PLAN DETAILS AND RATES

	MetLife Low Option		MetLife High Option	
Network: PDP Plus	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Basis of Reimbursement	Negotiated PDP fee	Maximum Allowable Charge (MAC)	Negotiated PDP fee	Maximum Allowable Charge (MAC)
Type A - Preventive	100%	100%	100%	100%
Type B - Basic	70%	70%	80%	80%
Type C - Major	Not covered	Not covered	50%	50%
Type D - Orthodontia (Child)	Not covered	Not covered	50%	50%
Individual Deductible (Annual)	$50.00	$50.00	$50.00	$50.00
Family Deductible (Annual)	$150.00	$150.00	$150.00	$150.00
Deductible Applies To	Type B & C	Type B & C	Type B & C	Type B & C
Waiting Period	No Waiting Period		No Waiting Period	
Calendar Year Maximum (Per covered individual)	$1,000.00	$1,000.00	$2,000.00	$2,000.00
Orthodontia Limit (children to age 19)	Not covered	Not covered	$1,250.00	$1,250.00
Child	To age 26		To age 26	

MONTHLY PREMIUM RATE SCHEDULE

Low Plan

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6
Member	$25.81	$27.92	$31.34	$33.45	$34.50	$36.61
Member + One	$53.53	$58.51	$69.33	$74.60	$76.32	$82.20
Member + Family	$90.40	$101.17	$110.63	$120.42	$128.91	$138.37

High Plan

	AREA 1	AREA 2	AREA 3	AREA 4	AREA 5	AREA 6
Member	$53.22	$59.31	$72.08	$77.37	$81.51	$87.90
Member + One	$108.96	$126.54	$145.38	$156.06	$166.42	$181.18
Member + Family	$167.09	$198.94	$226.13	$247.60	$262.63	$283.74

1. "In-Network Benefits" means benefits under this plan for covered dental services that are provided by a MetLife PDP Dentist "Out-of-Network Benefits" means benefits under this plan for covered dental services that are not provided by a Metlife PDP Dentist.
2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.
3. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - The Dentist's actual charge (The 'Actual Charge')
   - The Dentist's usual charge for the same or similar services (The 'Usual Charge') or
   - The usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan the Customary charge is based on the 70th percentile. Services must be necessary in terms of generally accepted dental standards.

AREA SCHEDULE

To determine the appropriate premium rates for the dental plan, look up the member's state of residence on this chart, and then look up the member's 3-digit zip code, if applicable. Use the Area number that applies to your state/zip to determine the premium rate from the Premium 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	6	995 - 999
Arizona	2	850-857
	3	859-865
Arkansas	2	716-729
California	2	923-925
	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
Colorado	3	800-816
Connecticut	4	060-069
Delaware	4	197, 199
	5	198
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
	3	600-608
Indiana	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	3	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	1	215
	2	206, 210-214, 216-219
	3	207-209
Massachusetts	3	010, 012-013
	4	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, 646-651, 653-659
	3	652

State	Area	First 3 Digits of Zip Code (if applicable)
Montana	3	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	3	870-875, 877-884
New York	2	104, 124-129, 133-136, 142
	3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	4	063, 105-108, 111-114, 116
	5	
	6	100-102
North Carolina	3	270-281, 283-289
	4	282
North Dakota	3	580-588
Ohio	2	430-435, 437-459
	3	436
Oklahoma	2	731, 735-749
	3	730, 734
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	3	028-029
South Carolina	3	290-299
South Dakota	2	570, 572-577
	3	571
Tennessee	2	370-385
Texas	1	782
	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	985-989, 993
	5	980-984
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831, 834

List of Covered Services and Limitations*

Type A – Preventive	How Many/How Often
Prophylaxis – Cleanings Oral Examination Topical Fluoride Applications Bitewing X-Rays (Adult/Child) Emergency Palliative Treatment – High Option Plan	• 1 cleaning in 6 consecutive months. • 1 oral exam in 6 consecutive months. • 1 fluoride treatment in 12 consecutive months for dependent child to age 26. • Adult/Child once per calendar year.
Type B – Basic Restorative	**How Many/How Often**
Full Mouth X-Rays Space Maintainers Sealants Periodontal Maintenance Fillings Emergency Palliative Treatment – Low Option Plan	• Full mouth panoramic x-rays: once per 60 months. • One space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 26. • One application of sealant material for each non-restored permanent 1st & 2nd molar tooth of a dependent child to age 16, once every 60 months. • Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 2 times in any year less the number of teeth cleanings received during such 12-month period. • Initial placement, replacement 24 months.
Type C – Major Restorative	**How Many/How Often**
Repair of Cast Restorations and Dentures Endodontics – Root Canal General Anesthesia Oral Surgery (Including Extractions) Periodontal Surgery Periodontal Scaling & Root Planing Dentures and Bridges Crowns/Inlays/Onlays Consultations Harmful Habits Appliance	 • Root Canal treatment is limited to once per tooth in a 24 month period. • When dentally necessary in connection with oral surgery, extractions or other covered dental Services. • Covered except as listed in the exclusions. • Once per quadrant every 36 months. • Once per quadrant in 24 month period. • Initial installation; Replacement once per 10 years. • Replacement 10 years. • 2 per 12 months.
Type D – Orthodontia	**How Many/How Often**
Available under the High Option Plan only	• Dependent children are covered up to age 26. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Initial payment due upon installation of the Orthodontic appliance; repetitive payments for the Orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum. • Orthodontic benefits end at cancellation of coverage

***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 scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) 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 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 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 Dental Automated Information Service.

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

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 or appliances which restore or alter occlusion or vertical dimension.
6. Restoration of tooth structure damaged by attrition, abrasion or erosion.
7. Restorations or appliances used for the purpose of periodontal splinting.
8. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
9. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
10. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
11. Missed appointments.
12. Services covered under any workers' compensation or occupational disease law; covered under any employer liability law; for which the employer of the person receiving such services is not required to pay; or received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
13. Services covered under other coverage provided by the Policyholder.
14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. Prescription drugs.
17. Services for which the submitted documentation indicates a poor prognosis.
18. 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.
19. 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.
20. Caries susceptibility tests.
21. 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.
22. Other fixed Denture prosthetic services not described elsewhere in this certificate.
23. Precision attachments, except when the precision attachment is related to implant prosthetics.
24. 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.
25. 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.
26. Addition of teeth to fixed and permanent Denture to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
28. Implants included, but not limited to any related surgery, placement, restorations, maintenance, and removal.
29. Repair of Implants.
30. Implants supported prosthetics to replace teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
32. Repair or replacement of an orthodontic device.[1]
33. Duplicate prosthetic devices or appliances.
34. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
35. Intra and extra oral photographic images.

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