MetLife®

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

**CERTIFICATE RIDER**

**Group Policy No.:** **KM 05987624-G**

**Employer:** **SAMCO CAPITAL MARKET**

**Effective Date:** **January 01, 2012**

The certificate is changed as follows:

The attached replaces the **"DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES"** and **"DENTAL INSURANCE: EXCLUSIONS"** sections in your certificate.

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

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

### Type A Covered Services

1. Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months.

2. Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months.

3. Bitewing x-rays but not more than 1 set every 12 months.

4. Full mouth or panoramic x-rays once every 60 months.

5. Cleaning of teeth (oral prophylaxis) once every 6 months.

6. Topical fluoride treatment for a Child under age 19, but not more than once in 12 months.

7. Sealants for a Child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 60 months.

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

### Type B 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.**

1. Intraoral-periapical x-rays.

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

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

4. Genetic test for susceptibility to oral diseases.

5. Diagnostic casts.

6. Space maintainers for a Child under age 19.

7. Sedative fillings.

8. Initial placement of amalgam fillings.

9. Replacement of an existing amalgam filling, but only if:

   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.

10. Initial placement of resin fillings.

11. Replacement of an existing resin filling, but only if:

    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

12. Emergency palliative treatment to relieve tooth pain.
13. Simple extractions.
14. Surgical extractions.
15. Oral surgery except as mentioned elsewhere in this certificate.
16. Pulp capping (excluding final restoration).
17. Pulp therapy.
18. Apexification/recalcification.
19. Therapeutic pulpotomy (excluding final restoration).
20. Root canal treatment, but not more than once in any 24 month period for the same tooth.
21. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 60 month period.
22. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 60 month period.
23. Periodontal soft & connective tissue grafts, but no more than one surgical procedure per quadrant in any 60 month period.

**Type C 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.**

1. Cone Beam Imaging, but not more than once for the same tooth position in 60 months.
2. Consultations, but not more than once in a 12 month period.
3. 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.
4. Tissue Conditioning, but not more than once in a 60 month period.
5. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 10 calendar years.
6. Initial installation of Cast Restorations.
7. Replacement of any Cast Restorations with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 10 calendar years of a prior replacement.
8. Simple Repairs of Cast Restorations but not more than once in a 12 month period.
9. Core buildup, but no more than once per tooth in a period of 10 calendar years.
10. Labial veneers, but no more than once per tooth in a period of 10 calendar years.

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (CONTINUED)

11. Post and cores, but no more than once per tooth in a period of 10 calendar years.

12. Initial installation of fixed and permanent Denture:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

13. Replacement of a non-serviceable fixed and permanent Denture if such Denture was installed more than 10 calendar years prior to replacement.

14. Initial installation of full or removable Dentures:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

15. 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.

16. Replacement of a non-serviceable full or removable Denture if such Denture was installed more than 10 calendar years prior to replacement.

17. 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.

18. 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 60 month period.

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

20. Addition of teeth to fixed and permanent Denture to replace natural teeth.

21. Addition of teeth to a partial removable Denture to replace natural teeth.

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

23. Implants, but no more than once for the same tooth position in a 10 calendar year period:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

24. Repair of implants, but not more than once in a 10 calendar year period.

25. Implant supported prosthetics, but no more than once for the same tooth position in a 10 calendar year period:

    - when needed to replace congenitally missing teeth; or
    - when needed to replace natural teeth.

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

27. Local chemotherapeutic agents.

28. Injections of therapeutic drugs.

29. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.

30. Occlusal adjustments, but not more than once in a 12 month period.

31. Fixed and removable appliances for correction of harmful habits.

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

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

**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, up to age 19, if the orthodontic appliance is initially installed while Dental Insurance is in effect for such Child.

The Lifetime Individual Maximum Benefit Amount for orthodontia is shown in the SCHEDULE OF BENEFITS.

## 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 or correction of a congenital defect of a newborn child.

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.

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

## DENTAL INSURANCE: EXCLUSIONS (CONTINUED)

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. Precision attachments, except when the precision attachment is related to implant prosthetics.
24. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
25. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.
26. Repair or replacement of an orthodontic device.
27. Duplicate prosthetic devices or appliances.
28. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
29. Intra and extraoral photographic images.