SCHEDULE OF BENEFITS

TEXAS HEALTH BENEFITS (EHB) PLAN

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

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

BENEFIT	**BENEFIT AMOUNT AND HIGHLIGHTS**

Dental Insurance For Your Dependents

This certificate only applies to a Child until the end of the Year in which the Child reaches age 19. This certificate describes the benefit available under the Pediatric Dental Essential Health Benefit. However if Your Dependent Child receives a covered service, and is also covered for that covered service under another certificate under the same policy between the Group Policyholder and MetLife, We will pay the higher of the two benefits for that covered service. After the calendar year in which the Child reaches age 19, benefits for a Child, are available under another certificate under the same policy between the Group Policyholder and MetLife.

Covered Percentage for:	**In-Network based on the Maximum Allowed Charge**	**Out-of-Network based on the Maximum Allowed Charge**
Type A Services	90%	90%
Type B Services	50%	50%
Type C Services	50%	50%
Type D Services (medically necessary Orthodontics)	50%	50%

Deductibles for:	**In-Network**	**Out-of-Network**
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type A, Type B & Type C	$100 for the following Covered Services Combined: Type A, Type B & Type C
Yearly Family Deductible	$300 for the following Covered Services Combined: Type A, Type B & Type C	$300 for the following Covered Services Combined: Type A, Type B & Type C

Maximum Benefit:	In-Network	Out-of-Network
Yearly Maximum	None	None
Lifetime Individual Maximum for Type D Covered Services (medically necessary Orthodontics)	None	None

Out-of-Pocket Annual Maximum:	In-Network	Out-of-Network
Individual Out-of-Pocket Annual Maximum (for 1 Child)	$350 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None
Family Out-of-Pocket Annual Maximum (for 2 or more Children)	$700 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams, oral evaluation for a patient under 3 years of age and counseling with a primary caregiver and limited oral evaluation – problem focused, with a combined frequency limitation of once every 6 months, also combined with detailed and extensive oral evaluation – problem focused, by report.

2. Full mouth x-rays, but not more than once every 60 months.

3. Bitewing x-rays, but not more than 1 set every 6 months. Periapical films on an emergency or episodic basis are a Covered Service.

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

5. Cleaning of teeth (oral prophylaxis), but not more than once every 6 months including periodontal cleanings.

6. Topical fluoride treatment, but not more than twice in 12 months.

7. Sealants which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 36 months.

8. Space maintainers.

9. Emergency palliative treatment of dental pain.

10. Preventive resin restoration in a moderate to high caries risk patient – applied to non-restored, non-decayed first and second permanent molars.

Type B Covered Services

1. Fillings: Amalgam and resin composite. Restorations are limited as follows:

   - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a Covered Service.
   - Composite resin or acrylic restorations on molar teeth will be benefited as an alternative benefit.
   - Micro filled resin restorations which are non-cosmetic.
   - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.

2. Sedative fillings.

3. Prefabricated crowns, but no more than one replacement for the same tooth surface within 60 months for a Covered Person under 15 years of age.

4. Simple extractions.

5. Surgical extractions. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.

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

7. Pulp capping.

8. Pulp therapy.

9. Therapeutic pulpotomy. (If a root canal is completed within 45 days of the pulpotomy, We will only pay benefits for the root canal therapy.)

10. Recementations.

11. Adjustment of a Denture made 6 or more months after installation by the same Dentist who installed it.

12. Relinings and rebasings of existing removable Dentures made 6 or more months after installation by the same Dentist who installed it, but not more than once in any 36 month period.

13. Tissue conditioning.

14. Consultations.

15. Adjunctive general services.

16. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty, and osseous surgery) has been performed. Periodontal maintenance is limited four times per 12 months less the number of teeth cleanings received during such 12 months.

17. Periodontal, non-surgical treatment.

18. Scaling and root planing, but not more than once per quadrant in any 24 month period.

19. Adding teeth to Dentures.

20. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when such anesthesia is determined to be medically necessary or Dentally Necessary.

21. Injections of therapeutic drugs.

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

Type C Covered Services

1. Periodontal surgery, but not more than one surgical procedure per quadrant in any 36 month period.

2. Periodontal soft and connective tissue grafts, but no more than one per unique site per 36 months.

3. Initial installation of Cast Restorations.

4. 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 60 months of a prior replacement.

5. Crown buildups/post and core, but no more than once per tooth in a period of 60 months.

6. Simple repairs of Cast Restorations.

7. Repair of Dentures.

8. Root canal treatment (initial treatment), but no more than once per tooth per lifetime.

9. Apexification/recalcification.

10. Full mouth debridements, but no more than once per lifetime.

11. Initial installation of full or removable Dentures, but no more than once every 60 months. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers are only available if they are Dentally Necessary.

12. Fixed partial dentures, but no more than once every 60 months, and only if they are Dentally Necessary and a partial cannot satisfactorily restore the case. (If fixed partial dentures are used when a partial could satisfactorily restore the case, the benefit determination will be based upon the partial which is the less costly service.)

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

14. Replacement of a non-serviceable removable Denture, but only if such Denture was installed more than 60 months prior to replacement.

15. Replacement of a non-serviceable fixed Denture, but only if such Denture was installed more than 60 months prior to replacement.

16. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation) but no more than once for the same tooth position in a 60 month period.

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

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

19. Occlusal guards, but no more than one every 12 months and only for a Covered Person age 13 and older.

20. Local chemotherapeutic agents.

21. Occlusal adjustments.

Type D Covered Services

Orthodontia, must be medically necessary and must begin while this insurance is in force. If the insurance 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.

The Lifetime Individual Maximum Benefit Amount and Out-of-Pocket Annual Maximum 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 and/or medically 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 a Dependent would not be required to pay in the absence of Dental Insurance.

3. Services or supplies received by Your Dependent before the Dental Insurance starts for that person.

4. Services not 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.

6. Replacement of an orthodontic appliance.

7. Services or appliances which restore or alter occlusion or vertical dimension.

8. Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.

9. Restorations or appliances used for the purpose of periodontal splinting.

10. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.

11. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.

12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.

13. Charges for 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 person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.

15. Services covered under other coverage provided by the Employer.

16. Temporary or provisional restorations.

17. Temporary or provisional appliances.

18. Prescription drugs.

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. Intra and extraoral photographic images.

22. Services for which the submitted documentation indicates a poor prognosis.

23. Caries susceptibility tests.

24. Labial veneers.

25. Modification of removable prosthodontic and other removable prosthetic services.

26. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.

27. Application of desensitizing agents.

28. Fixed and removable appliances for correction of harmful habits, unless part of overall treatment plan for medically necessary Orthodontia.

29. Precision attachments associated with fixed and removable prostheses.

30. Biopsies of hard or soft oral tissue.

31. Duplicate prosthetic devices or appliances.

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

33. Composite resin or acrylic restorations for posterior molars.

34. The prophylactic removal of third molars is not a Covered Service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.

35. Any procedures not specifically listed as a Covered Service.

36. The following services are not Covered Services:

    - a connector bar;
    - a stress breaker; or
    - coping.