



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

CERTIFICATE RIDER

Group Policy No.: TS 05050023-G
Employer: Civil Service Employees Association
Effective Date: April 1, 2020

The certificate is changed as follows:

The following replaces the "**C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES**" and "**D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES**" sections in your certificate;

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

- a. Oral exams but not more than once every 6 months.
- b. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, once every 6 months.
- c. 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), once every 6 months.
- d. Bitewing X-rays but not more than once every 6 months for all Covered Persons.
- e. Full mouth X-rays but not more than once every 5 years.
- f. Preventive treatment:
 - i. cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) but not more than once every 6 months; and
 - ii. topical fluoride treatment for a Dependent child under 14 years of age but not more than once every 12 months.
 - iii. Periodontal maintenance where periodontal treatment (such as osseous surgery, gingivectomy or gingivoplasty) has been previously performed, but the total of:
 - 1. the number of covered periodontal maintenance treatments; and
 - 2. the number of covered oral prophylaxes;will not exceed four treatments in a Dental Expense Period.
- g. Sealants (materials other than fluorides, painted on the grooves of the teeth in order to prevent future decay) which are applied to molars only, for Dependents up to age 14, but not more than once per tooth per lifetime.
- h. Space maintainers for a Dependent under 19 years of age.

2. Type B Expenses

If you are a late entrant, certain waiting periods must be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the late entrant waiting period that applies.

- a. Fillings - amalgam, silicate, or resin fillings.
- b. Extractions.
- c. Oral surgery (other than as described elsewhere in this certificate).
- d. Administration of general anesthesia, when dentally necessary (see NOTICES) as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.

- e. Root canal treatment.
- f. Periodontal surgery.
- g. Repair or relining of dentures.
- h. Repair or re-cementing of
 - i. crowns; or
 - ii. inlays or onlays; or
 - iii. dentures or bridgework.
- i. Repair of implants, but not more than once in a 12 month period.

3. Type C Expenses

If you are a late entrant, certain waiting periods must be satisfied before expenses for these services are payable. Refer to the SCHEDULE OF BENEFITS for the late entrant waiting period that applies.

- a. Inlays, onlays, crowns, laminates, and gold foils but no more than once in a 5 year period for the same tooth surface.
- b. Replacement of crowns, but not more than once for the same tooth in a 5 year period.
- c. Replacement of inlays or onlays, but not more than once for the same tooth surface in a 5 year period.
- d. Those services needed to replace one or more natural teeth for:
 - i. installation of fixed bridgework done for the first time.
 - ii. installation for the first time of:
 - 1. a partial removable denture; or
 - 2. a full removable denture.
- e. Replacing an existing removable denture or fixed bridgework if:
 - i. it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or
 - ii. it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 years prior to its replacement.
- f. Replacing an existing immediate temporary full denture by a new permanent full denture when:
 - i. the existing denture cannot be made permanent; and
 - ii. the permanent denture is installed within 12 months after the existing denture was installed.
- g. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

- h. 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 that are lost while the person receiving such benefits was insured for Dental Insurance under this certificate.
- i. 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 that are lost while the person receiving such benefits was insured for Dental Insurance under this certificate.
- j. With respect to residents of Minnesota, Oral surgical and non-surgical treatment of Temporomandibular joint disorders (TMJ) and craniomandibular disorder. This includes cone beam imaging and TMJ non-invasive physical therapies. However, cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period and TMJ non-invasive physical therapies will not be covered more than once in a 12 month period.

D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
2. 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:
 - a. scaling and polishing of teeth; or
 - b. fluoride treatments.
3. Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
 - a. it otherwise is a Covered Dental Expense; and
 - b. it is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
 - c. it is required for reconstructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.
4. Replacement of a lost, missing or stolen crown, bridge or denture.
5. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
6. Services or supplies which are covered by any employers' liability laws.
7. Services or supplies which any employer is required by law to furnish in whole or in part.
8. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
9. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
10. Services or supplies for which a Covered Person is not required to pay.

11. Services or supplies which are deemed experimental in terms of generally accepted dental standards.
12. Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
13. Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.
14. Any duplicate appliance or prosthetic device.
15. Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
16. Instruction for oral care such as hygiene or diet.
17. Periodontal splinting.
18. Temporary or provisional restorations.
19. Temporary or provisional appliances.
20. Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
21. Myofunctional therapy or correction of harmful habits.

22. Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.
23. Charges for broken appointments.
24. Charges by the Dentist for completing dental forms.
25. Sterilization supplies.
26. Services or supplies furnished by a family member.
27. Orthodontia.

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