For the savings you need, the flexibility you want and service you can trust.

## Benefit Summary

<table>
<thead>
<tr>
<th>SELECTED PLAN FEATURES AND COVERED SERVICES</th>
<th>PLAN PROVISIONS AND BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible Per Covered Member</td>
<td>$50</td>
</tr>
<tr>
<td>Annual Plan Maximum Per Covered Member</td>
<td>$1,500</td>
</tr>
<tr>
<td>Lifetime Maximum Orthodontic Benefit Per Covered Member</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Preventive Dental Care
- Dental exam and routine scaling and cleaning of teeth (limited to two instances in any one calendar year);
- Topical application of sodium fluoride or stannous fluoride to teeth, every 12 months for covered members under age 19;
- Dental X-rays - Full mouth x-rays are limited to one every 60 months. Bitewings are limited to 1 per year for adults and 1 every 6 months for children;
- Space maintainers to replace prematurely lost teeth; and
- Sealants for permanent teeth (limited to covered dependent children between the ages of 6 years and 18 years, once per tooth every 36 months).

100% of PDP Fee*; not subject to deductible.

Members who elect to use out of network dental providers **will be subject to** 100% of R&C Fee

### Basic Dental Care
- Fillings to restore diseased or broken teeth (multiple fillings on a single tooth surface will be considered as a single filling).
- Extraction of a tooth that is not impacted;
- General anesthesia when used in conjunction with oral surgery or other dental treatment, and, determined to be medically necessary;
- Injections of antibiotic drugs;
- Endodontic treatment, including root canal therapy; and
- Periodontal treatment, including gingivectomy, and treatment of other diseases of the gums and tissues of the mouth.

80% of PDP fee*; **subject to deductible**.

Members who elect to use out of network dental providers **will be subject to** 80% of R&C Fee
## SELECTED PLAN FEATURES AND COVERED SERVICES

<table>
<thead>
<tr>
<th>Plan Features and Covered Services</th>
<th>Plan Provisions and Benefits</th>
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</thead>
<tbody>
<tr>
<td><strong>Restorative Dental Care</strong></td>
<td>80% of PDP fee*; subject to deductible.</td>
</tr>
<tr>
<td>Inlays, onlays, and crowns;</td>
<td>Members who elect to use out of network dental providers will be subject to 80% of R&amp;C Fee.</td>
</tr>
<tr>
<td>Implants</td>
<td></td>
</tr>
<tr>
<td>Repairs or recementing of crowns, inlays, bridgework or dentures as well as the relining of denture;</td>
<td></td>
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<tr>
<td>Bridge pontic;</td>
<td></td>
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<tr>
<td>Oral surgery;</td>
<td></td>
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<tr>
<td>Osseous surgery;</td>
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<tr>
<td>Initial installation or addition of full or partial dentures or fixed bridgework, if they are necessary as the result of injured or diseased natural teeth being extracted while covered under this plan;</td>
<td></td>
</tr>
<tr>
<td>Replacement or alternation of full or partial dentures or fixed bridgework, if necessary as a result of an accidental injury requiring oral surgery, or oral surgery treatment involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue, while covered under the this plan.</td>
<td></td>
</tr>
<tr>
<td>Replacement of full denture, if it is required as the result of structural change within the mouth, and if it is made more than five years after the denture was installed; and</td>
<td></td>
</tr>
<tr>
<td>Replacement of a crown, if the replacement is made more than five years after the crown was installed.</td>
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</tbody>
</table>

**Restorative Dental Care (continued)**

<table>
<thead>
<tr>
<th>Plan Features and Covered Services</th>
<th>Plan Provisions and Benefits</th>
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<tbody>
<tr>
<td>Replacement of a crown, if the replacement is made more than five years after the crown was installed.</td>
<td>80% of PDP fee*; subject to deductible. Required waiting period of at least 2 years following enrollment in the plan.</td>
</tr>
<tr>
<td>Members who elect to use out of network dental providers will be subject to 80% of R&amp;C Fee.</td>
<td></td>
</tr>
</tbody>
</table>

**Orthodontic Dental Care**

- Including orthodontic appliances and treatment received during the orthodontic treatment. Orthodontic dental care will begin after one is covered by the plan. 

**These services include, but are not limited to:**

- Preventive treatment procedures; 
- Removable or fixed appliance therapy; and 
- Treatment of transitional and permanent dentition. 

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<tr>
<td>80% of PDP fee*; subject to deductible. Required waiting period of at least 6 months following enrollment in the plan(waiting period does not apply to new enrollees currently in treatment).</td>
<td>Members who elect to use out of network dental providers will be subject to 80% of R&amp;C Fee.</td>
</tr>
</tbody>
</table>

Lifetime benefit limit of $1,000.
*PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums.
PDP Savings* Example
This hypothetical example shows how receiving services from a PDP (in-network) dentist can save you money.

*Your Dentist says you need a Crown, a Restorative Dental Care service —
- PDP Fee: $375.00
- R&C** Fee: $500.00
- Dentist’s Usual Fee: $600.00

<table>
<thead>
<tr>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you receive care from a participating PDP dentist</td>
<td>When you receive care from a non-participating dentist</td>
</tr>
<tr>
<td>Dentist’s Usual Fee is:</td>
<td>Dentist’s Usual Fee is:</td>
</tr>
<tr>
<td>$600.00</td>
<td>$600.00</td>
</tr>
<tr>
<td>The PDP Fee is:</td>
<td>R&amp;C Fee is:</td>
</tr>
<tr>
<td>$375.00</td>
<td>$500.00</td>
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<tr>
<td>Your Plan Pays:</td>
<td>Your Plan Pays:</td>
</tr>
<tr>
<td>80% X $375 PDP Fee:</td>
<td>80% X $500 R&amp;C Fee:</td>
</tr>
<tr>
<td>- $300.00</td>
<td>- $400.00</td>
</tr>
<tr>
<td>Your Out-of-Pocket Cost:</td>
<td>Your Out-of-Pocket Cost:</td>
</tr>
<tr>
<td>$75.00</td>
<td>$200.00</td>
</tr>
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</table>

In this example, you save $125.00 ($200.00 minus $75.00)… by using a participating PDP dentist.

*Please note: These examples assume that your annual deductible has been met.

**R&C fee refers to the Reasonable and Customary (R&C) charge, 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.
Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife’s negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 15-45%* below the average fees charged in a dentist’s community for the same or substantially similar services.

*Based on internal analysis by MetLife.

How do I find a participating PDP dentist? There are more than 190,000 participating PDP dentist locations nationwide, including over 42,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-866-832-5759 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services? MetLife’s negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist’s fee and your plan’s payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan’s payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you’d like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed 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 e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-866-832-5759.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends 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’re still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fees* for dental services in your area.

* Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.
**Exclusions**

Some of the dental services, supplies or treatments that are not covered by the dental plan include, but are not limited to:

- Those that exceed the Preferred Dentist Program contracted in-network rates for covered dental charges;
- Those that are not medically necessary;
- Treatment not performed by a dental provider or doctor;
- Those that are provided by a immediate family member or household resident;
- Treatment performed by a licensed dental hygienist who is not supervised by a dental provider;
- Those that were received prior to being eligible for plan participation and coverage;
- Treatment due to injury or illness that is covered under any Workers' Compensation Law, occupational disease law or similar laws;
- Those charges incurred by a member from his/her dental provider for failure to keep a scheduled appointment;
- Those charges incurred for the completion of any forms required for benefits to be paid;
- Services for which you are not required to pay, or, for services in which no charge would have been made in the absence of dental benefits;
- Charges for services or supplies that do not meet accepted standards of dental practice, including charges for services or supplies that are experimental in nature;
- Charges or expenses for procedures, appliances and restorations, other than full dentures used to split or to change vertical dimension or to restore an occlusion;
- Surgical extraction of impacted teeth, but not including partially erupted teeth;
- To replace lost or stolen dentures and/or bridgework;
- The installation, replacement, or alternation of dentures or fixed bridgework, other than those services that are listed under covered services;
- Charges associated with dietary planning for the control of dental cavities, oral hygiene instruction, including plaque control, or training in dental care;
- Charges incurred for which benefits are paid under any public plan of dental insurance for which a covered person is eligible;
- Charges for services or supplies received as a result of dental disease or injury due to an act of war, declared or undeclared, or a warlike act in time of peace;
- A crown, gold restoration, or bridge, if the tooth was prepared before you or your dependent were covered by the plan;
- Root canal therapy if the pulp chamber was opened before you or your dependent were covered by the plan;
- An appliance, or the alteration of an appliance, if the impression was made before you or your dependent were covered by the plan;
- Charges or conditions for which others are responsible;
- Services or supplies received by a covered person before that individual is eligible for dental benefits;
- Use of materials, other than fluoride, to prevent tooth decay;
- Procedures that are cosmetic in nature (e.g. bleaching, whitening and bonding);
- For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy);
- Night or occlusional guard appliances;
- Services or supplies that are for cosmetic purposes, unless they are:
  - Otherwise a covered expense and are necessary because of an illness or injury that happened while you are covered or,
  - Required for reconstructive surgery because of a congenital disease or abnormality of a covered dependent that results in a functional defect;
- For prescription or non-prescription drugs, vitamins, or dietary supplements;
- For house or hospital calls for dental services;
- For hospitalization costs;
- For treatment of fractures and dislocations of the jaw;
Exclusions (continued)

- Charges for care, treatment, services or supplies to the extent that any benefit is provided by Medicare;
- Charges that were not considered to be a “covered expense”, due to a pre-determination of benefits;
- Charges for nitrous oxide, novocaine, xylociane, or any similar local anesthetic, when the charge is made separately from a covered dental expense;
- For the following that are not included as orthodontic benefits: Retreatment of orthodontic cases, changes in orthodontic treatments necessitated by patient neglect, or repair of an orthodontic appliance; and
- Services or supplies for which benefits are otherwise provided under the plan or any other plan that the System (or an affiliate) contributes to or sponsors.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

Metropolitan Life Insurance Company, New York, NY  L0412252054(exp1212)(All States)(DC, GU, MP, PR, VI)