

Plan Benefits — Choose a Plan

SILVER

Coverage Type	In-Network or Out-of-Network
Type A (e.g., cleanings, oral examinations)	100% of Negotiated Fee*
Type B (e.g., fillings)	50% of Negotiated Fee*
Type C (e.g., bridges and dentures)	Not covered
Deductible [±] — Individual (per calendar year)	\$50
Deductible [±] — Family (per calendar year)	\$150
Annual Maximum Benefit — Per Person	\$1,000 (Annual Combined) for In- or Out-of-Network

GOLD

Coverage Type	In-Network or Out-of-Network
Type A (e.g., cleanings, oral examinations)	100% of Negotiated Fee*
Type B (e.g., fillings)	70% of Negotiated Fee*
Type C (e.g., bridges and dentures)	40% of Negotiated Fee*
Deductible [±] — Individual (per calendar year)	\$50
Deductible [±] — Family (per calendar year)	\$150
Annual Maximum Benefit — Per Person	\$1,500 (Annual Combined) for In- or Out-of-Network

PLATINUM

Coverage Type	In-Network or Out-of-Network
Type A (e.g., cleanings, oral examinations)	100% of Negotiated Fee*
Type B (e.g., fillings)	80% of Negotiated Fee*
Type C (e.g., bridges and dentures)	50% of Negotiated Fee*
Type D Orthodontia	50% of Negotiated Fee*
Deductible [±]	
Individual (per calendar year)	\$25
Family (per calendar year)	\$75
Annual Maximum Benefit	
Per Person	\$3,000 (Annual Combined for In- or Out-of-Network)
Orthodontia (for children up to age 19 only).	Annual Combined (for In- or Out-of-Network) Maximum \$2,000 per child

In Network Savings¹ Example

This hypothetical example² shows how receiving services from a participating dentist can help save you money.

Your Dentist says you need a Crown, a Type C service —

- Negotiated Fee: \$670.00
- Dentist's Usual Fee: \$1,462.00

IN-NETWORK — Gold Plan When you receive care from a participating dentist		OUT-OF-NETWORK — Gold Plan When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	\$1,462.00	Dentist's Usual Fee is:	\$1,462.00
The Negotiated Fee is:	\$670.00		
Your Plan Pays:		Your Plan Pays:	
40% x \$670 Negotiated Fee:	–\$268.00	40% x \$670 Negotiated Fee:	–\$268.00
Your Out-of-Pocket Cost:	\$402.00	Your Out-of-Pocket Cost:	\$1,194.00

In this example, you save \$792.00 (\$1,194.00 minus \$402.00) ... by using a participating dentist.

Short on time? Enrolling is easy — it takes less than 5 minutes.

- Coverage will take effect on the 1st of the month following receipt of your enrollment form and payment of initial premium.

Questions? Call The Alumni Insurance Program at 1-800-922-1245.

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

[±] Deductible applies to Type B & C Services.

¹ Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

² Please note: This is a hypothetical example that reviews a porcelain/ceramic crown (D2740) in the Philadelphia area, zip 19151. It assumes that the annual deductible has been met and the annual maximum benefit has not been reached.

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

100% coverage for preventive care for in-network exams, cleanings and X-rays¹

Freedom to visit any dentist² you want whether they are in the MetLife network or not

Typical savings of 30%-45% on covered services when you use a participating dentist³

A Summary of Covered Services

Below is an abbreviated list of services covered by this MetLife Dental Insurance Plan.⁴

Type A Covered Services (for Silver, Gold and Platinum Plans)

- Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months.
- Full mouth or panoramic x-rays once every 5 years.
- Bitewing x-rays but not more than 1 set in a year.
- Cleaning of teeth (oral prophylaxis) once every 6 months.

Type B Covered Services (for Silver, Gold and Platinum Plans)

- Oral surgery, except as mentioned in the certificate.
- Problem-focused exams (combined with oral exams) but no more than 1 exam every 6 months.
- Periodontal maintenance is limited to four times in 12 months, less the number of teeth cleanings received during such 12-month period.
- Scaling and root planing –1 per quadrant in any 24 months.
- Surgical extractions.
- Simple extractions.
- Protective (sedative) fillings.
- Initial placement of amalgam fillings.
- Replacement of an existing amalgam filling, but only if:
 - at least 24 months have passed since the existing filling was placed; or
 - a new surface of decay is identified on that tooth.
- Prefabricated crown, but no more than one replacement for the same tooth surface within 10 calendar years.

Type C Covered Services (for Gold and Platinum Plans only)

- Periodontal surgery such as gingivectomy, gingivoplasty, and osseous surgery.
- Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12-month period.
- Other consultations, but not more than twice in a 12-month period.
- Initial installation of Cast Restorations.
- Replacement of any Cast Restorations with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 10 calendar years of a prior replacement.
- Core buildup, but no more than once per tooth in a period of 10 calendar years.
- Labial Veneers, but no more than once per tooth in a period of 10 calendar years.
- Replacement of a non-serviceable fixed and permanent Denture if such Denture was installed more than 10 calendar years prior to replacement.
- Root canal treatment, but not more than once in your lifetime for the same tooth.
- Initial installation of fixed and permanent Denture.
- Adjustments of Dentures:
 - if at least 6 months have passed since the installation of the existing removable Denture; and not more than once in any 12-month period.
- Repair of Dentures but not more than once in a 12-month period.
- Repair of implants but not more than once in a 12-month period.
- General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when it is determined such anesthesia is necessary in accordance with generally accepted dental standards.

Type D Covered Services (for Platinum Plan only)

- Orthodontia

Have any other questions? Please call 1-800-922-1245.

¹Preventive services (Type A) are 100% covered when you visit an in-network participating dentist. Subject to frequency limitations.

²Your out-of-network costs may be greater when you visit a dentist who does not participate in the MetLife network.

³Based 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.

⁴This is just a summary of covered services. Please see the certificate of insurance for complete plan details.

EXCLUSIONS – applies to all plans (except where noted)

Dental Insurance benefits will not be paid for charges incurred for:

- 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 a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- 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 which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by 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: water piks, toothbrushes, or dental floss.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- Decoration 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.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- 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.
- 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 and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- 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.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

Coverage may not be available in all states. Please call The Alumni Insurance Program at 1-800-922-1245 for more information.

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 may be higher. Discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving any high cost services. 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. 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 Information Service.

Coverage is provided under a group insurance policy (Policy form GPNP14-TRUST issued by Metropolitan Life Insurance Company, New York, NY (MetLife). Coverage terminates 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. 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. The group policy terminates when the group policy is terminated, you fail to pay your premiums, coverage is terminated for your class or you cease to be a member.

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

Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife for complete details.



The Alumni Insurance Program DENTAL

AREA SCHEDULE

How to use this chart:

To determine the appropriate premium rates for a dental plan, look up the enroller's state of residence on this chart, and then look up the enroller's 3-digit zip code, if applicable. Use the Area number that applies to your state/zip to determine the premium rate from the area rate schedule.

State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369
	2	355-361, 365-366
Alaska	5	995-999
Arizona	2	850-857
	3	859-865
Arkansas	2	716-729
	2	923-925
California	3	900, 905-922, 926-938, 952-953, 955-961
	4	901-904, 939, 945-946, 948, 950-951
	5	940-944, 947, 949, 954
	3	800-816
Connecticut	4	060-069
Delaware	4	197-199
D.C.	3	200, 202-205
Florida	2	320-322, 325-329, 334-338, 342-349
	3	323-324, 333, 339-341
	4	330-332
Georgia	2	306-310, 312, 319
	3	300-305, 311, 313-318, 398
Hawaii	3	967-968
Idaho	2	832-838
Illinois	1	624, 628-629
	2	609-623, 625-627
	4	600-608
Indiana	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	4	463-464
Iowa	1	508-510, 512-516
	2	500-507, 520-528
	3	511
Kansas	2	660-662, 664-679
Kentucky	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
Louisiana	2	700-701, 703-708, 710-714
Maine	3	042-044, 046-047, 049
	4	039-041, 045, 048
Maryland	2	210-219
	3	206-209
Massachusetts	4	010, 012-013
	5	011, 014-027
Michigan	2	486
	3	480-485, 487-499
Minnesota	3	550-551, 553-567
Mississippi	2	386-397
Missouri	1	645
	2	630-644, 646-659

State	Area	First 3 Digits of Zip Code (if applicable)
Montana	2	590-599
Nebraska	1	680-684, 689-690
	2	685-688, 691-693
Nevada	2	889-891
	4	893-898
New Hampshire	4	030, 032, 034-038
	5	031, 033
New Jersey	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
New Mexico	2	870-875, 877-884
	2	104, 124-129, 133-136, 142
New York	3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	4	063, 105-108, 111-114, 116
	5	100-102
North Carolina	3	270-289
North Dakota	2	580-588
Ohio	2	430-459
Oklahoma	2	730-731, 734-741, 743-749
Oregon	3	970-979
Pennsylvania	1	150-156, 159-161, 163-164, 171-172, 185, 187
	2	157-158, 162, 165-168, 170, 173-176, 180-184, 186, 188, 190-192
	3	169, 177-179, 189, 193-196
Puerto Rico	1	006-007, 009
Rhode Island	4	028-029
South Carolina	3	290-299
South Dakota	2	570-577
Tennessee	2	370-385
	1	782
Texas	2	754-759, 764-769, 773-774, 776-781, 783-785, 788-789, 794-799
	3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Utah	1	840-847
Vermont	4	050-054, 056-059
Virginia	2	230-246
	3	201, 220-229
Virgin Islands	3	008
Washington	3	990-992, 994
	4	986-989, 993
	5	980-985
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831



Coverage is available
Denotes state where coverage is not available at this time

