



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

CERTIFICATE RIDER

Group Policy No.: 157051-1-G
Policyholder: Henderson County Public Schools
Effective Date: July 1, 2016

The certificate is changed as follows:

Applicable to Dental Insurance

1. In the **SCHEDULE OF BENEFITS**, replace Yearly Individual Deductible and Yearly Family Deductible under **Dental Insurance For You and Your Dependents** with the following:

“Yearly Individual Deductible	\$75 for the following Covered Services Combined: Type B; Type C	\$75 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	\$225 for the following Covered Services Combined: Type B; Type C	\$225 for the following Covered Services Combined: Type B; Type C”

2. In the **SCHEDULE OF BENEFITS**, replace Yearly Individual Maximum under **Dental Insurance For You and Your Dependents** with the following:

“Yearly Individual Maximum	\$2,000 for the following Covered Services: Type A; Type B; Type C	\$2,000 for the following Covered Services: Type A; Type B; Type C”
----------------------------	--	---

3. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace item 5 under **Type A Covered Services** with the following:

“5. Bitewing x-rays 1 set in a Year.”

4. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, replace items 6 and 8 under **Type B Covered Services** with the following:

“6. 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.”

“8. Replacement of an existing resin-based composite 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.”

5. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete items 4, 11 and 12 from **Type A Covered Services** and add the following to **Type B Covered Services**:
 - “21. Sealants or sealant repairs for a Child under age 16, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
 22. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
 23. Interim caries arresting medicament application applied to permanent bicuspid and 1st and 2nd molar teeth first and second permanent molars, once per tooth every 60 months.
 24. Full mouth or panoramic x-rays once every 60 months.”

6. In **DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES**, delete items 10, 12 and 13 from **Type B Covered Services** and add the following to **Type C Covered Services**:
 - “32. Oral surgery, except as mentioned elsewhere in this certificate.
 33. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
 34. 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.”

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