

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	Out-of-Network
Type A (e.g., cleanings, oral examinations)	100% of Negotiated Fee*	100% of Negotiated Fee*
Type B (e.g., fillings)	80% of Negotiated Fee*	80% of Negotiated Fee*
Type C (e.g., bridges and dentures)	50% of Negotiated Fee*	50% of Negotiated Fee*
Type D Orthodontia	50% of Negotiated Fee*	50% of Negotiated Fee*
Deductible ±	In-Network	Out-of-Network
Individual (per calendar year)	\$25	\$25
Family (per calendar year)	\$75	\$75
Annual Maximum Benefit	In-Network	Out-of-Network
Per Person	\$3,000 (Annual Combined for In- or Out-of-Network)	
Orthodontia (for children up to age 19 only).	Lifetime 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 can take less than 5 minutes.

- Go to <http://startprotecting.com/4797> and enroll today.
- Coverage will take effect on the 1st of the month following receipt of your enrollment form and payment of initial premium.

Questions? Call 1-855-874-0264

*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.

¹Savings 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. ²Please 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.

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 dentist you want whether they are in the MetLife network or not²

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 – 1 set per calendar year for adults and dependent children under age 19
- 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 – once per quadrant in any 24 month period.
- 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 (Gold and Platinum Plans only)

- Periodontal surgery such as gingivectomy, gingivoplasty, and osseous surgery – once per quadrant in any 36 month period.
- 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 (Platinum Plan only)

- Orthodontia

Have any other questions? Please call 1-855-874-0264.

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

²Your out-of-pocket 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 You would not be required to pay in the absence of Dental Insurance.
- Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person.
- Services which are primarily cosmetic (for residents of Texas, see notice page section in your 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 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.
- 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.
- 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.
- Precision attachments, 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.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth).
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders and cone beam imaging. This exclusion does not apply to residents of Minnesota.
- Orthodontic services or appliances except under Platinum Plan (coverage only for children up to age 19).
- Repair or replacement of an orthodontic device.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
- Intra and extraoral photographic images.
- Type C Services are excluded for Silver Plan only.

Coverage may not be available in all states. Please contact USI Affinity at 1-855-874-0264 for additional details.

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 GPNP99-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.