

Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.



Enrollment Period: 7/1/2026 - 6/30/2027

Network: PDP Plus

Coverage Type	Plan option 1 Base		Plan option 2 Buy Up	
	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of Maximum Allowable Charge* % of R&C Fee**	In-Network ¹ % of Negotiated Fee ²	Out-of-Network ¹ % of Maximum Allowable Charge* % of R&C Fee**
Type A³: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B³: Basic Restorative (fillings, extractions)	80%	55%	90%	55%
Type C³: Major Restorative (bridges, dentures)	60%	35%	60%	35%
Type D: Orthodontia	60% (Adult) 75% (Child)	50% (Adult) 50% (Child)	60% (Adult) 75% (Child)	50% (Adult) 50% (Child)
Deductible^{† 3}				
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
Annual Maximum Benefit³				
Per Person	\$1,750	\$1,750	\$2,000	\$2,000
Orthodontia Lifetime Maximum				
Per Person	\$1,750 (Adult) \$2,000 (Child)	\$1,750 (Adult) \$2,000 (Child)	\$1,750 (Adult) \$2,500 (Child)	\$1,750 (Adult) \$2,500 (Child)

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

¹ "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
² Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
³ Your plan includes incentive provisions. Deductibles, plan maximums and/or co-insurance percentages may differ by plan member.
*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.
**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 charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
†Applies to Type A, B and C Services. Applies only to Type B & C Services.

List of Primary Covered Services & Limitations*

The service categories 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. [†]If Dentally Necessary, You and Your Dependents may be eligible for additional dental treatment if diagnosed with one or more specified medical conditions. Please see the Description of Covered Services section of this Certificate for additional details.

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Plan Type	Plan Option 1: Base How Many/How Often	Plan Option 2: Buy Up How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per benefit period	Two per benefit period
Oral Examinations	Two exams per benefit period	Two exams per benefit period
Topical Fluoride Applications	One fluoride treatment per benefit period for dependent children up to age 14	One fluoride treatment per benefit period for dependent children up to age 14
X-rays	<ul style="list-style-type: none"> • Full mouth X-rays; one per 5 years • Bitewings X-rays; two sets per benefit period 	<ul style="list-style-type: none"> • Full mouth X-rays; one per 5 years • Bitewings X-rays; two sets per benefit period
Periodontics	Maintenance and prophylaxis treatments limited to two per benefit plan year	Maintenance and prophylaxis treatments limited to two per benefit plan year
Space Maintainers	One per lifetime per area of the mouth for dependent children up to age 14	One per lifetime per area of the mouth for dependent children up to age 14
Type B — Basic Restorative		
Fillings	One in 24 months	One in 24 months
Simple Extractions		
Oral Surgery		
Endodontics	Root canal treatment once per tooth per 24 months	Root canal treatment once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	<ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant, every 2 years • Periodontal surgery once per site, every 3 years 	<ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant, every 2 years • Periodontal surgery once per site, every 3 years
Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations	One per benefit period	One per benefit period
Implants	Replacement once every 5 years	Replacement once every 5 years

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<p>Bridges and Dentures</p>	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the plan. Dentures and bridgework replacement; one every 5 calendar 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 	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the plan. Dentures and bridgework replacement; one every 5 calendar 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
<p>Crowns, Inlays and Onlays</p>	<p>Replacement once every 5 calendar years</p>	<p>Replacement once every 5 calendar years</p>
<p>Type D — Orthodontia</p>		
	<ul style="list-style-type: none"> You, your spouse and your children, up to age 18, 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 	<ul style="list-style-type: none"> You, your spouse and your children, up to age 18, 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.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that 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.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.



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Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.^{††} The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email 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.

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. 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.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. 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.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

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;
- 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;
- 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;
- 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 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;

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- 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;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Duplicate prosthetic devices or appliances; and
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture

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 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. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.

†Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

Savings from enrolling in a dental benefit plan featuring the MetLife Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit a dentist, and the cost of services rendered.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. 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. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US\$500,000. Treatment must be authorized and arranged by AXA Assistance's designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.