Dental Benefits
Savings, flexibility and service. For healthier smiles.

MetLife

Plan Design for:
High Plan Option
Effective Date:

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

It’s easy to get these valuable dental benefits.
Review the Overview of Benefits and Savings Example .......... Page 1
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Frequently Asked Questions ................................. Pages 4 – 5

Your Out-Of-Pocket Expenses are Lower When You Visit a Participating Dentist In Network.

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>IN NETWORK¹</th>
<th>OUT OF NETWORK¹</th>
</tr>
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<tbody>
<tr>
<td>Type A - Preventive</td>
<td>100% of Negotiated Fee¹</td>
<td>100% of R&amp;C Fee²</td>
</tr>
<tr>
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<td>90% of Negotiated Fee</td>
<td>80% of R&amp;C Fee</td>
</tr>
<tr>
<td>Type C - Major Restorative</td>
<td>60% of Negotiated Fee</td>
<td>50% of R&amp;C Fee</td>
</tr>
<tr>
<td>Type D - Orthodontia</td>
<td>50% of Negotiated Fee</td>
<td>50% of R&amp;C Fee</td>
</tr>
</tbody>
</table>

Deductible³
   Individual
   Family

   In Network
   Out of Network

   $0
   $0
   $50
   $150

Annual Maximum Benefit
   Per Person
   Orthodontia Lifetime Maximum
   Ortho applies to Adult & Child*   In Network
   Out of Network

   $1,500
   $2,000
   $1,000
   $2,000
   Up to dependent age limit – 26
   Up to dependent age limit – 26

³ Applies to Type B and C services only.

An Example of Savings When You Visit a MetLife Participating Dentist
Take a look at an example* that shows how receiving services from a MetLife Participating Dentist can save you money:

Your Dentist says you need a Crown, Type C Service*
   Negotiated Fee: $600.00
   Dentist’s Usual Fee: $925.00

   *Please note: this example assumes that your annual deductible has been met.

   (In Network)  (Out of Network)
   When you receive care from a MetLife Participating Dentist...  When you receive care from a Non-Participating Dentist...
   The Negotiated Fee is: $600.00
   Your Plan Pays: (60% x $600 Negotiated Fee) $360.00
   Your Out-of-Pocket Cost: $240.00
   Dentist’s Usual Fee is: $925.00
   Your Plan Pays: 50% x $900 R&C Fee) $450.00
   Your Out-of-Pocket Cost: $475.00

   In this example, YOU SAVE $385.00 ($625.00 minus $240.00)...by using a MetLife Participating dentist!
Visiting a MetLife Participating Dentist gives you the opportunity to maximize the value of your plan.
There is additional information in this overview concerning MetLife Participating Dentists.
Please note, this is only an example and may not match your plan design.
List of Covered Services & Limitations*

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<td>• 1 fluoride treatment in 12 months for dependent children up to 14th birthday.</td>
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<td>• 1 sealant per permanent 1st &amp; 2nd non-restored non-decayed molar in 60 months for a dependent child up to 19th birthday.</td>
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<td>Prophylaxis (Cleanings)</td>
<td>• 1 cleaning in 6 months.</td>
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<td>Oral Examinations</td>
<td>• 1 oral exam in 6 months.</td>
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<tr>
<td>Bitewing X-rays</td>
<td>• Adult – 1 time in 12 months / Child – 1 time in 12 months up to 19th birthday.</td>
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<td>Periodontics</td>
<td>• Periodontal maintenance: 4 periodontal treatments in 1 year, includes 2 cleanings.</td>
</tr>
</tbody>
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<tr>
<th>TYPE B – BASIC RESTORATIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space Maintainers</td>
<td>• Space Maintainers for dependent children up to 14th birthday.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>• Periodontal scaling &amp; root planing: 1 per quadrant in any 24 month period.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>• Periodontal surgery: 1 per quadrant in any 36 month period.</td>
</tr>
<tr>
<td>Oral Surgery: Simple Extractions</td>
<td>• When dentally necessary in connection with oral surgery, extractions or other covered dental services.</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td></td>
</tr>
<tr>
<td>Full Mouth X-rays</td>
<td>• 1 full mouth X-ray in 60 months.</td>
</tr>
<tr>
<td>Amalgam and Composite Fillings</td>
<td>• 1 in 24 months.</td>
</tr>
<tr>
<td>Endodontics</td>
<td>• Root Canal treatment limited to 1 in 24 months.</td>
</tr>
<tr>
<td>Consultations</td>
<td>• 1 per 12 months.</td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: Surgical Extractions</td>
<td></td>
</tr>
<tr>
<td>Other Oral Surgery</td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>TYPE C – MAJOR RESTORATIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants</td>
<td>• Services: 1 per tooth position in 10 years. Repairs: 1 per 12 months.</td>
</tr>
<tr>
<td>Crowns/Ilnlays/Onlays</td>
<td>• 1 replacement per 10 years.</td>
</tr>
<tr>
<td>Bridges</td>
<td>• 1 in 10 years.</td>
</tr>
<tr>
<td>Dentures</td>
<td>• 1 in 10 years.</td>
</tr>
<tr>
<td>Crown, Denture and Bridge Repairs</td>
<td>• 1 per 12 months.</td>
</tr>
<tr>
<td>Prefabricated Stainless Steel &amp; Resin Crowns</td>
<td>• 1 replacement per 10 years.</td>
</tr>
</tbody>
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<tr>
<th>TYPE D – ORTHODONTIA</th>
<th>HOW MANY/HOW OFTEN</th>
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<tr>
<td></td>
<td>• Spouse and/or domestic partner (if eligible) and children/student up to age 26. Age limitations may vary by state.</td>
</tr>
<tr>
<td></td>
<td>• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.</td>
</tr>
<tr>
<td></td>
<td>• Payments are on a repetitive basis.</td>
</tr>
<tr>
<td></td>
<td>• Benefit for initial placement of the appliance will be made representing 20% of the total benefit.</td>
</tr>
<tr>
<td></td>
<td>• Orthodontic benefits end at cancellation of coverage.</td>
</tr>
</tbody>
</table>

* 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 pretreatment 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 plans 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.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. As your MetLife group representative for costs and complete details.

If you have additional questions regarding Dental Benefits, underwritten by MetLife, please contact MetLife at 1-800-ASK-4-MET (1-800-275-4638) or the Liazon Employee Service Team at 1-866-LIAZON-1 (1-866-542-9661).
We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. Services for which you would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by you or your dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (for residents of Texas, see notice page section in your certificate).
5. 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.
   For NY Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: waterpiks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
   • covered under any workers’ compensation or occupational disease law;
   • covered under any employer liability law;
   • received at a facility maintained by the Employer, labor union, mutual benefit association, or VA Hospital.
   For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any worker’s compensation, occupational disease or employer liability law as follows:
   • for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers’ Compensation Act only to the extent such services are the liability of the employee, employer or workers’ compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act;
   • for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.
   This exclusion only applies for North Carolina Sitused Groups.
15. Services:
   • 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.
   This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers’ compensation, occupational disease or employer liability law for which the employee/dependent received benefits under that law.
   This exclusion only applies for Virginia Sitused Groups.
17. Services:
   • for which the employer of the person receiving such services is not required to pay;
   • received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA Hospital.
   This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
22. Services for which the submitted documentation indicates a poor prognosis.
23. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.
   Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.
   The term does not include:
   • any plan, program or coverage provided by a government as an employer; or
   • Medicare (For Oregon, Maryland or Missouri Sitused Groups, this exclusion does not apply)
   • Medicaid (This exclusion only applies for Oregon, Maryland or Missouri Sitused Groups)
24. 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.
25. 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.
26. Caries susceptibility tests.
27. 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.
28. Other fixed Denture prosthetic services not described elsewhere in this certificate.
29. Precision attachments, except when the precision attachment is related to implant prosthetics.
30. Initial installation or replacement of a full or removable 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.
31. Addition of teeth to a partial removable 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.
32. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
33. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. 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.
35. Fixed and removable appliances for correction of harmful habits.¹
36. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.¹
37. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.¹
38. Orthodontic services or appliances.¹
39. Repair or replacement of an orthodontic device.¹
40. Duplicate prosthetic devices or appliances.
41. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
42. Intra and extraoral photographic images.
43. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers you to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner’s immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms “Referral”, “Health Care Practitioner”, “Health Care Entity”, “Beneficial Interest” and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article. This exclusion only applies for Maryland Sitused Groups

¹ Some of these exclusions may not apply. Please see your plan design and certificate for details.

Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. As your MetLife group representative for costs and complete details.
MetLife Preferred Dentist Program Overview Frequently Asked Questions

Q. How does the program work?
A. With a dental benefit plan featuring the MetLife Preferred Dentist Program, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses. The program is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

Q. Do I need an ID card?
A. No, you do not need to present an ID card to confirm that you’re eligible. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Customer service phone number. When you or your dentist calls 1-800-ASK-4-MET, you can verify your coverage eligibility quickly and easily.

Q. Who is a MetLife Participating Dentist?
A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated 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. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. How do I find a MetLife Participating dentist?
A. There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who 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.

Q. What is a negotiated fee?
A. A negotiated fee refers to the Negotiated Fee schedule which participating dentists agree to accept as payment in full. The fee is typically 15% to 45% below average fees of dentists in your area. Your plan may reimburse you for all or part of the Negotiated Fee. When you use a MetLife Participating dentist, you are responsible only for the difference between MetLife’s benefit payment amount and the Negotiated Fee.

Q. Do my dependents have to visit the same dentist that I select?
A. No, you and your dependents each have the freedom to choose any dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses.

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

*Due to contractual requirements, MetLife is prevented from soliciting certain providers.

Q. Can I find out what my out-of-pocket expenses will be before receiving a service?
A. 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.

Q. How do I file a claim?
A. Claim forms are available from your human resources department or can be downloaded and printed out from MetLife’s dental website at www.metlife.com/dental. Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a Participating Dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife’s Dental Customer Service Department at 1-800-ASK-4-MET after your plan’s effective date.

Dental Claims Address:
MetLife Dental Claims,
P.O. BOX 981282,
El Paso, TX 79998-1282

Q. If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
A. Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods:

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services (if applicable)
- 24 months on Orthodontia Services (if applicable)
MetLife Preferred Dentist Program Overview Frequently Asked Questions (continued)

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

Q. Does the Preferred Dentist Program offer any discounts on non-covered services?
A. Negotiated fees 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 permitted, you may only be responsible for the negotiated fee.
*Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. May I choose a non-participating dentist?
A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn’t agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist’s fee and your plan’s benefit payment.

Q. How can I learn about what dentists in my area charge for different procedures?
A. If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area.* You’ll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.
* The Dental Procedure Fee Tool application is provided by go2dental.com, an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a vendor. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

Q. How does MetLife coordinate benefits with other insurance plans?
A. 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.

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the negotiated fee or, for out-of-network care, the actual charge for the service rendered and the negotiated fee or R&C fee (if out-of-network care) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-5) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: completion of a prosthetic device, crown or root canal therapy.

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.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com
Dental Benefits
Savings, flexibility and service. For healthier smiles.

MetLife

Plan Design for:
Medium Plan Option
Effective Date:

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

It's easy to get these valuable dental benefits.
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Your Out-Of-Pocket Expenses are Lower When You Visit a Participating Dentist In Network.

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<td>50% of Negotiated Fee</td>
<td>25% of Negotiated Fee</td>
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<td>Deductible³</td>
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</tr>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$50</td>
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<td>Family*</td>
<td>$0</td>
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<tr>
<td>Annual Maximum Benefit</td>
<td>In Network</td>
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</tr>
<tr>
<td>Per Person</td>
<td>$1,000</td>
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¹Spouse and/or domestic partner (if eligible) and children/student up to age 26
²In Network Benefits means benefits under this plan for covered dental services that are provided by a MetLife Participating Dentist. Out of Network Benefits means benefits under this plan for covered dental services that are not provided by a MetLife Participating Dentist.
³Negotiated Fee refers to the fees that in-network dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums.

An Example of Savings When You Visit a MetLife Participating Dentist
Take a look at an example* that shows how receiving services from a MetLife Participating Dentist can save you money:

Your Dentist says you need a Crown, Type C Service*
Negotiated Fee: $600.00
Dentist's Usual Fee: $925.00

*Please note: this example assumes that your annual deductible has been met.

(In Network)
When you receive care from a MetLife Participating Dentist...
The Negotiated Fee is: $600.00
Your Plan Pays: (50% x $600 Negotiated Fee) $300.00
Your Out-of-Pocket Cost: $300.00

(Out of Network)
When you receive care from a Non-Participating Dentist...
Dentist's Usual Fee is: $925.00
Your Plan Pays: (25% x $600 Negotiated Fee) $150.00
Your Out-of-Pocket Cost: $775.00

In this example, YOU SAVE $475.00 ($775.00 minus $300.00) ...by using a MetLife Participating Dentist!
Visiting a MetLife Participating Dentist gives you the opportunity to maximize the value of your plan.

There is additional information in this overview concerning MetLife Participating Dentists.

Please note, this is only an example and may not match your plan design.
# List of Covered Services & Limitations*

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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE B – BASIC RESTORATIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Space Maintainers</td>
<td>• Space Maintainers for dependent children up to 14th birthday.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>• Periodontal scaling &amp; root planing: 1 per quadrant in any 24 month period.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>• Periodontal surgery: 1 per quadrant in any 36 month period.</td>
</tr>
<tr>
<td>Oral Surgery: Simple Extractions</td>
<td>When dentally necessary in connection with oral surgery, extractions or other covered dental services.</td>
</tr>
<tr>
<td>General Anesthesia</td>
<td>• 1 full mouth X-ray in 60 months.</td>
</tr>
<tr>
<td>Full Mouth X-rays</td>
<td>• 1 in 24 months.</td>
</tr>
<tr>
<td>Amalgam and Composite Fillings</td>
<td>• Root Canal treatment limited to 1 in 24 months.</td>
</tr>
<tr>
<td>Endodontics</td>
<td>• 1 per 12 months.</td>
</tr>
<tr>
<td>Consultations</td>
<td></td>
</tr>
<tr>
<td>Emergency Palliative Treatment</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery: Surgical Extractions</td>
<td></td>
</tr>
<tr>
<td>Other Oral Surgery</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TYPE C – MAJOR RESTORATIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants</td>
<td>• Services: 1 per tooth position in 10 years. Repairs: 1 per 12 months.</td>
</tr>
<tr>
<td>Crowns/Inlays/Onlays</td>
<td>• 1 replacement per 10 years.</td>
</tr>
<tr>
<td>Bridges</td>
<td>• 1 in 10 years.</td>
</tr>
<tr>
<td>Dentures</td>
<td>• 1 in 10 years.</td>
</tr>
<tr>
<td>Crown, Denture and Bridge Repairs</td>
<td>• 1 per 12 months.</td>
</tr>
<tr>
<td>Prefabricated Stainless Steel &amp; Resin Crowns</td>
<td>• 1 replacement per 10 years.</td>
</tr>
</tbody>
</table>

*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 pretreatment 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 plans 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.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. As your MetLife group representative for costs and complete details.

If you have additional questions regarding Dental Benefits, underwritten by MetLife, please contact MetLife at 1-800-ASK-4-MET (1-800-275-4638) or the Liazon Employee Service Team at 1-866-LIAZON-1 (1-866-542-9661).
We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. Services for which you would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by you or your dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (for residents of Texas, see notice page section in your certificate).
5. 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; or
   • fluoride treatments.
For NY Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to, water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
   • covered under any workers’ compensation or occupational disease law;
   • covered under any employer liability law;
   • received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any worker’s compensation, occupational disease or employer liability laws as follows:
   • for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers’ Compensation Act only to the extent such services are the liability of the employer, employer or employer’s compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act, or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act;
   • for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.
This exclusion only applies for North Carolina Sitused Groups.
15. Services:
   • 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.
This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers’ compensation, occupational disease or employer liability laws for which the employee/dependent received benefits under that law.
This exclusion only applies for Virginia Sitused Groups.
17. Services:
   • for which the employer of the person receiving such services is not required to pay;
   • received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.
This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
22. Services for which the submitted documentation indicates a poor prognosis.
23. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.
Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.
The term does not include:
• any plan, program or coverage provided by a government as an employer;
or
• Medicare (For Oregon, Maryland or Missouri Sitused Groups, this exclusion does not apply).
• Medicaid (This exclusion only applies for Oregon, Maryland or Missouri Sitused Groups)
24. 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-invasive conscious sedation or analgesia such as nitrous oxide.
25. 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.
    For NY Sitused Groups, this exclusion does not apply.
26. Caries susceptibility tests.
27. 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.
28. Other fixed Denture prosthetic services not described elsewhere in this certificate.
29. Precision attachments, except when the precision attachment is related to implant prosthetics.
30. Initial installation or replacement of a full or removable 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.
31. Addition of teeth to a partial removable 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.
32. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
33. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. 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.
35. Fixed and removable appliances for correction of harmful habits.1
36. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.1
37. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
   This exclusion does not apply to residents of Minnesota.1
38. Orthodontic services or appliances.1
39. Repair or replacement of an orthodontic device.1
40. Duplicate prosthetic devices or appliances.
41. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
42. Intra and extraoral photographic images.
43. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers you to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner’s immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms “Referral”, “Health Care Practitioner”, “Health Care Entity”, “Beneficial Interest” and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article. This exclusion only applies for Maryland Sitused Groups

1 Some of these exclusions may not apply. Please see your plan design and certificate for details.

Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. As your MetLife group representative for costs and complete details.
MetLife Preferred Dentist Program Overview Frequently Asked Questions

Q. How does the program work?
A. With a dental benefit plan featuring the MetLife Preferred Dentist Program, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses. The program is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

Q. Do I need an ID card?
A. No, you do not need to present an ID card to confirm that you’re eligible. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Customer service phone number. When you or your dentist calls 1-800-ASK-4-MET, you can verify your coverage eligibility quickly and easily.

Q. Who is a MetLife Participating Dentist?
A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated 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. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. How do I find a MetLife Participating dentist?
A. There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who 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.

Q. What is a negotiated fee?
A. A negotiated fee refers to the Negotiated Fee schedule which participating dentists agree to accept as payment in full. The fee is typically 15% to 45% below average fees of dentists in your area. Your plan may reimburse you for all or part of the Negotiated Fee. When you use a MetLife Participating dentist, you are responsible only for the difference between MetLife’s benefit payment amount and the Negotiated Fee.

Q. Do my dependents have to visit the same dentist that I select?
A. No, you and your dependents each have the freedom to choose any dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses.

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

* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

Q. Can I find out what my out-of-pocket expenses will be before receiving a service?
A. 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.

Q. How do I file a claim?
A. Claim forms are available from your human resources department or can be downloaded and printed from MetLife’s dental website at www.metlife.com/dental. Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a Participating Dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife’s Dental Customer Service Department at 1-800-ASK-4-MET after your plan’s effective date.

Dental Claims Address:
MetLife Dental Claims,
P.O. BOX 982182,
El Paso, TX 79998-1282

Q. If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
A. Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

• No waiting period on Preventive Services
• 6 months on Basic Restorative (Fillings)
• 12 months on all other Basic Services
• 24 months on Major Services (if applicable)
• 24 months on Orthodontia Services (if applicable)
Q. What services are covered by my plan?
A. All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Q. Does the Preferred Dentist Program offer any discounts on non-covered services?
A. Negotiated fees 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 permitted, you may only be responsible for the negotiated fee.
* Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. May I choose a non-participating dentist?
A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn’t agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist’s fee and your plan’s benefit payment.

Q. How can I learn about what dentists in my area charge for different procedures?
A. If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area.* You’ll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by go2dental.com, Inc., an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a vendor. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

Q. How does MetLife coordinate benefits with other insurance plans?
A. 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.

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the negotiated fee or, for out-of-network care, the actual charge for the service rendered and the negotiated fee or R&C fee (if out-of-network care) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-5) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: completion of a prosthetic device, crown or root canal therapy.
Dental Benefits
Savings, flexibility and service. For healthier smiles.

MetLife

Plan Design for:
Low Plan Option
Effective Date:

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

It's easy to get these valuable dental benefits.
Review the Overview of Benefits and Savings Example .............. Page 1
List of Covered Services and Limitations .............................. Pages 2 – 3
Frequently Asked Questions ............................................ Pages 4 – 5

Your Out-Of-Pocket Expenses are Lower When You Visit a Participating Dentist In Network.

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>IN NETWORK(^1)</th>
<th>OUT OF NETWORK(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A – Preventive</td>
<td>100% of Negotiated Fee(^2)</td>
<td>100% of Negotiated Fee(^2)</td>
</tr>
<tr>
<td>Type B – Basic Restorative</td>
<td>80% of Negotiated Fee</td>
<td>50% of Negotiated Fee(^2)</td>
</tr>
<tr>
<td>Type C – Major Restorative*</td>
<td>0% of Negotiated Fee</td>
<td>0% of Negotiated Fee(^2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible(^2)</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$50</td>
</tr>
<tr>
<td>Family**</td>
<td>$0</td>
<td>$150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Maximum Benefit</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Person</td>
<td>$750</td>
<td>$500</td>
</tr>
</tbody>
</table>

*Not provided with this plan
**Spouse and/or domestic partner (if eligible) and children/student up to age 26

\(^1\) In Network: Benefits means benefits under this plan for covered dental services that are provided by a MetLife Participating Dentist. Out of Network: Benefits means benefits under this plan for covered dental services that are not provided by a MetLife Participating Dentist.
\(^2\) Negotiated Fee refers to the fees that in-network dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums.

An Example of Savings When You Visit a MetLife Participating Dentist
Take a look at an example* that shows how receiving services from a MetLife Participating Dentist can save you money:

Your Dentist says you need a Filling, Type B Service*
Negotiated Fee: $75.00
Dentist's Usual Fee: $100.00

*Please note: this example assumes that your annual deductible has been met.

(In Network)
When you receive care from a MetLife Participating Dentist...
The Negotiated Fee is: $75.00
Your Plan Pays: (80% x $75 Negotiated Fee) $60.00
Your Out-of-Pocket Cost: $15.00

(Out of Network)
When you receive care from a Non-Participating Dentist...
Dentist's Usual Fee is: $100.00
Your Plan Pays: (50% x $75 Negotiated Fee) $37.50
Your Out-of-Pocket Cost: $62.50

In this example, YOU SAVE $47.50 ($62.50 minus $15.00)...by using a participating dentist!
Visiting a MetLife Participating Dentist gives you the opportunity to maximize the value of your plan.
There is additional information in this overview concerning MetLife Participating dentists.

Please note, this is only an example and may not match your plan design.
### List of Covered Services & Limitations*

<table>
<thead>
<tr>
<th>TYPE A – PREVENTIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical Fluoride Applications</td>
<td>1 fluoride treatment in 12 months for dependent children up to 14th birthday.</td>
</tr>
<tr>
<td>Sealants</td>
<td>1 sealant per permanent 1st &amp; 2nd non-restored non-decayed molar in 6 months for a dependent child up to 14th birthday.</td>
</tr>
<tr>
<td>Prophylaxis (Cleanings)</td>
<td>1 cleaning in 6 months.</td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>1 oral exam in 6 months.</td>
</tr>
<tr>
<td>Bitewing X-rays</td>
<td>Adult – 1 time in 12 months / Child – 1 time in 12 months up to 19th birthday.</td>
</tr>
<tr>
<td>Periodontics</td>
<td>Periodontal maintenance: 2 periodontal treatments in 1 year, includes 2 cleanings.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<td>Periodontics</td>
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<td>Oral Surgery: Simple Extractions</td>
<td>1 full mouth X-ray in 60 months.</td>
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<td>Full Mouth X-rays</td>
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<td>Emergency Palliative Treatment</td>
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<tr>
<th>TYPE C – MAJOR RESTORATIVE</th>
<th>HOW MANY/HOW OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type C Services are not provided with this plan.</td>
<td></td>
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The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict between this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. As your MetLife group representative for costs and complete details.

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If you have additional questions regarding Dental Benefits, underwritten by MetLife, please contact MetLife at 1-800-ASK-4-MET (1-800-275-4638) or the Liazon Employee Service Team at 1-866-LIAZON-1 (1-866-542-9661).
We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. 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; or
   • fluoride treatments.
   For NY Situated Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water pikes, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services:
   • covered under any workers’ compensation or occupational disease law;
   • covered under any employer liability law;
   • received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
   For North Carolina and Virginia Situated Groups, this exclusion does not apply.
14. Services paid under any worker’s compensation, occupational disease or employer liability law as follows:
   • for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers’ Compensation Act only to the extent such services are the liability of the employee, employer or workers’ compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ compensation Act;
   • for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.
   This exclusion only applies for North Carolina Situated Groups.
15. Services:
   • for which the employer of the person receiving such services is not required to pay; or
   • received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
   This exclusion only applies for North Carolina Situated Groups.
16. Services covered under any workers’ compensation, occupational disease or employer liability law for which the employee/Dependent received benefits under that law.
   This exclusion only applies for Virginia Situated Groups.
17. Services:
   • for which the employer of the person receiving such services is not required to pay; or
   • received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.
   This exclusion only applies for Virginia Situated Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
22. Services for which the submitted documentation indicates a poor prognosis.
23. Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Dental Insurance under the Group Policy be paid first.
   Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government.
   The term does not include:
   • any plan, program or coverage provided by a government as an employer; or
   • Medicare (For Oregon, Maryland or Missouri Situated Groups, this exclusion does not apply.)
   • Medicaid (This exclusion only applies for Oregon, Maryland or Missouri Situated Groups)
24. 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.
25. 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.
   For NY Situated Groups, this exclusion does not apply.
26. Caries susceptibility tests.
27. 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.
28. Other fixed denture prosthetic services not described elsewhere in this certificate.
29. Precision attachments, except when the precision attachment is related to implant prosthetics.
30. Initial installation or replacement of a full or removable 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.
31. Addition of teeth to a partial removable 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.
32. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
33. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. 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.
35. Fixed and removable appliances for correction of harmful habits.¹
36. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.¹
37. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
   This exclusion does not apply to residents of Minnesota.¹
38. Orthodontic services or appliances.¹
39. Repair or replacement of an orthodontic device.¹
40. Duplicate prosthetic devices or appliances.
41. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
42. Intra and extraoral photographic images.
43. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner’s Immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms “Referral”, “Health Care Practitioner”, “Health Care Entity”, “Beneficial Interest” and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
   This exclusion only applies for Maryland Situated Groups

¹ Some of these exclusions may not apply. Please see your plan design and certificate for details.
Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. As your MetLife group representative for costs and complete details.
MetLife Preferred Dentist Program Overview Frequently Asked Questions

Q. How does the program work?
A. With a dental benefit plan featuring the MetLife Preferred Dentist Program, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses. The program is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

Q. Do I need an ID card?
A. No, you do not need to present an ID card to confirm that you're eligible. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Customer service phone number. When you or your dentist calls 1-800-ASK-4-MET, you can verify your coverage eligibility quickly and easily.

Q. Who is a MetLife Participating Dentist?
A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated 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 analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. How do I find a MetLife Participating dentist?
A. There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who 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.

Q. What is a negotiated fee?
A. A negotiated fee refers to the Negotiated Fee schedule which participating dentists agree to accept as payment in full. The fee is typically 15% to 45% below average fees of dentists in your area. Your plan may reimburse you for all or part of the Negotiated Fee. When you use a MetLife Participating dentist, you are responsible only for the difference between MetLife's benefit payment amount and the Negotiated Fee.

Q. Do my dependents have to visit the same dentist that I select?
A. No, you and your dependents each have the freedom to choose any dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses.

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

*Due to contractual requirements, MetLife is prevented from soliciting certain providers.

Q. Can I find out what my out-of-pocket expenses will be before receiving a service?
A. 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.

Q. How do I file a claim?
A. Claim forms are available from your human resources department or can be downloaded and printed out from MetLife's dental website at www.metlife.com/dental. Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a Participating Dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1-800-ASK-4-MET after your plan's effective date.

Dental Claims Address:
MetLife Dental Claims,
P.O. BOX 981282,
El Paso, TX 79998-1282

Q. If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
A. Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods:
- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services (if applicable)
- 24 months on Orthodontia Services (if applicable)
Q. What services are covered by my plan?
A. All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Q. Does the Preferred Dentist Program offer any discounts on non-covered services?
A. Negotiated fees 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 permitted, you may only be responsible for the negotiated fee.

* Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Q. May I choose a non-participating dentist?
A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan’s benefit payment.

Q. How can I learn about what dentists in my area charge for different procedures?
A. If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area. You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by go2dental.com, Inc., an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a vendor. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

Q. How does MetLife coordinate benefits with other insurance plans?
A. 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.

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the negotiated fee or, for out-of-network care, the actual charge for the service rendered and the negotiated fee or R&F fee (if out-of-network care) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: completion of a prosthetic device, crown or root canal therapy.

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.
**MetLife Preferred Dentist Program (PDP) Overview**

**Frequently Asked Questions**

**How does the MetLife PDP work?**
With a dental benefit plan featuring the MetLife PDP, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses. The MetLife PDP is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

**Do I need an ID card?**
No, you do not need to present an ID card to confirm that you’re eligible. You should notify your dentist that you participate in MetLife’s PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

- Customer service phone number. When you or your dentist calls 1-800-ASK-4-MET, you can verify your coverage eligibility quickly and easily.

**What is a MetLife PDP dentist?**
A general dentist or specialist who meets MetLife’s strict credentialing standards and accepts negotiated fees as payment-in-full for services rendered. There are over 187,000 participating dentist locations nationwide, including more than 45,000 specialist locations. This makes it easier to find a participating PDP dentist near your home or workplace, while you’re away on vacation, or while your covered dependents are away at college.

**How do I find a MetLife PDP dentist?**
You can call the PDP automated Computer Voice Response line to obtain an up-to-date directory of participating dentists in your area. A list of up to 205 participating dentists in the requested ZIP code is then mailed to your home the next business day.

To receive your personalized directory, call 1-800-474-PDP1 (7371) Mon.-Fri. 5:00am to 11:00 pm ET or Saturday 7 am to 4:00 pm ET. You can also conduct online provider searches (with directions and mapping capabilities) via MetLife’s Dental Internet site at www.metlife.com/dental.

Please Note: Be sure to verify provider participation when you make your appointment.

**What is a negotiated fee?**
A negotiated fee refers to the PDP fee schedule which participating dentists agree to accept as payment in full. The fee is typically 15% to 45% below average fees of dentists in your area. Your plan may reimburse you for all or part of the PDP fee. When you use a MetLife PDP dentist, you are responsible only for the difference between MetLife’s benefit payment amount and the PDP fee.

*Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

**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. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses.

**My dentist does not participate in the PDP. Is there anything I can do to encourage my dentist to participate?**
The MetLife PDP Network is continually expanding and new providers may be added if they meet MetLife’s credentialing standards. You may ask your dentist to complete a MetLife PDP nomination card or visit the dentist directory online at www.metlife.com/dental, and MetLife will send him or her information on how to apply for participation. The timing depends on how quickly MetLife receives the necessary information. Please note that there may be instances where a dentist chooses not to participate and others where MetLife does not accept the application under our stringent credentialing requirements.

**Can I find out how much services will cost and obtain an estimate of what will be covered prior to treatment?**
Yes. MetLife recommends that you have your dentist submit a request for a pre-treatment estimate for services in excess of $300.00. This often applies to services such as: crowns, bridges, inlays, and periodontics. When your dentist suggests treatment, have him or her send an undated claim form, along with the proposed treatment plan, to MetLife. You and your dentist will receive a benefit estimate (online or by fax) for most procedures while you’re still in the office, so you can discuss treatment and payment options, and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

**How do I file a claim?**
Claim forms are available from your human resources department or can be downloaded and printed out from MetLife’s dental website at www.metlife.com/dental. Remember to bring one with you to your appointment.

Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a participating PDP dentist. MetLife will mail you a concise explanation of benefits (EOB) statement after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife’s Dental Customer Service Department at 1-800-ASK-4-MET after your plan’s effective date.

**Dental Claims Address:** MetLife Dental Claims
P.O. BOX 981282
El Paso, TX 79998-1282

**If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?**
Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative Services (Filling)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

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.

Metropolitan Life Insurance Company, New York, NY 10166

L0812273658[exp0913][All States]
You Can Benefit from MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information including planning tools and oral health awareness material.* MetLife is able to deliver services that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits, requiring you to follow the steps outlined below.

Registration Process for MyBenefits

Provide Your Group Name

Access MyBenefits at www.metlife.com/mybenefits and enter your group name and click "Submit."

The Login Screen

On the Home Page, you can access general information. To begin accessing personal plan information, click on "Register Now" and perform the on-time registration process. Going forward, you will be able to log-in directly.

Step 1: Enter Personal Information

Enter your first and last name, identifying data and e-mail address.

Step 2: Create a User Name and Password

Then you will need to create a unique user name and password for future access to MyBenefits.

The User Name and Password requirements may vary by company setup. General setup includes a User Name between 8-20 characters, containing at least one letter and one number, and a password between 6-20 characters, containing at least one letter and one number.

Step 3: Security Verification Questions

Now, you will need to choose and answer three identity verification questions to be utilized in the event you forget your password.

Step 4: Terms of Use

Finally, you will be asked to read and agree to the website's Terms of Use.

Step 5: Process Complete

Now you will be brought to the "Thank You" page.

Lastly, a confirmation of your registration will be sent to the e-mail address you provided during registration.

*Available only to dental benefits participants.
Your new dental plan

MetLife

Welcome to MetLife. You can count on us to deliver the service and support you need. Your dedicated Customer Service number, 1-800-ASK-4-MET (1-800-275-4638), is available to help you get quick answers to your dental coverage questions.

Please follow the detailed steps below when calling MetLife to confirm your plan benefits. We recommend you take this flyer with you the first time you visit your dentist as a MetLife enrollee. And remember, if you speak with a representative, make sure to let him or her know you are new to MetLife.

1-800-ASK-4-MET

Welcome to MetLife → PRESS 1 – Employee, member or a provider → PRESS 1 – Dental Inquiries →
→ PRESS 1: If you are the policy holder or a covered family member
→ PRESS 2: If you are the dental services provider
→ PRESS 3: Spanish
→ PRESS 4: Mandarin

Please enter the employee’s Social Security Number or ID Number, followed by the pound (#) sign. You may also be asked for your ZIP Code and the first three letters of your last name.

If eligibility is not found.

You may be asked “If you or your employer have recently selected dental coverage with MetLife, press 1, otherwise press 2.” PRESS 1.

→ PRESS 1: To request network dentist program directories
→ PRESS 2: To order claim forms
→ PRESS 3: To hear the claim filing address
→ PRESS 4: For verification of dental coverage or to speak to a Customer Service Consultant

If eligibility is found, but it isn’t for your current plan.

→ PRESS 1: For claim inquiries
→ PRESS 2: To request a list of participating MetLife dentists in your area
→ PRESS 3: To request a claim form
→ PRESS 4: For general inquiries including ID cards and claim filing instructions

If eligibility is found, your call continues through standard self-service options.

→ PRESS 1: For claim filing information
→ PRESS 2: For inquiries on ID cards
→ PRESS 3: For instructions on filing pre-treatment estimates
→ PRESS 4: For information on our International Dental Travel Assistance Program
→ PRESS 5: To speak with a Customer Service Consultant
Instructions for your dentist

Please follow the steps below to confirm benefits information for your patient.

Call 1-877-MET-DDS9 (1-877-638-3379).

PRESS 2 – For other inquiries

Please enter the provider's nine digit Tax ID number.

Please enter the employee's Social Security Number or ID number, followed by the pound (#) sign.

If eligibility is not found.

PRESS 1: For general inquiries including requesting X-ray returns or directories

PRESS 1: To request the return of X-rays submitted with a claim or pre-treatment estimate

PRESS 2: For instructions on filing claims & pre-treatment estimates

PRESS 3: For inquiries regarding the Preferred Dentist Program

PRESS 4: To request a directory

PRESS 5: To speak with a Customer Service Consultant

If eligibility is found, but it isn't for your patient's current plan.

PRESS 1: To request a fax of the patient's claim history

PRESS 2: For all claim inquiries or requests

PRESS 3: For general inquiries including requesting X-ray returns or directories

PRESS 4: To select another employee

PRESS 5: To speak with a Customer Service Consultant

If eligibility is found, your call continues through standard self-service options.

PRESS 1: To request the return of X-rays submitted with a claim or pre-treatment estimate

PRESS 2: For instructions on filing claims & pre-treatment estimates

PRESS 3: For inquiries regarding the Preferred Dentist Program

PRESS 4: To request a directory

PRESS 5: To speak with a Customer Service Consultant

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

MetLife
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com