILLION FOUR HUNDRED FIFTY -TWO THOUSAND THREE HUNDRED NINETY-TWO DOLLARS ($2,452,392.00)

WHEREAS, the City of Atlantic City desires to enter into a Contract with **METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE** providers of health benefits and services for employee dental coverage for the City of Atlantic City; and

WHEREAS, the City of Atlantic City has awarded a contract as an extraordinary, unspecifiable service, pursuant to N.J.S.A. 40A:11-5(1)(a)(ii)(m) and non-fair and open process in accordance with the Pay to Play Law, N.J.S.A. 19:44A-20.4 et seq.; and

WHEREAS, the present contract with the Delta Dental ends on February 28, 2023, and requires a thirty (30) day Notice to Quit.

WHEREAS, to satisfy the thirty (30) day notice requirement and move to forward with the new Dental Insurance provider **METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE** the City must extend the Delta Dental Insurance contact to March 31, 2023.

WHEREAS, METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE has completed and submitted a Business Entity Disclosure Certification which certifies that **METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE** has not made any reportable contributions to a political or candidate committee in the City of Atlantic City and/or City Council in the previous one year, and that the contract will prohibit **METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE** from making any reportable contributions through the term of the contract; and

WHEREAS, the Business Disclosure Entity Certification and the Determination of Value shall be placed on file with this resolution; and

NOW, THEREFORE, BE IT RESOLVED by the Council of the City of Atlantic City that the Mayor is duly authorized to execute and the City Clerk to attest an agreement with **METROPOLITAN LIFE INSURANCE CO. D/B/A MET LIFE** for Employee Dental Benefit from **APRIL 1, 2023 to MARCH 31, 2025** for a total sum not to exceed **TWO MILLION FOUR HUNDRED FIFTY -TWO THOUSAND THREE HUNDRED NINETY-TWO DOLLARS ($2,452,392.00)** to be approved as to form and execution by the City Solicitor, which contract shall set forth more specifically the services to be performed; and

BE IT FURTHER RESOLVED that a Certificate from the Chief Officer from accounts 3-01-23-220-100-DEN $919,647.00, 4-01-23-220-100-DEN $1,226,196.00, and 5-01-23-220-DEN $306,549.00 said funds are from the 2023, 2024, and 2025 budgets contingent upon the cancellation of the DELTA DENTAL INSURANCE. The remaining funds are contingent upon the passage of temporary & permanent budgets to satisfy the aforesaid award of contract. In the event said funds are not appropriated for the Agreement, said Agreement shall become null and void.

BE IT FURTHER RESOLVED that a Certificate of Funds from the Chief Officer from account 3-01-23-220-100-DEN in the amount of **ONE HUNDRED TWENTY-THREE THOUSAND ONE HUNDRED FORTY-TWO DOLLARS and TWENTY-EIGHT CENTS ($123,142.28)** has been attached to fund the thirty (30) day extension with Delta Dental Insurance from **FEBRUARY 28, 2023, to MARCH 31, 2023.**

BE IT FURTHER RESOLVED that Public Notice of this Resolution shall be published in the THE PRESS at least once pursuant to the requirements of N.J.S.A 40A:11-1, et seq.,

March 2, 2023 1:57 PM

DO NOT USE SPACE BELOW THIS LINE

RECORD OF COUNCIL VOTE ON FINAL PASSAGE

COUNCIL MEMBER	AYE	NAY	N.V	A.B.	MOT.	SEC.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	MOT.	SEC.
DUNSTON	X						SHABAZZ	X				X	
KURTZ	X						TIBBITT	X					
MARSHALL	X						WEEKES	X					
MORSHED	X					X	ZIA	X					
							RANDOLPH, PRESIDENT	X					

X-Indicates Vote NV-Not Voting AB-Absent MOT-Motion SEC-Second

This is a Certified True copy of the Original Resolution on file in the City Clerk's Office.

DATE OF ADOPTION: FEBRUARY 15, 2023

Paula Geletei

/s/ Paula Geletei, City Clerk