Non-Unit Employee Health and Welfare Fund Dental Plan Benefits

Network: PDP Plus
Benefit Summary

Coverage Type	In-Network	Out-of-Network
Type A – cleanings, oral examinations	100% of Negotiated Fee*	100% of R&C Fee**
Type B – fillings	80% of Negotiated Fee*	80% of R&C Fee**
Type C –bridges and dentures	50% of Negotiated Fee*	50% of R&C Fee**
Type D – orthodontia	50% of Negotiated Fee*	50% of R&C Fee**
Deductible†	**In-Network**	**Out-of-Network**
Individual	$25.00	$25.00
Family	$75.00	$75.00
Annual Maximum Benefit	**In-Network**	**Out-of-Network**
Per Person	$1,500	$1,500
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**
Per Person	$1,500	$1,500

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

**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

† Applies only to Type B & C Services.

In-Network Savings* Example

This hypothetical example** 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
- R&C Fee***: $1,386.00
- Dentist's Usual Fee: $1,462.00

IN-NETWORK When you receive care from a participating dentist		**OUT-OF-NETWORK** 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	R&C Fee is:	$1,386.00
Your Plan Pays:		***Your Plan Pays:***	
50% X $670 Negotiated Fee:	- $335.00	50% X $1,386 R&C Fee:	- $693.00
Your Out-of-Pocket Cost:	$335.00	Your Out-of-Pocket Cost:	$769.00

In this example, you save $434.00 ($769.00 minus $335.00) by using a participating dentist.

*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.

**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. Fees in your area may be different.

***R&C Fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. The example shown reflects an 80th percentile R&C fee. The R&C percentile used to calculate out-of-network benefits for your plan may differ.

List of Primary Covered Services & Limitations

Type A - Preventive	**How Many/How Often**
Prophylaxis (cleanings)	• Once every six months.
Oral Examinations	• One exam every six months.
Topical Fluoride Applications	• One fluoride treatment per calendar year for dependent children up to 19th birthday.
X-rays	• Full mouth X-rays: one per 60 months. • Bitewing X-rays: one set per calendar year for adults; one set per 6 month period for dependent children.
Space Maintainers	• Space Maintainers for dependent children up to 19th birthday.
Sealants	• One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd permanent molar of a dependent child up to 16th birthday.
Type B - Basic Restorative	**How Many/How Often**
Fillings	
Simple Extractions	• Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
Crown, Denture, and Bridge Repair/Recementations	
Endodontics	• Root canal treatment limited to once per tooth per 24 months.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
Type C - Major Restorative	**How Many/How Often**
Implants	• Replacement: once every 7 years.
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 7 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/Onlays	• Replacement: once every 7 years.
Type D - Orthodontia	**How Many/How Often**
	• Your Children, up to age 26, 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.

The service categories and plan limitations shown above 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.

Common Questions… Important Answers

Who is a participating Preferred Dentist Program dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in full for covered 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 refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums.

How do I find a participating dentist? 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.

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

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife Preferred Dentist Program, your out-of-pocket expenses 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.

Can my dentist apply for participation in the network? Yes. If your current dentist does not participate in the Preferred Dentist Program and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 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.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

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

How can I learn about what dentists in my area charge for different procedures? 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 Verifpoint, an independent vendor. 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.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. ** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provisions 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.

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 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 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;
- 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 picks, toothbrushes, or dental floss;
- Missed appointments;
- 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 Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- 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
- 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;
- Initial installation 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;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- 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;
- 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.
- Duplicate prosthetic devices or appliances;

Other 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. 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. 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) 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.

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