Dental

Metropolitan Life Insurance Company

Network: PDP Plus

Benefit Summary: All Active Full Time Employees (30 hours)

Plan Option 1	**In-Network**[1]	**Out-of-Network**[1]
Coverage Type:	**PDP Plus** % of Negotiated Fee[2]	**Out-of-Network** 90% of R&C Fee[4]
Type A: Preventive	100%	100%
Type B: Basic Restorative	80%	80%
Type C: Major Restorative	50%	50%
Type D: Orthodontia	50%	50%
Deductible[3]		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit:		
Per Individual	$2,250	$2,250
Orthodontia Lifetime Maximum - Ortho applies to Child Only	Child up to age 19 years for Orthodontia coverage	
	$1,000 per Person	$1,000 per Person
Dependent Age:	Eligible for benefits until the day that he/she turns 26	

Late Enrollment Waiting Period: If you do not enroll during the initial enrollment period you will have to wait until the next available enrollment period.

[1] "In-Network" benefits refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network" benefits refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2] Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefit maximums. Negotiated fees are subject to change.
[3] Applies only to Type B and C services.
[4] R&C Fee refers to the Reasonable and Customary fee, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

Monthly Rates:
Your premium will be paid through convenient payroll deduction. The monthly cost shown below for "Employee + Family" covers all eligible children. Child(ren)'s eligibility is from birth up to age 26, age 26 if a full-time student.

Employee Only	$34.32	**Employee + Family**	$101.31
Employee + One	$72.81		

List of Primary Covered Services & Limitations* *If Dentally Necessary, You and Your Dependents may be eligible for additional dental treatment if diagnosed with one or more specified medical conditions. Please see the Description of Covered Services section of this Certificate for additional details.

Type A – Preventive	**How Many/How Often**
Prophylaxis (cleanings)	▪ Two times in 12 months
Oral Examinations	▪ Two exams per calendar year
Topical Fluoride Applications	▪ One fluoride treatment per calendar year for dependent children under age 16
Bitewing X-rays	▪ Bitewings X-rays: one set per 12 months for adults; one set per 12 months for children
Type B – Basic Restorative	▪ **How Many/How Often**
Sealants	1 per molar in 36 months for a child under age 16
Full Mouth X-Rays	Once in 36 months
Amalgam Fillings	▪ Replacement once every 24 months
Simple Extractions	
Oral Surgery	
Endodontics	▪ Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Type C – Major Restorative	▪ **How Many/How Often**
Space Maintainers	▪ 1 per lifetime for a child under age 16
Periodontics	▪ Periodontal scaling and root planing once per quadrant, every 24 months ▪ Periodontal surgery once per quadrant, every 24 months ▪ Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Implants	▪ Replacement; once every 10 years
Crown, Denture and Bridge Repair/Recementations	▪ Repair, once every 12 months ▪ Recementations, once every 12 months
Bridges and Dentures	▪ Initial placement to replace one or more natural teeth, which are lost while covered by the plan Dentures and bridgework replacement; one every 10 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement; once every 10 years
Endodontics	Root canal treatment limited to once per tooth per lifetime
Type D – Orthodontia	▪ **How Many/How Often**
	▪ Your children, up to age 19, are covered while Dental insurance is in effect.

	▪ All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia ▪ Payments are on a repetitive basis Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your Plan benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Common Questions…. Important Answers

Who is a participating dentist?
A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees typically range from 30-45% below the average fees charged in a dentist's community for the same or substantially similar services.[1]

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan?
The certificate of insurance sets forth the covered services under the plan. Please review the enclosed plan benefits to learn more.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist (out-of-network) your out-of-pocket costs may be higher.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[2] The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services[3] you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.[4] Please remember to hold on to all receipts to submit a dental claim.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No. You and your dependents each have the freedom to choose any dentist.

Alternate Benefits
Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

[1]Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit a dentist and the cost of services rendered. Negotiated fees are subject to change.
[2]Due to contractual requirements, MetLife is prevented from soliciting certain providers.
[3]AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.
[4]Refer to your dental benefits plan summary for your out-of-network dental coverage.

Exclusions
This plan does not cover the following services, treatments and supplies:

- 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
- Services for which you would not be required to pay in the absence of Dental insurance
- Services or supplies received by you or your Dependent before the Dental insurance starts for that person
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate)
- 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
    - Fluoride treatments
- Services or appliances which restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion or erosion
- Restoration or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco
- Personal supplies or devices including, but not limited to water picks, toothbrushes or dental floss
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work
- Missed appointments
- 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

    - Received at a facility maintained by the Employer, labor union, mutual benefit association or VA hospital
- Services covered under other coverage provided by the Employer
- Temporary or provisional restorations
- Temporary or provisional appliances
- Prescription drugs
- Services for which the submitted documentation indicates a poor prognosis
- The following when charged by the Dentist on a separate basis:
    - Claim form completion
    - Infection control such as gloves, masks and sterilization of supplies
    - Local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide
- 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
- Caries susceptibility tests
- Initial installation of a fixed and permanent denture to replace one or more natural teeth which were missing before such person was insured for Dental insurance, except for congenitally missing natural teeth
- Precision attachments, except when the precision attachment is related to implant prosthetics
- Adjustment of a denture made within 6 months after installation by the same Dentist who installed it
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental insurance, except for congenitally missing natural teeth
- Fixed and removable appliances for correction of harmful habits
- Treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota
- Repair or replacement of an orthodontic device
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance, cast restoration or denture
- Intra and extraoral photographic image

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.