


Benefits

Overview

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Welcome!

Why is having a good Dental plan so important?

Maintaining good oral health matters. Studies show that those with dental coverage are more likely to visit the dentist¹. And of course staying on top of your care is the key to preventing costly problems that can add up. Plus, going to the dentist regularly can help prevent problems that have been linked to diabetes or heart disease². That's where a good dental plan comes in. The right coverage makes it easier to visit the dentist and helps lower your costs³. You get support to keep up with dental cleanings and other preventive care that helps you live healthier. Now that's something to smile about!

Freedom to go to any dentist.

MetLife's Preferred Dentist Program is a Dental PPO plan. So you can visit any licensed dentist, in or out of the network, and receive benefits.

If you prefer to go to a participating dentist, you can count on our large and constantly growing network. Plus, all participating dentists must meet rigorous selection standards⁴.

Find a participating dentist today at <https://www.metlife.com/dental>.

For better savings³, visit a participating general dentist or specialist. Visits are covered with any dentist you choose even if he or she is out of network but you'll get the most competitive prices with a participating provider. With MetLife Dental, you have a large network of providers available to you.

Dental Claim Inquiries and Phone Numbers

Customer Service Number	(800) 942-0854 (Hours 8:00 AM to 11:00 PM ET)
Customer Service Email	dentalinfo@metlifeservice.com (24-48 hour response time)
Out of Country Customer Service	(800) 962-1401
Claims Fax Number	(859) 389-6505 (Include ATTN: Claims)
PDP (Hearing Impaired)	(800) 638-4863

Managing your dental benefits is easy!

Once enrolled, MetLife's MyBenefits tool, www.mybenefits.metlife.com, is your secure self-service website available 24/7. You can use the site to get estimates on care or check coverage and claim status.

MetLife Mobile App⁵ - It's easy. Search "MetLife" at iTunes App Store or Google Play to download the app. Then use your MetLife MyBenefits log in information to access these features.

¹ 2013 US Survey of Dental Care Affordability and Accessibility; Empirica Research; July 2013.

² American Dental Association; Dentists: Doctors of Oral Health. Accessed April 2016, www.ada.org/en/about-the-ada/dentists-doctors-of-oral-health

³ Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the costs for services received. ⁴ Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's.

⁵ Certain features of the MetLife Mobile App are not available for all MetLife Dental Plans.

Why dental insurance makes sense

What does dental insurance protect?

Dental problems can be unpredictable and expensive. For example, did you know that a crown can cost up to \$1,462?¹

Dental insurance not only helps you pay for your dental care, it can help prevent problems.

When your preventive care is covered, you're more likely to go for cleanings and checkups — this can help you avoid problems before they become too costly or complicated.

More to smile about

- See whatever dentist you want. Even if your dentist isn't in the network, you can go to him or her — just remember you usually save more when you stay in network.²
- You have a wide choice of participating dentists. Plus, dentists in the network are carefully selected.³
- Take advantage of negotiated fees that are typically 30–45% less than average charges in the same area.⁴
- Your dentist usually handles claims — which means less paperwork for you.
- Find out what you'll pay ahead of time. Your dentist can request a pre-treatment estimate for any service that is more than \$300. This helps you manage your costs and care.⁵

Understanding your PPO plan is as easy as 1, 2, 3:

1. Understand the types of procedures

Different plans pay different percentages for these procedures.

And, while they may change depending on your plan, the definitions below usually describe the standard service types.

- Preventive Care — cleanings, X-rays and exams
- Basic Care — fillings and extractions
- Major Care — bridges, crowns and dentures

2. Know the percentages

- Look on your Plan Summary — next to each of these categories is a percentage. That's the percentage MetLife will pay for covered services, and you'll be responsible for the rest.

3. Look at out-of-pocket costs

- Next, check to see if the plan has an Annual Deductible — that's the amount you'll have to pay each year before your benefits kick in.
- Also, check the Annual Maximum Benefit — that's the most MetLife will pay in a year. There's also a difference between the Individual Maximum (for each family member) and the Family Annual Maximum (which applies to the total that is paid for everyone in your family).

Now that you know the benefits of having dental coverage, learn more and enroll today!

1. Based on MetLife data for a crown (D2740) in ZIP code 19151. This cost reflects the 80th percentile Reasonable and Customary (R&C) fee. R&C fees are calculated 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. This example is used for informational purposes only. Fees in your area may be different.
2. 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.
3. Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's. If you should have any questions, contact MetLife Customer Service.
4. Negotiated Fees refer 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. Negotiated fees are subject to change.
5. MetLife strongly recommends that you have your dentist submit a pretreatment estimate to MetLife if the cost is expected to exceed \$300. When your dentist suggests treatment, have him or her send a claim form, along with the proposed treatment plans and supporting documentation to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pretreatment estimate depending upon annual maximums, deductibles, plan frequency limits and other plan provisions at time of payment.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

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Understanding Your Dental Plan

MetLife dental plans featuring the Preferred Dentist Program are designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network.

The goal is to deliver affordable protection for a healthier smile and a healthier you. You also get great service and educational support to help you stay on top of your care.

Freedom of choice to go to any dentist.

You have the flexibility to visit any dentist — your dentist — and receive coverage under the plan. Just remember that non-participating dentists haven't agreed to accept negotiated fees¹. That means you usually save² more dental dollars when you go to a participating dentist.

If you prefer to stay in the network, there are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. Plus, all participating dentists go through a rigorous selection and review process.³ This way you don't need to worry about quality. You also don't need any referrals.

To check out the general dentists and specialists in the PDP Plus network, visit www.metlife.com/dental.

Additional savings when you visit participating dentists.

Your out-of-pocket costs are usually lower when you visit in-network dentists. That's because they have agreed to accept negotiated fees that are typically 30% to 45% less than average dental charges in the same community. This may help lower your final costs and stretch your plan maximum.

Service where and when you want it.

MyBenefits, your secure self-service website, is available 24/7.⁴ You can use the site to get estimates on care or check coverage and claim status. Plus, if you are on the go and need to find an in-network provider, view a claim or see your ID card, there's an app for that. Search "MetLife" at the iTunes App Store or Google Play to download the app.⁵

Educational tools and resources.

The right dental care is an essential part of good overall health. That's why you and your dentist get resources to help make informed decisions about your oral health. You'll find a range of topics on our online dental education website, www.oralfitnesslibrary.com. Read up on the link between dental and overall health, kids' dental health and more. You can also put your oral health to the test by taking an online risk assessment.

The information below explains certain terms to make it easier for you to understand and use your benefits.

1. Coverage Types. Dental procedures are grouped into the following categories: Preventive (Type A), Basic Restorative (Type B), Major Restorative (Type C), and Orthodontia (Type D). Your group's plan determines how each procedure is categorized (Type A, B, C, D). Generally, benefits for Type A procedures pay at the highest benefits level because they prevent and diagnose dental disease.

Network: XYZ Benefit Summary		
Coverage Type	In-Network	Out-of-Network
Type A – cleanings, oral examinations	XX% of Negotiated Fee	XX% of R&C Fee or XX% of Negotiated Fee
Type B – fillings	XX% of Negotiated Fee	XX% of R&C Fee or XX% of Negotiated Fee
Type C – bridges and dentures	XX% of Negotiated Fee	XX% of R&C Fee or XX% of Negotiated Fee
Type D – orthodontia	XX% of Negotiated Fee	XX% of R&C Fee or XX% of Negotiated Fee
Deductible	In-Network	Out-of-Network
Individual	\$XX,XX	\$XX,XX
Family	\$XXX,XX	\$XXX,XX
Annual Maximum Benefit	In-Network	Out-of-Network
Per Person	\$X,XXX	\$X,XXX
Orthodontia Lifetime Maximum	In-Network	Out-of-Network
Per Person	\$X,XXX	\$X,XXX

2. Co-insurance. The co-insurance percentage helps determine what your out-of-pocket costs will be for each coverage type. Each Type – A, B, C, and D – has a pre-set percentage that represents what your plan will reimburse for the services in each category. Your total out-of-pocket responsibility is subject to any deductibles, benefit maximums, plan provisions, if you receive out-of-network services, and your plan's basis for reimbursement. Please see your Dental Plan Benefits Summary for more information. Copay. This is the fixed amount that you have to pay for covered services. Copayment amounts are listed in the Procedure Charge Schedule that you received with your Dental Benefits Plan Summary. Your total out-of-pocket responsibility is subject to any deductibles, benefit maximums, plan provisions, if you receive out-of-network services, and your plan's basis for reimbursement. Please see your Dental Plan Benefits Summary and Procedure Charge Schedule for more information.
3. Deductible. This is the amount you must pay out-of-pocket before benefit payments will be made by the plan. For most plans, the deductible amounts for in-network services are less than the amount for out-of-network services. Many plans do not require that a deductible be met for Type A services.
4. Annual Maximum Benefit. This is the total amount the plan will pay in the plan year. Once this amount is reached, no further benefits will be paid.
5. Orthodontia Lifetime Maximum. Not all plans cover Orthodontia Treatment. If your plan covers Orthodontia there is a Lifetime Maximum that is applicable only to Orthodontia. This does not affect your Annual Maximum Benefit for Types A, B, and C coverage. The Lifetime Maximum is the total amount the plan will pay for orthodontic services for each covered person (subject to any plan age limitations). Once this amount is reached, no further benefits will be paid.

Putting it all together – maximizing the value of your dental benefits.

- Make the most of your benefits — visit a participating dentist to reduce your out-of-pocket costs.
- Keep a healthy dental regimen by getting routine exams and cleanings – the cost of preventive services (Type A) is usually less than the cost for fillings, root canals, extractions, etc. – and can help to prevent the need for these higher-cost treatments.
- It is recommended that you request a pre-treatment estimate for services that cost more than \$300. The estimate will give you an idea of what your out-of-pocket costs will be. To receive a benefit estimate, have your dentist submit a request online at www.metdental.com or by calling 1-877-MET- DDS9 (phone number and website for dental professionals only).
- Visit the dental education website at www.oralfitnesslibrary.com for important tools and resources to help you become more informed about dental care.

Remember, dental coverage can be an important part of protecting your health and finances. By using the educational tools and benefits made available to you through this plan, you'll be better prepared to protect your oral health and your budget.

1 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. Negotiated fees are subject to change. The R&C fee referenced in the table in the Out-of-Network column refers to the Reasonable and Customary 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.

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

3 Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's. If you should have any questions, contact MetLife Customer Service.

4 With the exception of scheduled or unscheduled systems maintenance or interruptions, the MyBenefits website is typically available 24 hours a day, 7 days a week.

5 To use the MetLife mobile app, employees can choose to register at metlife.com/mybenefits from a computer or directly through the app. Certain features of MetLife US Mobile App are not available for some MetLife Dental Plans.

Like most group benefits 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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Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Network: PDP Plus

Coverage Type	Plan option 1 Gold Plan		Plan option 2 Silver Plan	
	In-Network % of Negotiated Fee*	Out-of-Network % of Scheduled Amount*** of R&C Fee***	In-Network % of Negotiated Fee*	Out-of-Network % of Scheduled Amount*** of R&C Fee***
Type A: Preventive (cleanings, exams, X-rays)	100%	90%	100%	90%
Type B: Basic Restorative (fillings, extractions)	80%	40%	60%	40%
Type C: Major Restorative (bridges, dentures)	50%	40%	30%	25%
Type D: Orthodontia	50%	40%	NA	NA
Deductible †				
Individual	\$50	\$50	\$75	\$75
Family	\$150	\$150	\$225	\$225
Annual Maximum Benefit				
Per Person	\$1,300	\$1,000	\$1,000	\$500
Orthodontia Lifetime Maximum				
Per Person	\$1,000	\$1,000	NA	NA

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

*Negotiated Fee refers 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 benefits maximums. Negotiated fees are subject to change.

**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.

Plan Type	Plan Option 1: Gold Plan How Many/How Often	Plan Option 2: Silver Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year



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Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to his/her 19th birthday	One fluoride treatment per calendar year for dependent children up to his/her 19th birthday
Brush Biopsies	No more than once in any 24 month period	No more than once in any 24 month period
X-rays (Bitewings)	Bitewing X-rays; one set per calendar year	Bitewing X-rays; one set per calendar year
Space Maintainers	Space maintainers for dependent children up to his/her 14th birthday	Space maintainers for dependent children up to his/her 14th birthday
Type B — Basic Restorative		
Fillings	Unlimited, but subject to the Annual Maximum	Unlimited, but subject to the Annual Maximum
Simple Extractions	Unlimited, but subject to the Annual Maximum	Unlimited, but subject to the Annual Maximum
Crown, Denture and Bridge Repair/ Recementations	Unlimited, but subject to the Annual Maximum	Unlimited, but subject to the Annual Maximum
X-Rays (Full Mouth)	Full Mouth X-Rays limited to one per 60 month.	Full Mouth X-Rays limited to one per 60 months.
Periodontics	<ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant, every 24 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year (4 perio maintenance and 0 cleaning, or 3 perio maintenance and 1 cleaning, or 2 perio maintenance and 2 cleanings, or 1 perio maintenance and 3 cleanings) 	<ul style="list-style-type: none"> • Periodontal scaling and root planing once per quadrant, every 24 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year (4 perio maintenance and 0 cleaning, or 3 perio maintenance and 1 cleaning, or 2 perio maintenance and 2 cleanings, or 1 perio maintenance and 3 cleanings)
Sealants	One application of sealant material once per tooth per lifetime of a dependent child up to his/her 19th birthday	One application of sealant material once per tooth per lifetime of a dependent child up to his/her 19th birthday
Type C — Major Restorative		
Implants	Replacement once per tooth every 10 years	Replacement once per tooth every 10 years
Bridges and Dentures	<ul style="list-style-type: none"> • Dentures limited to once per tooth per 10 years for persons 13 years of age and older • Bridges limited to once per tooth per 10 years for persons 16 years of age and older 	<ul style="list-style-type: none"> • Dentures limited to once per tooth per 10 years for persons 13 years of age and older • Bridges limited to once per tooth per 10 years for persons 16 years of age and older
Crowns, Inlays and Onlays	Limited to once per tooth per 10 years for persons 13 years of age and older	Limited to once per tooth per 10 years for persons 13 years of age and older
Endodontics	Root canal treatment limited to once per tooth per 24 months	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	When dentally necessary in connection with oral surgery, extractions or other covered dental services

Dental Insurance

Periodontics	Periodontal surgery once per quadrant, every 36 months	Periodontal surgery once per quadrant, every 36 months
Oral Surgery (Surgical Extractions)	Unlimited, but subject to the Annual Maximum	Unlimited, but subject to the Annual Maximum
Type D — Orthodontia		
	<ul style="list-style-type: none"> 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 quarterly basis Orthodontic benefits end at cancellation of coverage 	<ul style="list-style-type: none"> NA

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.

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;
- 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, toothes, 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;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;

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- 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;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- 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), including but not limited to occlusal guards and night guards;
- 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

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. 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. 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 / G.2130-S) issued by Metropolitan Life Insurance Company (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. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.

Dental Insurance

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 certificate of insurance/summary plan description sets forth the covered services under the plan. Please review the enclosed plan benefits to learn more.

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.

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.

[†]Based on internal analysis by MetLife. Negotiated fees refer 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. Negotiated fees are subject to change.

^{††}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.

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

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. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.

Metlife