My Benefit Advisor Plan Summary

With the MetLife Dental Insurance plan, your acceptance is guaranteed.

- **100% coverage** for preventive care for in-network exams, cleanings and X-rays[1]
- **Freedom to visit any dentist** you want whether they are in the MetLife network or not[2]
- **Typical savings of 30% - 45%** on covered services when you use a participating dentist[3]

Eligibility

All members[4], their spouses/domestic partners, and dependent children[5] may apply.

Plan Benefits

Silver Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of Negotiated
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	50%	50%
Type C: Major Restorative (bridges, dentures)	Not Covered	Not Covered
Type D: Orthodontia	Not Covered	Not Covered
Deductible†		
Individual (per calendar year)	$50.00	$50.00
Family (per calendar year)	$150.00	$150.00
Annual Maximum Benefit		
Per Person	$1,000 (Annual Combined) for In and Out of Network	

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

† only to Type B Services

Gold Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of Negotiated Fee*
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	70%	70%
Type C: Major Restorative (bridges, dentures)	40%	40%
Type D: Orthodontia	Not Covered	Not Covered
Deductible†		
Individual (per calendar year)	$50.00	$50.00
Family (per calendar year)	$150.00	$150.00
Annual Maximum Benefit		
Per Person	$1,500 (Annual Combined) for In and Out of Network	

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

†Applies only to Type B and C Services.

Platinum Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of Negotiated Fee*
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%
Type D: Orthodontia	50%	50%
Deductible†		
Individual (per calendar year)	$25.00	$25.00
Family (per calendar year)	$75.00	$75.00
Annual Maximum Benefit		
Per Person	$3,000 (Annual Combined) for In and Out of Network	
Orthodontia Lifetime Maximum		
Per Person (for children up to age 19 only).	$2,000 (Lifetime Combined) for In and Out of Network	

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

† Applies only to Type B and C Services.

List of Primary Covered Services & Limitations

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

Type A: Preventive

Covered Services for Silver, Gold, and Platinum Plans

- Prophylaxis (cleanings) - Once every six (6) months
- Oral Examinations - One exam every six (6) months
- Topical Fluoride Applications - Two fluoride treatments in a 12 month period for dependent children up to their 19th birthday
- X-rays –
  - Full mouth X-rays; one per five (5) years
  - Bitewings X-rays; one set per calendar year for adults; one set per calendar year for children
- Space Maintainers - Space maintainers for dependent children up to their 14th birthday, once every three (3) years
- Sealants - One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to their 19th birthday

Type B: Basic Restorative

Covered Services for Silver, Gold, and Platinum Dental Plans

- Initial Placement of amalgam fillings
- Existing amalgam filling, but only if:
  - At least 24 months have passed since the existing filling was placed; or
  - A new surface of decay is identified on that tooth
- Simple Extractions
- Surgical Extractions
- Oral Surgery
- Periodontics –
  - Periodontal scaling and root planing once per quadrant, every 24 months
- Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in twelve (12) months, less the number of teeth cleanings received during such 12-month prefabricated crown, but no more than one replacement for the same tooth surface within ten (10) calendar years.

Type C: Major Restorative

Covered Services for the Gold and Platinum Plans

- Crown, Denture, Implant, and Bridge Repair/Recementations – once in a 12 month period
- Implants- Replacement once every 10 years
- Bridges and Dentures
  - Dentures and bridgework replacement; one every 10 years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
- Crowns, Inlays and Onlays - Replacement once every 10 years
- Endodontics - Root canal treatment limited to once in your lifetime per tooth
- General Anesthesia or intravenous sedation - When dentally necessary in connection with oral surgery, extractions or other covered dental services
- Periodontics-
  - Periodontal surgery once per quadrant, every 36 months

Type D: Orthodontia

Covered Services for the Platinum Plan

- Your children, up to age 19, are covered while Dental insurance is in effect**.**
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary
- Orthodontic benefits end at cancellation of coverage

Exclusions

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

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which covered person would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by a covered person before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;

- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by a disease;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: waterpiks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the Participating Association of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Participating Association;
- Biopsies of hard or soft oral tissue;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation or replacement of Cast Restorations (Silver Plan);
- Repair of Cast Restorations (Silver Plan);
- Re-Cementing of Cast Restorations or Dentures (Silver Plan);
- Labial veneers (Silver Plan);
- Core buildup and cast post and core (Silver Plan);
- Root Canal treatment and other endodontic services except as mentioned elsewhere (Silver Plan);
- Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery (Silver Plan);
- Initial installation or replacement of Dentures (Silver Plan);
- Addition of teeth to a partial Denture (Silver Plan);
- Adjustments and repairs of Dentures (Silver Plan);
- Relinings and Rebasings of Dentures (Silver Plan);

- Tissue conditioning (Silver Plan);
- Modification of removable prosthodontic and other removable prosthetic services (Silver Plan);
- Implants including, but not limited to any related surgery, placement, maintenance, and removal (Silver Plan);
- Repair of implants (Silver Plan);
- Fixed Partial Dentures (Silver Plan);
- Other fixed partial Denture services (Silver Plan);
- General anesthesia or intravenous sedation (Silver Plan);
- Consultations (Silver Plan);
- Occlusal adjustments (Silver Plan);
- Apexification/recalcification (Silver Plan);
- Full mouth debridements (Silver Plan);
- Preventive resin restorations;
- Interim caries arresting medicament application (Platinum Plan);
- Modification of removal prosthodontic and other removable prosthetic services;
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it (Gold and Platinum Plans);
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of New Mexico.This exclusion does not apply to residents of Minnesota;
- Orthodontic services or appliances (Silver and Gold Plans);
- Repair of an orthodontic device (Silver and Gold Plans);
- Replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances (Gold and Platinum Plans);
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture;
- Intra and extraoral photographic images
- Type C Services (Silver Plan).

Limitations

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

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99-TRUST (7/10)) issued by MetLife. Coverage terminates when your membership ceases, the participating association ceases to participate in the trust, insurance ceases for your class, 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.

1. Preventive services (Type A) are 100% covered when you visit an in-network participating dentist. Subject to frequency limitations.
2. Your out-of-pocket costs may be greater when you visit a dentist who does not participate in the MetLife network.
3. Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.
4. You must be a member of your participating association to qualify for this insurance plan.
5. Refers to your unmarried dependent child up to age 26.

Coverage may not be available in all states. Please contact My Benefit Advisor at 1-855-874-0267 for more information.

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 My Benefit Advisor at 1-855-874-0267 for costs and complete details.

Policy form GPNP15-2T
Certificate form GCERT2015-DENTAL

Policy number: 160667-G

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MY BENEFIT ADVISOR