MetLife
Metropolitan Life Insurance Company
[200 Park Avenue] New York, New York

INDIVIDUAL DENTAL INSURANCE POLICY

SCHEDULE OF BENEFITS [PPO-14]

This SCHEDULE OF BENEFITS lists the services available under the policy, as well as co-insurance percentages, deductibles, maximum benefit amounts, frequency limitations, and exclusions. This SCHEDULE OF BENEFITS is attached to and made a part of the policy

I. TABLE OF COVERED PERCENTAGES, DEDUCTIBLES, AND MAXIMUM BENEFIT AMOUNTS

BENEFIT	**BENEFIT AMOUNT**	
Covered Percentage for:	**In-Network based on the Maximum Allowed Charge**	**Out-of-Network based on the Maximum Allowed Charge**
Preventive and Diagnostic Services	100%	100%
Basic Restorative Services*	80%	80%
Major Restorative Services*	50%	50%
Orthodontic Covered Services*	50%	50%
Deductibles for:		
Calendar Year Individual Deductible	$25 for the following Covered Services Combined: Basic Restorative; Major Restorative	$25 for the following Covered Services Combined: Basic Restorative; Major Restorative
Calendar Year Family Deductible	$75 for the following Covered Services Combined: Basic Restorative; Major Restorative	$75 for the following Covered Services Combined: Basic Restorative; Major Restorative
Maximum Benefit:		
Calendar Year Individual Maximum	$2,000 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative	$2,000 for the following Covered Services: Preventive and Diagnostic; Basic Restorative; Major Restorative

SCHEDULE OF BENEFITS (continued)

I. TABLE OF COVERED PERCENTAGES, DEDUCTIBLES, AND MAXIMUM BENEFIT AMOUNTS (continued)

Maximum Benefit (continued):

Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$1,000	$1,000

***NOTE: Waiting Periods apply to Basic Restorative, Major Restorative, and Orthodontic Covered Services. Please see the section entitled DESCRIPTION OF COVERED SERVICES for more information.**

II. ADDITIONAL DEFINITIONS USED IN THIS SCHEDULE OF BENEFITS

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 Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied.

Waiting Period for a Covered Service means the length of time for which a Covered Person must be covered under this policy in order to qualify for benefits for that Covered Service.

III. BENEFIT AMOUNTS

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by a Covered Person for a Covered Service as shown on page 1 of this SCHEDULE OF BENEFITS, subject to the conditions set forth in this policy.

In-Network

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

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

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

Out-of-Network

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

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

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

III. BENEFIT AMOUNTS (continued)

Maximum Benefit Amounts

The Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network are shown on pages 1 and 2 of this SCHEDULE OF BENEFITS. 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 $100 in benefits for such service, $100 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 on page 1 of this SCHEDULE OF BENEFITS.

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

We apply amounts used to satisfy Calendar Year Individual Deductibles to the Calendar Year Family Deductible. Once the Calendar Year Family Deductible is satisfied, no further Calendar Year Individual Deductibles are required to be met.

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

Alternate Benefit

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

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

For example:

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

Alternate Benefit (continued)

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

Orthodontic Covered Services

Orthodontia treatment must begin while this policy is in effect. If the policy ends during the course of the treatment, the monthly payments will end. Dental procedures performed in connection with Orthodontia treatment are considered under the orthodontia benefit and are Covered Services.

Orthodontic treatment generally consists of initial placement of an appliance and a specified number of periodic follow-up visits as initially requested by the Dentist.

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

The benefit payable for the periodic follow-up visits will be based on the lower of:

- the amount charged by the Dentist; and
- the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment if:

- insurance is in effect for the person receiving the orthodontic treatment; and
- proof is given to Us that the orthodontic treatment is continuing.

IV. 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.

V. DESCRIPTION OF COVERED SERVICES

Preventive and Diagnostic Services

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

Basic Restorative Services (Covered after a Waiting Period of 6 months)

1. Intraoral-periapical and extraoral x-rays.
2. Full mouth or panoramic x-rays once every 60 months.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
5. Genetic test for susceptibility to oral diseases.
6. Emergency palliative treatment to relieve tooth pain.
7. Initial placement of amalgam or resin fillings.
8. Replacement of an existing amalgam or resin fillings, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
9. Protective (Sedative) Fillings.
10. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any calendar year less the number of teeth cleanings received during such 12 month period.
11. Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
12. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration).

V. DESCRIPTION OF COVERED SERVICES (continued)

Basic Restorative Services (Covered after a Waiting Period of 6 months) (continued)

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

14. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.

15. Preventive resin restorations which are applied to non-restored first and second permanent molars, once per tooth every 60 months.

16. Pulp therapy.

17. Simple extractions.

Major Restorative Services (Covered after a Waiting Period of 12 months)

1. Apexification/recalcification.

2. Diagnostic casts.

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. Local chemotherapeutic agents.

5. Injections of therapeutic drugs.

6. Initial installation of full or partial Dentures (other than implant supported prosthetics):

    - 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 under this policy.

7. Addition of teeth to a partial removable Denture to replace natural teeth removed while insurance under this policy was in effect for the person receiving such services.

8. Replacement of a non-serviceable Denture if such Denture was installed more than 10 years prior to replacement.

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

10. Relinings and rebasings of existing removable Dentures:

    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.

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

V. DESCRIPTION OF COVERED SERVICES (continued)

Major Restorative Services (Covered after a Waiting Period of 12 months) (continued)

12. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.

13. Initial installation of Cast Restorations (except implant supported Cast Restorations).

14. Replacement of any Cast Restoration (except implant supported Cast Restorations) with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth within 10 years of the initial installation or a prior replacement.

15. Prefabricated crown, but no more than one replacement for the same tooth within 10 years.

16. Core buildup, but no more than once per tooth in a period of 10 years.

17. Posts and cores, but no more than once per tooth in a period of 10 years.

18. Oral Surgery, except as mentioned elsewhere in this SCHEDULE OF BENEFITS.

19. Consultations or interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.

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

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

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

23. Periodontal surgery, including gingivectomy, gingivoplasty, and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.

24. Surgical extractions.

25. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation):

    - 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 under this policy.

    but no more than once for the same tooth position in a 10 year period.

26. Repair of implants, but not more than once in a 12 month period.

V. DESCRIPTION OF COVERED SERVICES (continued)

Major Restorative Services (Covered after a Waiting Period of 12 months) (continued)

27. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 year period.
28. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 year period.
29. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 year period.
30. Tissue conditioning, but not more than once in a 36 month period.
31. Simple repair of Cast Restorations or Dentures, but not more than once in a 12 month period.
32. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
33. Full mouth debridements, but not more than once per lifetime.
34. Occlusal adjustments, but not more than once in a 12 month period.
35. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards, but not more than once in a 24 month period.
36. Cleaning and inspection of a removable appliance once every 6 months.

Orthodontic Covered Services (Covered after a Waiting Period of 12 months)

Orthodontia for a Child up to age 19.

SCHEDULE OF BENEFITS (continued)

EXCLUSIONS

We will not pay benefits under this policy 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 a Covered Person before insurance under this policy starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed dental hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic, unless required for the treatment or correction of a congenital defect of a newborn Child or for the treatment of a congenital cleft in the lip or palate or both;
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 or implant to replace one or more teeth which were missing before such person was insured under this policy, 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 any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the Covered Person receiving such services is required to pay; or
    - received at a facility maintained by an employer, labor union, mutual benefit association, or VA hospital;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;

SCHEDULE OF BENEFITS (continued)

EXCLUSIONS (continued)

19. 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;
20. 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;
21. caries susceptibility tests;
22. fixed and removable appliances for correction of harmful habits;
23. biopsies of hard or soft oral tissue;
24. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
25. modification of removable prosthodontic and other removable prosthetic services;
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, Cast Restoration or Denture;
29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging cone beam imaging associated with the treatment of temporomandibular joint disorders;
30. intra and extraoral photographic images;
31. replacement of an orthodontic device;
32. any services for which a Waiting Period applies where the Covered Person has not satisfied the Waiting Period requirement on the date of the service;
33. services delivered outside the United States, except for Emergency Dental Conditions up to a maximum benefit of $100 per calendar year.