

NOTICE TO INSUREDS

READ THIS NOTICE CAREFULLY BEFORE ACCESSING THE FOLLOWING INFORMATION. MetLife is providing this Electronic Document describing the insurance benefits provided for in your certificate of insurance as a convenience. Central Region Insurance Services Pool maintains the group insurance policy, including a copy of the certificate of insurance that is available for you to review and copy if necessary. If there is any conflict between the information in this Electronic Document and the group insurance policy and certificate, the policy and certificate shall control in all respects.



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

CERTIFICATE RIDER

Group Policy No.: 119154-2

Policyholder: Central Region Insurance Services Pool (CRISP)

Member School District: Granger School District,
Mt. Adams School District,
Naches School District,
Toppenish School District,
Wapato School District,
West Valley School District,
Yakima School District,
Zillah School District

Effective Date: September 17, 2009

The certificate is changed as follows:

1. The Policyholder name is changed from Central Washington School Districts Risk Pool to Central Region Insurance Services Pool (CRISP).
2. The definition of Child in the DEFINITIONS section of the certificate is revised as follows:
coverage for a Child is regardless of student status, support status or full-time employment status.
3. The SCHEDULE OF BENEFITS in the certificate is replaced with the section that follows.

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

SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
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For Employees hired on or after January 1, 2009:

1st Year of Dental Insurance
(See **NOTE** below)

Type A Services	70%	70%
Type B Services	70%	70%

2nd Year of Dental Insurance
(See **NOTE** below)

Type A Services	80%	80%
Type B Services	80%	80%

3rd Year of Dental Insurance
(See **NOTE** below)

Type A Services	90%	90%
Type B Services	90%	90%

4th Year and thereafter of Dental
Insurance (See **NOTE** below)

Type A Services	100%	100%
Type B Services	100%	100%

For Employees hired prior to January 1, 2009:
(See **NOTE** below)

Type A Services	100%	100%
Type B Services	100%	100%

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For All Employees

Type C Services	50%	50%
Temporomandibular Joint Disorder (TMJ)	50%	50%
Orthodontic Covered Services	50%	50%

Deductibles for:

Yearly Individual Deductible	\$25 for the following Covered Services: Type B; Type C including Temporomandibular Joint Disorder	\$25 for the following Covered Services: Type B; Type C including Temporomandibular Joint Disorder
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Maximum Benefit:

Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C including Temporomandibular Joint Disorder	\$2,000 for the following Covered Services: Type A; Type B; Type C including Temporomandibular Joint Disorder
Yearly Individual Maximum for Temporomandibular Joint Disorder	\$1,000	\$1,000
Lifetime Individual Maximum for Orthodontic Covered Services	\$2,000	\$2,000
Lifetime Individual Maximum for Temporomandibular Joint Disorder (TMJ)	\$5,000	\$5,000

NOTE:

- For Employees hired on or after January 1, 2009, the Covered Percentage for You and Your Dependent will increase each Year by 10% provided You received Type A Services and/or Type B Services in the prior Year. If You did not receive Type A Services and/or Type B Services during the prior Year, Your Coverage Percentage for Type A Services and/or Type B Services will reduce by 10% but Your Covered Percentage will not be reduced below 70% for Type A Services and/or Type B Services.
- For Employees hired prior to January 1, 2009, Your Type A Services and/or Type B Services Covered Percentage will begin at 100%. However, the Covered Percentage will be subject to a 10% reduction for You and Your Dependent in January 2010 if You did not receive any Type A Services and/or Type B Services from January 1, 2009 through December 31, 2009



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Central Washington School Districts Risk Pool

Member School District: Granger School District,
Mt. Adams School District,
Naches School District,
Toppenish School District,
Wapato School District,
West Valley School District,
Yakima School District,
Zillah School District

Group Policy Number: 119154-2

Type of Insurance: Dental Insurance

MetLife Toll Free Number(s):
For Claim Information FOR DENTAL CLAIMS: 1-800-942-0854

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

FRAUD WARNING

If You have applied for insurance under a policy issued in the following state, or if You reside in the following state, note the following applicable warning:

For Residents of Washington

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

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SCHEDULE OF BENEFITS

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For You and Your Dependents

Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	100%	100%
Type C Services	50%	50%
Temporomandibular Joint Disorder (TMJ)	50%	50%
Orthodontic Covered Services	50%	50%

Deductibles for:

Yearly Individual Deductible	\$25 for the following Covered Services: Type B; Type C including Temporomandibular Joint Disorder	\$25 for the following Covered Services: Type B; Type C including Temporomandibular Joint Disorder
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Maximum Benefit:

Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C including Temporomandibular Joint Disorder	\$2,000 for the following Covered Services: Type A; Type B; Type C including Temporomandibular Joint Disorder
Yearly Individual Maximum for Temporomandibular Joint Disorder	\$1,000	\$1,000
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Lifetime Individual Maximum for Temporomandibular Joint Disorder (TMJ)	\$5,000	\$5,000

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

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

Cast Restoration means an inlay, onlay, or crown.

Child means the following:

Your natural or adopted child; Your stepchild who resides with You; or a child who resides with and is fully supported by You; and who, in each case, is:

- under age 25; and
 - unmarried;
 - supported by You; and
 - not employed on a full-time basis.

The definition of Child will always include newborns.

An adopted child includes a child for which You have assumed a legal obligation for total or partial support in anticipation of adoption.

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

The term does not include any person who;

- is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada.

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

Contributory Insurance includes: Dental Insurance for Your Dependents.

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.

DEFINITIONS (continued)

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

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

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

Dental Hygienist means a person trained to:

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

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

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

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

Dentist means:

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

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

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

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

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

DEFINITIONS (continued)

"**Experimental**" - A service or supply shall, in Our discretion, be considered 'Experimental' if any of the following conditions are present:

- Food and Drug Administration (FDA) approval is required in order for the service or supply to be lawfully marketed, and such approval has not been granted at the time the service or supply is prescribed or rendered.
- A current investigational new drug or new device application has been submitted and filed with the FDA.
- The prescribed service or supply is available to the Covered Person only through participation in FDA Phase I or Phase II clinical trials, or through FDA Phase III experimental or research clinical trials.
- The protocols or consent document of the entity prescribing or rendering the service or supply describes the service or supply as an alternative to more conventional therapies.
- The prescribed service or supply is available only subject to the approval of an Institutional Review Board, as defined by federal statute.
- Authoritative dental or scientific literature published in the United States and written by experts in the field demonstrates that recognized dental or scientific experts:
 1. classify the service or supply as experimental or investigational, or
 2. indicate that additional research is necessary before the service or supply could be classified as equally or more effective than conventional therapies.
- As a whole the service or supply would not be classified as Experimental or Investigational given the above criteria, but one or more essential provisions of the service or supply are Experimental or Investigational based on the above criteria.
- However, a drug approved by the FDA as an "investigational new drug for treatment use" shall not be considered Experimental or Investigational.

We will make the decision as to whether a service or supply is or should be classified as Experimental. In making such determination the specific and exclusive resources We will rely on will be limited to:

- Dental records of the Covered Person.
- The consent document signed, or required to be signed, in order to receive the prescribed service or supply.
- Protocols of the entity rendering the prescribed service or supply.
- Opinions advanced by Peer Review entities with which We contract to conduct reviews.
- Authoritative peer reviewed dental or scientific literature published in the United States regarding the prescribed service or supply for treatment of the Covered Person's diagnosis, including but not limited to: "United States Pharmacopoeia," and "American Hospital Formulary Service."
- The published opinions of the American Medical Association (AMA), the American Dental Association (ADA) or of specialty organizations recognized by the AMA or ADA.
- Federal laws or final regulations, issued by or applicable to the FDA, National Institutes of Health, or department of Health and Human Services regarding the prescribed service or supply.

MetLife will monitor the status of an Experimental service or supply and may decide using the criteria set forth above, that a service or supply which at one time was considered Experimental may now be covered.

Full-Time means Active Work on the Member School District's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 17 hours a week.

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.

DEFINITIONS (continued)

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.

Member School District means a school district which is a member of and participates in the Central Washington School Districts Risk pool.

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

Physician means:

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

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
 - parents;
 - children (natural, step or adopted);
 - siblings;
 - grandparents; or
 - grandchildren.

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.

DEFINITIONS (continued)

Reasonable and Customary Charge is the lowest of:

- a. the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies); or
- b. the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- c. the usual charge of most other Dentists or other providers of similar training or experience in the same geographic area for the same or similar services or supplies.

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 does not include any person who:

- is in the military of any country or subdivision of any country;
- lives outside of the United States or Canada.

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

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

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

You and **Your** mean 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 Classified Employees of Granger School District
All Classified Employees of Mt. Adams School District
All Classified Employees of Naches School District
All Classified Employees of Toppenish School District
All Classified and Certified Employees of Wapato School District
All Classified (Transportation only) Employees of West Valley School District
All Classified Employees of the Yakima School District
All Classified and Certified Employees of Zillah School District**

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

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

1. January 1, 2008; and
2. if your employment date is prior to the 16th day of the calendar month, the first day of the month following the date You enter that class; or
3. if your employment date is the 16th day of the calendar month or later, the first day of the second month following the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, 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.

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;
5. the date You retire in accordance with the Member School District's retirement plan; or
6. the date the Member School District ceases to participate in the Central Washington School Districts Risk Pool.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

**All Classified Employees of Granger School District
All Classified Employees of Mt. Adams School District
All Classified Employees of Naches School District
All Classified Employees of Toppenish School District
All Classified and Certified Employees of Wapato School District
All Classified (Transportation only) Employees of West Valley School District
All Classified Employees of the Yakima School District
All Classified and Certified Employees of Zillah School District**

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.

If You are in an eligible class on January 1, 2008, You will be eligible for Dependent insurance on the later of:

1. the first day of the month following the date You enter a class eligible for insurance, if your employment date is prior to the 16th day of the calendar month; or
2. the first day of the second month following the date You enter a class eligible for insurance, if your employment date is the 16th day of the calendar month or later;
3. the date You obtain a Dependent.

If You enter an eligible class after January 1, 2008, You will be eligible for Dependent insurance on the later of:

1. the first day of the month following the date You enter a class eligible for insurance, if your employment date is prior to the 16th day of the calendar month; and
2. the first day of the second month following the date You enter a class eligible for insurance, if your employment date is the 16th day of the calendar month or later;
3. the date You obtain a Dependent.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Dental 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 Member School District Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Member School District how much You will be required to contribute.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for Dependent Dental Insurance, 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 insurance will take effect on the day You resume Active Work.

Enrollment During the Next Dental Enrollment Period Following the Date You Become Eligible For Dependent Insurance

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Dental Insurance until the next enrollment period for Dental Insurance, as determined by the Member School District, following the date You first become eligible. At that time You will be able to enroll for insurance for which You are then eligible.

The insurance enrolled for will take effect on the first day of the calendar year 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 During Any Subsequent Dental Enrollment Period

During any subsequent annual enrollment period as determined by the Member School District, You may enroll for Dependent Dental Insurance for which You are eligible or choose a different option than the one for which Your Dependents are currently enrolled. The Dependent Dental Insurance enrolled for or changes to Your Dependent Dental Insurance made during a subsequent enrollment period will take effect on the first day of the calendar year following the enrollment period, if You are Actively at Work on that 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 Dependent Dental Insurance for which You are eligible or change the amount of Your Dependent Dental Insurance between annual enrollment periods only 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. However, if the Qualifying Event includes the birth, adoption or placement for adoption of a dependent child, You will have 60 days from the date of birth or date of placement to make the 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 first day of the month following the date of Your request, if You are Actively at Work on that date.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Qualifying Event includes:

- the marriage
- birth, adoption or placement for adoption of a dependent child
- divorce, legal separation or annulment
- death of a dependent
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage.

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

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date the Group Policy ends;
3. the date Insurance for Your Dependents ends under the Group Policy;
4. the date Insurance for Your Dependents ends for Your class;
5. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
6. the end of the period for which the last premium has been paid;
7. the last day of the calendar month in which the person ceases to be a Dependent;
8. the date You retire in accordance with the Member School District's retirement plan; or
9. the date the Member School District ceases to participate in the Central Washington School Districts Risk Pool.

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave.

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 Member School District.

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

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

Rules if You or 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 Deductibles;
 - Annual Maximum Benefits;
 - 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 or You and Your Dependents were NOT 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 under the Family and Medical Leave Act of 1993 (FMLA) for continuation of insurance. Please contact the Member School District for information regarding the FMLA.

COBRA CONTINUATION FOR DENTAL INSURANCE

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 Member School District for information regarding continuation of insurance under COBRA.

AT YOUR OPTION: CONTINUATION OF DENTAL INSURANCE DURING A STRIKE, LOCKOUT OR LABOR DISPUTE

If Dental Insurance for You or Dental Insurance for Your Dependents would end because You are no longer actively at work with the Member School District because of a strike, lockout, or other labor dispute; You will have the right to continue such insurance during the strike, lockout, labor dispute subject to the following conditions:

- a. You must make a written request to continue the insurance and make any payment which is required for the cost of the insurance; and
- b. the insurance will end on the earliest of the following dates:
 - 6 months after the date the insurance would otherwise have ended;
 - the date the plan ends;
 - if a payment which is required by Your employer for the cost of the insurance is not made, the last day of the period for which a required payment was made;
 - the date that You are eligible for similar insurance under any other group plan or program;
 - the date Your employer fails to pay the required premium to us for the insurance or Dental Insurance for Your Dependents
 - in the case of a Dependent, the date that person ceases to be a Dependent.

AT THE MEMBER SCHOOL DISTRICTS'S OPTION

The Member School District has elected to continue insurance by paying premiums for his 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.

1. if You cease Active Work due to layoff contact the Member School District to determine if Your insurance can be continued and for how long.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

2. if You cease Active Work due to any other Member School District approved leave of absence discuss with the Member School District at the time You receive approval to take the leave of absence whether Your insurance can be continued and for how long.
3. for Dental Insurance, if You cease Active Work due to injury or sickness contact the Member School District to determine if Your insurance can be continued and for how long;
4. for Dental Insurance, if You cease Active Work due to strike contact the Member School District to determine if Your insurance can be continued and for how long;

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 1-800-942-PDP1 (7371) or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

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

In-Network

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

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

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

Out-of-Network

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

DENTAL INSURANCE (continued)

Maximum Benefit Amounts

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

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

Deductibles

The Deductible amounts are shown in the Schedule of Benefits.

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

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service.

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 maybe 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.

DENTAL INSURANCE (continued)

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 payable on a quarterly basis during the 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.

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 31-day period after Your insurance ends for the completion of installation of a prosthetic device if:

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

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

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

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

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

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams twice in a Year.
2. Full mouth or panoramic x-rays once every Year.
3. Bitewing x-rays once:
 - every 6 months for a Child; and
 - in a Year for everyone else.
4. Intraoral-periapical and extraoral x-rays.
5. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
6. Cleaning of teeth (oral prophylaxis) twice in a year.
7. Topical fluoride treatment for a Child under age 20, twice in a Year.
8. Space maintainers for a Child under age 19.
9. Sealants for a Child under age 19 , which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.

Type B Covered Services

1. Emergency palliative treatment to relieve tooth pain.
2. Amalgam or resin fillings.
3. Sedative Fillings.
4. Oral Surgery except as mentioned elsewhere in this certificate.
5. Root canal treatment, but not more than once in any 24 month period for the same tooth.
6. Periodontal scaling and root planing but not more than once per quadrant in any 24 month period.
7. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
8. Simple extractions.
9. Surgical extractions.
10. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such 12 month period.
11. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).
12. Pulp therapy and apexification/recalcification.
13. Local chemotherapeutic agents.
14. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards, for example when it is Dentally Necessary because the covered person is under the age of 7 or physically or developmentally disabled.
15. Injections of therapeutic drugs.
16. 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.
17. Repair of Dentures.
18. Repair or re-cementing of Cast Restorations.
19. Initial installation of Cast Restorations.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

20. Replacement of any Cast Restoration with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within a 5 year period of a prior replacement.
21. Prefabricated stainless steel crown or prefabricated resin crown, in either case, only for primary teeth and limited to once per tooth.
22. Core buildup, but no more than once per tooth in a period of 5 years.
23. Posts and cores, but no more than once per tooth in a period of 5 years.
24. Labial veneers, but no more than once per tooth in a period of 5 years.
25. Consultations, but not more than once in a 12 month period.

Type C Covered Services

1. 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 under this certificate.
2. 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.
3. Replacement of a non-serviceable Denture if such Denture was installed more than, 5 years prior to replacement.
4. 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.
5. Fixed and removable appliances for correction of harmful habits.
6. Implants but no more than once for the same tooth position in a, 60 month period.
7. Repair of implants, but not more than once in a 12 month period.
8. Implant supported prosthetics but no more than once for the same tooth position in, 5 year period.
9. Repair of implant supported prosthetics, but not more than once in a 12 month period.
10. Non-surgical treatment of temporomandibular joint disorders.

The Aggregate Maximum Benefit for temporomandibular joint disorders is shown in the SCHEDULE OF BENEFITS.

Orthodontic Covered Services

Orthodontia, if the orthodontic appliance is initially installed while Dental Insurance is in effect for You, Your Spouse, and Dependent children up to age 23.

If You did not have coverage for orthodontic services at the time the initial placement was made, benefits will not be payable for orthodontic services under this Dental Insurance.

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 not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - scaling and polishing of teeth; or
 - fluoride treatments;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn child;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. services covered under other coverage provided by the Member School District;
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. tissue conditioning, modification of removable prosthodontic and other removable prosthetic services;

DENTAL INSURANCE: EXCLUSIONS (continued)

24. application of desensitizing agents and occlusal adjustment;
25. precision attachments associated with fixed and removable prostheses;
26. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
27. duplicate prosthetic devices or appliances;
28. replacement of a lost or stolen appliance or crown, inlay/onlay, or Denture;
29. repair or replacement of an orthodontic device;
30. intra and extraoral photographic images;
31. diagnostic casts and diagnostic photographs.

DENTAL INSURANCE: COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense means a necessary dental expense for which both of the following are true:

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

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

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

The term does not include:

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

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

Claim Determination Period means a period that starts on any January 1 and ends on the next December 31. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- for persons who are not covered in North Carolina, for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

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

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

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

The term does not include any of the following:

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

The provisions of This Plan which limit benefits based on benefits or services provided under:

- Government Plans;
- Plans which the Policyholder (or an affiliate) contributes to or sponsors; or

Will not be affected by these Coordination of Benefits provisions.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both insured under This Plan as employees, each person's insurance will be treated as a separate Plan.

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

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

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

RULES TO DECIDE WHICH PLAN IS PRIMARY

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

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

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

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

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

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

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

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

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

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

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

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

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

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

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

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

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

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

EFFECT ON BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

FILING A CLAIM

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

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 INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance 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.

Notice of claim and Proof may also be given to Us by following the steps set forth below:

Step 1

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of 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.

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4

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

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

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

Routine Questions on Dental Insurance Claims

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

Claim Submission

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

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

Initial Determination

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

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

However, notification of a denial of a claim will be provided to You within 20 days of receipt of a fully documented request when the denial is based upon the exclusion for services which We deem experimental in nature. MetLife may extend this period beyond 20 days by notifying You prior to the expiration of the 20 days and obtaining Your written consent to the extension.

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

Appealing the Initial Determination

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

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

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

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

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

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

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

In a situation where an adverse determination has been made and a delay would jeopardize Your life or materially jeopardize Your health, MetLife shall expedite the appeal process and issue a decision no later than 72 hours after receipt of Your appeal.

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

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.

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

Dental Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to contest life 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.

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life .

Misstatement of Age

If Your or Your Dependent's 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.
 - If such overpayment occurs, You have an obligation to reimburse Us.

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.

We may recover such overpayment in accordance with that agreement.

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.

"THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION"

Privacy Notice to Our Customers

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

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

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism. What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our “**affiliates**”) or with other companies.

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

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

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

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

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

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

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

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

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

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

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