The MetLife Federal Dental Plan

http://www.federaldental.metlife.com

2008

A Nationwide Dental PPO Plan

Who may enroll in this Plan: All Federal employees and annuitants in the United States and overseas who are eligible to enroll in Federal Employees Dental and Vision Insurance Program.

Enrollment Options for this Plan:

• **High Option – Self Only**	• **Standard Option – Self Only**
• **High Option – Self Plus One**	• **Standard Option – Self Plus One**
• **High Option – Self and Family**	• **Standard Option – Self and Family**

This Plan has 6 enrollment regions, including international; please see the end of this brochure to determine your region and corresponding rates

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FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The Act directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants.

This brochure describes the benefits of The MetLife Federal Dental Plan under Metropolitan Life Insurance Company (MetLife) contract OPM-06-00060-6 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

MetLife

501 US Highway 22

Bridgewater, NJ 08807

888) 865-6854 TDD (888) 260-5376

www.federaldental.metlife.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits.

OPM negotiates rates with each carrier annually. Rates are shown at the end of this brochure.

The MetLife Federal Dental Insurance Plan is responsible for the selection of In-Network providers in your area. Contact us at (888) 865-6854 TDD (888) 260-5376 for the names of participating providers or to request a provider directory. You may also view current In-Network providers via our web site at www.federaldental.metlife.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should make coverage decisions based on the plan benefits, not based on a specific provider. When you phone for an appointment, please remember to verify that the provider is currently in the MetLife PDP network. If your provider is not currently participating in the provider network, you can ask him or her to join. Or ask your dentist to visit www.metdental.com or call (877) MET-DDS9. Note this website and phone number are specifically for dentists and not accessible to employees/annuitants.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

This MetLife Federal Dental Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

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How We Have Changed For 2008

Effective 1/1/08 MetLife will follow the traditional Coordination of Benefits (COB). This means that for dates of service on or after 1/1/08, MetLife will pay the difference between what the primary carrier pays and the allowable fee.

For specific details regarding COB please refer to the "Section 3 How You Obtain Care" in this brochure and/or contact MetLife at 1-888-865-6854/ TDD 1-888-260-5376.

Effective 1/1/08 MetLife will no longer require your Social Security Number to submit your claim for payment, access our website or provide customer service through our Call Center. MetLife will issue you a MetLife ID number that will be printed on your ID card. However, it is not necessary to provide this number to your dentist to receive services or for you to obtain information from MetLife' Call Center, your name, address and group number - 120731 will suffice.

The following covered services are clarified as follows in the MetLife Federal Dental Plan:

D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – age 15 - 22 Limited to 2 every 12 months
D1206 Topical fluoride varnish - Limited to 1 in 12 months for persons over age 22 and for persons less than age 22 limited to 2 in 12 months

Remember all exams, oral evaluations and treatments such as fluorides are combined under the one limitation under the plan. **For example,** if you have a periodic oral evaluation and a limited oral examination both services are combined, so that, not more than the maximum allowable expense and limitation are paid under the plan.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several national plans and in some areas regional, dental Preferred Provider Organizations (PPO), and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Visit www.opm.gov/insure/dentalvision for more information.
Enroll Through BENEFEDS	You enroll through the Internet at www.BENEFEDS.com. See Section 2 Enrollment for more information.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2007 Open Season, your coverage will begin on January 1, 2008. Premium deductions will start with the first full pay period beginning on/after January 1, 2008. You can use your benefits as soon as your coverage becomes effective.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental enrollment. This year the Open Season runs from November 12, 2007 through December 10, 2007. You do not need to re-enroll each Open Season unless you wish to change plans or plan options. Your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2 Enrollment for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may be able to continue enrollment after your death. Please see Section 1 Eligibility for more information.
Waiting Period	The only waiting period is for orthodontic services. To meet this requirement, the dependent receiving the services must be enrolled in the same plan/option for the entire waiting period.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP if you are eligible for the Federal Employees Health Benefits (FEHB) Program. Enrollment in the FEHB Program is not required.

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government

You may continue your FEDVIP enrollment into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for the 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You can enroll in FEDVIP again when you begin to receive your annuity.

Survivor Annuitants

If you are a survivor of a deceased Federal/ U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

Family Members

Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

FEDVIP rules and FEHB rules for family member eligibility are the same. For more information on family member eligibility, see the FEHB Handbook at www.opm.gov/insure/handbook or contact your employing agency or retirement system.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants;
- Former spouses of employees or annuitants;
- FEHB temporary continuation of coverage (TCC) enrollees; or
- Anyone receiving an insurable interest annuity who is not also an eligible family member.

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not wish to change plans or options your enrollment will continue automatically. **Please note:** your plan(s) premiums may change for 2008.

Note: You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Note: A Self Plus One enrollment option does not exist under the FEHB Program.

Self and Family: A Self and Family enrollment covers you as the employed enrollee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Opportunities to Enroll or Change Enrollment

OpenSeason

If you are an eligible employee or an eligible annuitant, you can enroll in a dental plan during the November 12 through December 10, 2007 Open Season. Coverage is effective January 1, 2008.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these open season enrollments and changes will be set by OPM. If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.

New hire / Newly eligible

You can enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a new survivor annuitant if not already covered under FEDVIP;
- an employee returning to service following a break in service of at least 31 days.

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an open season.

The following chart lists the QLEs and the enrollment actions you may take.

Qualifying Life Event	From Not Enrolled to Enrolled	INCREASE Enrollment Type	DECREASE Enrollment Type	Cancel	CHANGE from one plan to another
Acquiring an eligible family member	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty no-pay status	No	No	No	Yes	No
Return to pay status from active military duty	Yes	No	No	No	No
Annuity/compensation restored	Yes	Yes	Yes	No	No

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area and
- You cannot request a new enrollment based on a QLE before the QLE occurs. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Canceling an enrollment

You can cancel your enrollment only during the annual open season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date. You should contact BENEFEDS at www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 during the annual Open Season to terminate your enrollment.

When Coverage Stops

Coverage ends when you:

- no longer meet the definition of an eligible employee or annuitant;
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments; or
- cancel the enrollment during open season.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Note: Coverage ends for a covered individual when MetLife does not receive premium for that covered individual

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

However, we will pay benefits for a 31 day period after your insurance ends if before coverage ends the dentist:

- prepared the abutment teeth for the completion of installation of prosthetic devices;
- made an impression;
- prepared the tooth for cast restoration; or
- your dentist opened the pulp chamber before your insurance ends; and the device is installed or treatment was finished within 31 days after the termination date of coverage.

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

Current FSAFEDS participants must re-enroll to participate in 2008. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-800-952-0450.

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans. You will be required to submit your claim on behalf of the MetLife Federal Dental Plan to the FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Heath Care Flexible Spending Account (LEX HCFSA).

Section 3 How You Obtain Care

Identification Cards / Enrollment confirmation

When you enroll you will receive a paper confirmation letter along with an identification card ("ID Card"). If you were enrolled in the MetLife Federal Dental Plan in 2007 and continue coverage for 2008, MetLife will provide you with a new confirmation letter and a new ID card. If you require a replacement ID card you will be able to download and print your ID card by going to http://www.federaldental.metLife.com. The ID card is neither a guarantee of benefits nor does your provider need it to render dental services. Your dentist may call 1 (877) 638-3379 to confirm your enrollment in the Plan and the benefits available to you.

Where You Get Covered Care

You can obtain care from any licensed dentist in the United States or overseas.

- **Plan Providers**

We list our Plan Providers on our website at http://www.federaldental.metlife.com. Which we update weekly. When you make your appointment please advise the dentist office that you are enrolled in the FEDVIP plan and wish to use your In-Network benefits. This will also serve to confirm that the dentist is a MetLife provider. You may also contact customer service at 1 (888) 865-6854.

- **In-Network**

An employee is not required to select a primary care dentist. Employees are free to select the dentist of their choice. Plan benefits are available, subject to Plan provisions, whether the dentist participates in our network or not. If you use a MetLife network provider, you are responsible only for covered charges up to our negotiated Plan Allowance per procedure. MetLife's network consists of independently credentialed and contracted providers. To find a dentist in your area to go to: http://www.federaldental.metlife.com. You may also contact customer service at 1 (888) 865-6854

- **Out-of-Network**

All plan designs allow for Out-of-Network benefits for the patient. Allowable charges will be based on the 80th percentile of our Usual and Customary charges.

Emergency Services

All expenses for Emergency Services are payable as any other expense. If you utilize the services of an Out-of-Network dentist for Emergency Services, benefits will be paid under the Out-of-Network plan provisions. You are responsible for the difference between the Plan payment and billed charges.

Plan Allowance

The Plan Allowance is the amount we allow for a specific procedure. When you use a Participating provider, your out of pocket is limited to the difference between the Plan Allowance and our payment. When you use an Out-of-Network provider, you are responsible for the difference between the Plan Allowance and our payment plus the difference between the amount the provider bills and the Plan Allowance.

Pre-certification

Pre-determination (Pre-certification) of benefits procedure is recommended for any procedure which is anticipated to cost at least $300 or which involves mandatory consultant review. Mandatory consultant review applies to such services as but not limited to, periodontal services, crowns, bridges, inlays/onlays (when performed together) veneers, implants (when a plan provides benefits for these procedures) and overdentures, among other services.

Alternate benefits applicable to your treatment plan may be determined during the Pre-certification. However, should the services billed differ from those pre-certified, MetLife reserves the right to determine if any Alternate Benefit is applicable to the actual services rendered.

Alternate Benefit

If MetLife determines that a less costly covered service other than the covered service the dentist performed could have been performed to treat a dental condition, we will pay benefits based upon the less costly service if such service would produce a professionally acceptable result under generally accepted dental standards.

For example, when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, or when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch we may base our benefit determination upon the amalgam filling or partial denture which is the less costly service.

If we pay benefits based upon a less costly service in accordance with this section the Dentist may charge you or your dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network dentist.

Dental Review

MetLife's claim review is conducted by licensed Dentist Consultants who review the clinical documentation submitted by your treating dentist. These Dentist Consultants review this material checking for dental necessity for certain procedures such as crowns, bridges, onlays, implants, periodontal treatments, as well as other services. The Dentist Consultants may also recommend that an alternate benefit be applied to a service in accordance with the terms of the Plan therefore it is very important that these types of dental services are pre-determined for benefits so that you and your dentist are aware of the coverage terms and benefits before services are performed.

Coordination of Benefits (COB)

If you have dental coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. We are responsible for coordinating benefits with the primary payor.

We will also coordinate benefit payments with the payment of benefits under other group health benefits coverage you may have and the payment of dental costs under no-fault insurance that pays benefits without regard to fault.

Effective for dates of services on or after January 1, 2008, MetLife will use the traditional definition of Coordination of Benefits. We may request that you verify/identify your health insurance plan(s) annually or at time of service

If you are covered under an FEHB plan, your MetLife Federal Dental benefits will be coordinated using the COB provision. Regardless of whether you or your dentist have submitted your claim to the FEHB carrier MetLife will estimate benefits based on the FEHB plan code provided by BENEFEDS to MetLife unless the primary carrier' COB statement is submitted with your claim submission.

For more information about Coordination of Benefits, go to www.federaldental.metlife.com.

Examples: Coordination of Benefits with High-Option coverage where services are provided by an In-Network provider.

Where the covered individual has FEHB coverage that offers dental benefits, MetLife is always secondary to the FEHB carrier*	**Services are provided by In-Network Provider**
Provider submitted charge for a one surface amalgam filing*	$108.00
In-Network fee**	$60.00
FEHB Paid as primary carrier (or MetLife' estimate of FEHB carrier's payment)	$16.00
Regular Benefits payable in the absences of other insurance.	$42.00 ($60.00 at 70%)
Payment by MetLife	$42.00
Patient's responsibility to the provider.**	$2.00
Where MetLife is secondary to a non-FEHB dental carrier. *	**Services are provided by In-Network Provider**
Provider submitted charge for two surface amalgam filling.	$121.00
In-Network Fee.	$73.00
Payable by Primary Carrier.	$60.50
Regular benefit payable in the absence of other insurance.	$51.10 ($73.00 at 70%)
Payment by MetLife.	$12.50 ($73.00 - $60.50)
Patient's responsibility to the provider.**	$0

* This example assumes all deductibles have been met and annual maximums have not been reached.

** Assumes the provider has no other contractual relationship regarding negotiated fees with the primary carrier.

Example: Coordination of Benefits with High-Option coverage where services are provided by an In-Network provider.

Where the covered individual has FEHB coverage that offers dental benefits, MetLife is always secondary to the FEHB carrier.*	**Services are provided by an Out-of-Network Provider**
Provider submitted charge for one surface amalgam Filling.	$108.00
In-Network fee.	N/A
FEHB carrier's payment (or MetLife's estimate of FEHB carrier's payment).	$16.00
Regular Benefit payable in the absence of other insurance.	$64.80 ($108 x 60%)
Payment by MetLife**	$64.80
Patient's responsibility to provider**	$27.20
Where MetLife is secondary to a non-FEHB dental carrier.*	**Services are provided by an Out-of-Network Provider**
Provider submitted charge for two surface amalgam filings.	$121.00
In-Network Fee.	N/A
Payment of Primary Carrier.	$96.80
Regular benefit payable in the absence of other insurance.	$72.60 ($121.00-$96.80)
Payable by MetLife	$24.20 ($121.00-$96.80)
Patient's responsibility to the provider. **	$0
*This example assumes all deductibles have been met and annual maximums have not been reached. ** Assumes the provider are within the Usual and Customary guidelines.	

Right of Recovery

If the amount we pay is more than we should have paid under this coordination of benefits provision. we may recover the excess from one or more of:

- the person we have paid or for whom we have paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

Rating Areas

Your rates are determined based on where you live or file your taxes. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates might change because of the move. Your rates will not be impacted if you temporarily reside in another location.

Limited Access Areas

If you live in an limited access area and you receive covered services from an Out-of-Network provider, we will pay benefits based on our In-Network Plan Allowances.

The determination of network adequacy is base on a ration of Federal eligible to network and **general** dentistry providers in a particular area. This rule is not applicable to **specialists** in an area. To determine if you are in a limited access area, or if the services of a Specialist are needed, please contact MetLife 1 (888) 865-6854 TDD 1 (888) 260-5376. MetLife reviews provider access on a quarterly basis to ensure you have reasonable access to an In-Network provider in your area.

Claim Determination Period

A period that starts on any January 1 and ends on the next December 31. A claim determination period for any covered person will not include the periods of time during which that person is not covered under this Plan.

Section 4 Your Cost for Covered Services

Deductible

A deductible is a fixed amount of expenses you must incur for certain covered services and supplies before we will pay for covered services. There is no family deductible limit. Covered charges credited to the deductible are also counted to the Plan maximums and limitations.

	In-Network High Option	In-Network Standard Option	Out-of-Network High Option	Out-of-Network Standard Option
Class A	$0	$0	$50	$100
Class B	$0	$0	$50	$100
Class C	$0	$0	$50	$100
Orthodontics	$0	$0	$0	$0

Coinsurance

Coinsurance is the percentage of our Plan Allowance that you must pay for your care. Coinsurance does not begin until you meet your deductible, if applicable.

	In-Network High Option	In-Network Standard Option	Out-of-Network High Option	Out-of-Network Standard Option
Class A	0%	0%	10%	40%
Class B	30%	45%	40%	60%
Class C	50%	65%	60%	80%
Orthodontics	50%	50%	50%	50%

Annual Benefit Maximum

Once you reach this amount, you are responsible for all additional charges. The Annual Benefit Maximums within each option are combined between in and out of network services. The total Annual Benefit Maximum will never be greater than the In-Network Maximum Annual Benefit Maximum.

	In-Network High Option	In-Network Standard Option	Out-of -Network High Option	Out-of-Network Standard Option
Annual Benefit Maximum	$3,000	$1,200	$3,000	$600

Lifetime Benefit Maximum

The Lifetime Benefit Maximum for Orthodontic benefits is $3,000 in the High Option whether or not an In-Network Provider delivers the services. The Lifetime Benefit Maximum for the Standard Option is $1,500 for In-Network benefits and $1,000 for Out-of-Network. There are no other Lifetime Benefit Maximums under this Plan.

In-Network Services

There is no requirement to use a participating provider. However, In-Network plan benefits will be paid if you use the services of a participating provider, resulting in a lower out of pocket expense to you in most cases. No referral process is needed for access to specialty care.

If you reside in an area that does not have a participating dentist based on criteria established by OPM your benefits will be paid at the In-Network benefit level.

If your participating (PDP) dentist decides to terminate his or her relationship with MetLife all treatments that began prior to the termination will be payable as in network benefits. All new treatment or treatment plans that do not start prior to the termination are payable are an Out-of-Network expense. Remember you only pay the difference between the Plan Allowance and the plan payment for In-Network services.

Out-of-Network Services

All services rendered by an Out-of-Network dentist will be paid Out–of-Network benefits. All benefits are payable based on the 80th percentile of MetLife's Usual and Customary charges for a dentist in your area.

Calendar Year

The calendar year refers to the Plan year, which is defined as January 1, 2008 to December 31, 2008.

Section 5 Dental Services and Supplies
Class A Basic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet Generally Accepted Dental Protocols.
- The calendar year deductible is $0, if you use an in network provider. There is no family deductible. If you elect to use an Out-of-Network provider, the Standard Option contains a $100 deductible per person, and the High Option has a $50 deductible per person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible. The calendar year deductible applies to Type A expenses provided by an Out-of-Network provider.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $3,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- All Exams, oral evaluations and treatments such as fluorides are combined under one limitation under the plan. **For example,** if you have a periodic oral evaluation and a limited oral examination both services are combined, so that, not more than the maximum allowable expense and limitation are paid under the Plan.
- All services requiring more than one visit are payable based on the completion date of the treatment.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network: Preventive and Diagnostic services – $0 (PDP Fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: Preventive and Diagnostic services - 10% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums.**

Standard Option

- **In-Network: Preventive and Diagnostic Services - $0 (PDP Fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: 40% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums**

Diagnostic and Treatment Services

ADA Codes	Covered Services	Limitations
D0120	Periodic oral evaluation	1 every 6 months
D0140	Limited oral evaluation - problem focused	1 every 6 months
D0150	Comprehensive oral evaluation	1 every 6 months

Diagnostic and Treatment Services – continued on next page

Diagnostic and Treatment Services (continued)		
Additional Procedures covered as Basic Services		
ADA Codes	**Covered Services**	**Limitations**
D0180	Comprehensive periodontal evaluation	1 every 6 months
D0210	Intraoral – complete series (including bitewings)	1 every 60 (sixty) months
D0220	Intraoral periapical first film	
D0230	Intraoral - periapical - each additional film	
D0240	Intraoral occlusal film	
D0270	Bitewing - single film	Adult - 1 set every calendar year Children - 1 set every 6 months
D0272	Bitewings - two films	Adult – 1 set every calendar year Children – 1 set every 6 months
D0274	Bitewings - four films	Adult - 1 set every calendar year Children – 1 set every 6 months
D0277	Vertical bitewings – 7 to 8 films	Adults - 1 set every calendar year Children - 1 set every 6 months
D0330	Panoramic film	1 film every 60 (sixty) months
Preventive Services		
D1110	Prophylaxis	Adult - 1 every 6 months
D1120	Prophylaxis	Child - 1 every 6 months
D1203	Topical application of fluoride (excluding prophylaxis)	Child - 2 every 12 months
D1204	Topical application of fluoride (excluding prophylaxis)	Age 15- 22 - 2 every 12 months
D1206	Topical fluoride varnish	Over age 22 - 1 in 12 months Less than age 22 - 2 in 12 months
D1351	Sealant - per tooth unrestored permanent molars	Up to age 18 - 1 sealant per tooth every 36
D1510	Space maintainer – fixed – unilateral	Children under age 19
D1515	Space maintainer – fixed – bilateral	Children under age 19
D1520	Space maintainer - removable – unilateral	Children under age 19
D1525	Space maintainer - removable – bilateral	Children under age 19
D1550	Re-cementation of space maintainer	Children under age 19
Additional Procedures covered as Basic Services		
D9110	Palliative treatment of dental pain minor procedure	

Services Not Covered: ***Please refer to Section 7 for a list of the General Exclusions)***		
ADA Code	**Description of Service**	
D0320	TMJ arthrogram	
D0321	Other TMJ films	
D0322	Tomographic survey	
D0360	Cone Beam CT	
D0362	Cone Beam multiple images 2 dim.	
D0363	Cone Beam multiple images 3 dim.	
D0416	Viral culture	
D0425	Caries test	
D0431	Adjunctive pre-diagnostic test	
D0475	Declassification procedure	
D0476	Special stains for microorganisms	
D0477	Special stains not for microorganisms	
D0478	Immunohistochemical stains	
D0479	Tissue in-situ-hybridization	
D0481	Electron microscopy	
D0482	Direct immunofluorescence	
D0483	In-direct immunofluorescence	
D0484	Consultation on slides prepared elsewhere	
D0485	Consultation including preparation of slides	
D0486	Brush biopsy sample	
D1310	Nutritional counseling	
D1320	Tobacco counseling	
D1330	Oral Hygiene Instruction	
D1555	Removal of fixed space maintainer	

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the minor restorative care or treatment of a covered condition and meet Generally Accepted Dental Protocols.
- The calendar year deductible is $0, if you use an In-Network provider. Should you elect to use an out-of -network provider, the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy their own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $3,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network: $0 deductible and then you pay 30% of the network allowance (PDP fee) for covered services as defined by the Plan, subject to Plan deductibles and maximum.**
- **Out-of-Network: $50 deductible and then you pay 40% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximum.**

Standard Option

- **In-Network: $0 deductible and then you pay 45% of the network allowance (PDP fee) for covered services as defined by the Plan, subject to Plan deductibles and maximum.**
- **Out-of-Network: $100 deductible and then you pay 60% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximum.**

Minor Restorative Services

ADA Codes	Covered Services	Limitations
D2140	Amalgam one surface, primary or permanent	
D2150	Amalgam two surfaces, primary or permanent	
D2160	Amalgam three surfaces, primary or permanent	
D2161	Amalgam four or more surfaces, primary or permanent	
D2330	Resin–based composite - one surface, anterior	
D2331	Resin-based composite - two surfaces, anterior	

Minor Restorative Services – continued on next page

Minor Restorative Services (continued)

Additional Procedures covered as Minor Covered Services

ADA Codes	Covered Services	Limitations
D2332	Resin-based composite - three surfaces, anterior	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
D2910	Re-cement inlay	
D2920	Re-cement crown	
D2930	Prefabricated stainless steel crown - primary tooth	1 per tooth in 60 months
D2931	Prefabricated stainless steel crown - permanent tooth	1 per tooth in 60 months
D2951	Pin retention - per tooth, in addition to restoration	

Endodontic Services

ADA Codes	Covered Services	Limitations
D3220	Therapeutic pulpotomy (excluding final restoration)	If a root canal is performed within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and are limited to once per tooth per lifetime.
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment.	Primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and are limited to once per tooth per lifetime.

Periodontal Services

ADA Codes	Covered Services	Limitations
D4341	Periodontal scaling and root planning-four or more teeth per quadrant	1 every 24 months
D4342	Periodontal scaling and root planning-one to three teeth, per quadrant	1 every 24 months
D4910	Periodontal maintenance	4 in 12 months combined with the prophylaxis after the completion of active periodontal therapy.

Prosthodontic Services		
ADA Codes	**Covered Services**	**Limitations**
D5410	Adjust complete denture - maxillary	
D5411	Adjust complete denture - mandibular	
D5421	Adjust partial denture – maxillary	
D5422	Adjust partial denture - mandibular	
D5510	Repair broken complete denture base	
D5520	Replace missing or broken teeth - complete denture (each tooth)	
D5610	Repair resin denture base	
D5620	Repair cast framework	
D5630	Repair or replace broken clasp	
D5640	Replace broken teeth - per tooth	
D5650	Add tooth to existing partial denture	
D5660	Add clasp to existing partial denture	
D5710	Rebase complete maxillary denture -	1 in a 36-month period 6 months after the initial installation
D5720	Rebase maxillary partial denture	1 in a 36-month period 6 months after the initial installation
D5721	Rebase mandibular partial denture	1 in a 36-month period 6 months after the initial installation
D5730	Reline complete maxillary denture (chairside)	1 in a 36-month period 6 months after the initial installation
D5731	Reline complete mandibular denture (chairside)	1 in a 36-month period 6 months after the initial installation
D5740	Reline maxillary partial denture (chairside)	1 in a 36-month period 6 months after the initial installation
D5741	Reline mandibular partial denture (chairside)	1 in a 36-month period 6 months after the initial installation
D5750	Reline complete maxillary denture (laboratory)	1 in a 36-month period 6 months after the initial installation
D5751	Reline complete mandibular denture (laboratory)	1 in a 36-month period 6 months after the initial installation
D5760	Reline maxillary partial denture (laboratory)	1 in a 36-month period 6 months after the initial installation
D5761	Reline mandibular partial denture (laboratory) Rebase/Reline	1 in a 36-month period 6 months after the initial installation
D5850	Tissue conditioning (maxillary)	
D5851	Tissue conditioning (mandibular)	
D6930	Recement fixed partial denture	
D6980	Fixed partial denture repair, by report	

Oral Surgery

ADA Codes	Covered Services	Limitations
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth – partially bony	
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony with unusual surgical complications	

D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
D7310	Alveoloplasty in conjunction with extractions	per quadrant
D7311	Alveoloplasty in conjunction with extractions-	one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions	per quadrant
D7321	Alveoloplasty not in conjunction with extractions	one to three teeth or tooth spaces, per quadrant
D7471	Removal of exostosis	
D7510	Incision and drainage of abscess - intraoral soft tissue	
D7910	Suture of recent small wounds up to 5 cm	
D7971	Excision of pericoronal gingiva	
Services Not Covered: **(Please refer to Section 7 for a list of General Exclusions)**		
ADA Code	Description of service	
D7292	Surgical replacement screw retained	
D7293	Surgical replacement with surgical flap	
D7294	Surgical replacement without the surgical flap	
D7880	TMJ Appliance	
D7899	TMJ Therapy	
D7997	Appliance Removal	
D7998	Intraoral placement of a fixation device	

Class C Major

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the major restorative care or treatment of a covered condition and meet Generally Accepted Dental Protocols.
- The calendar year deductible is $0 if you use an In-Network provider. Should you elect to use an out-of-network provider the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $3,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- All services requiring more than one visit are payable based on the completion date of the treatment.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network: $0 deductible and then you pay 50% of the Network Allowance (PDP fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: $50 deductible and then you pay 60% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums.**

Standard Option

- **In-Network: $0 deductible and then you pay 65% of the Network Allowance (PDP fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: $100 deductible and then you pay 80% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums.**

Major Restorative Services

ADA Codes	Covered Services	Limitations
D0160	Detailed and extensive oral evaluation - problem focused, by report	
D2510	Inlay - metallic – one surface	An alternate benefit will be provided
D2520	Inlay - metallic – two surfaces	An alternate benefit will be provided
D2530	Inlay - metallic – three surfaces	An alternate benefit will be provided
D2542	Onlay - metallic - two surfaces	1 per tooth every 60 months
D2543	Onlay - metallic - three surfaces	1 per tooth every 60 months
D2544	Onlay - metallic - four or more surfaces	1 per tooth every 60 months
D2740	Crown - porcelain/ceramic substrate	1 per tooth every 60 months

Major Restorative Services continued on next page

Major Restorative Services (continued)

ADA Codes	Covered Services	Limitations
D2750	Crown - porcelain fused to high noble metal	1 per tooth every 60 months
D2751	Crown - porcelain fused to predominately base metal	1 per tooth every 60 months
D2752	Crown - porcelain fused to noble metal	1 per tooth every 60 months

D2780	Crown - 3/4 cast high noble metal	1 per tooth every 60 months
D2781	Crown - 3/4 cast predominately base metal	1 per tooth every 60 months
D2783	Crown - 3/4 porcelain/ceramic	1 per tooth every 60 months
D2790	Crown - full cast high noble metal	1 per tooth every 60 months
D2791	Crown - full cast predominately base metal	1 per tooth every 60 months
D2792	Crown - full cast noble metal	1 per tooth every 60 months
D2794	Crown – titanium	1 per tooth every 60 months
D2950	Core buildup, including any pins	1 per tooth every 60 months
D2954	Prefabricated post and core, in addition to crown	1 per tooth every 60 months
D2980	Crown repair, by report	

Endodontic Services		
ADA Codes	**Covered Services**	**Limitations**
D3310	Anterior root canal (excluding final restoration)	
D3320	Bicuspid root canal (excluding final restoration)	
D3330	Molar root canal (excluding final restoration)	
D3346	Retreatment of previous root canal therapy-anterior	
D3347	Retreatment of previous root canal therapy-bicuspid	
D3348	Retreatment of previous root canal therapy-molar	
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	
D3353	Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)	
D3410	Apicoectomy/periradicular surgery – anterior	
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	
D3425	Apicoectomy/periradicular surgery - molar (first root)	
D3426	Apicoectomy/periradicular surgery (each additional root)	
D3450	Root amputation - per root	
D3920	Hemisection (including any root removal) - not including root canal therapy	
Periodontal Services		
ADA Codes	**Covered Services**	**Limitations**
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant	1 every 36 months
D4211	Gingivectomy or gingivoplasty – one to three teeth, per quadrant	1 every 36 months
D4240	Gingival flap procedure, including root planning, four of more contiguous teeth or bounded teeth spaces per quadrant	1 every 36 months
D4249	Clinical crown lengthening-hard tissue	
D4260	Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant	1 every 36 months
D4270	Pedicle soft tissue graft procedure	
D4271	Free soft tissue graft procedure (including donor site surgery)	
D4273	Subepithelial connective tissue graft procedures (including donor site surgery)	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime

Prosthodontic Services		
ADA Codes	**Covered Services**	**Limitations**
D5110	Complete denture - maxillary	1 every 60 months
D5120	Complete denture - mandibular	1 every 60 months
D5130	Immediate denture – maxillary	1 every 60 months
D5140	Immediate denture - mandibular	1 every 60 months
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	1 every 60 months
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	1 every 60 months
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	1 every 60 months
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	1 every 60 months
D5281	Removable unilateral partial denture-one piece cast metal (including clasps and teeth)	1 every 60 months
D6053	Implant supported complete denture	1 every 60 months
D6054	Implant supported partial denture	1 every 60 months
D6058	Abutment supported porcelain/ceramic crown	1 every 60 months
D6059	Abutment supported porcelain fused to high noble metal crown	1 every 60 months
D6060	Abutment supported porcelain fused to predominately base metal crown	1 every 60 months
D6061	Abutment supported porcelain fused to noble metal crown	1 every 60 months
D6062	Abutment supported cast high noble metal crown	1 every 60 months
D6063	Abutment supported cast predominately base metal crown	1 every 60 months
D6064	Abutment supported cast noble metal crown	1 every 60 months
D6065	Implant supported porcelain/ceramic crown	1 every 60 months
D6066	Implant supported porcelain fused to high metal crown	1 every 60 months
D6067	Implant supported metal crown	1 every 60 months
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	1 every 60 months
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	1 every 60 months
D6070	Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture	1 every 60 months
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture	1 every 60 months
D6072	Abutment supported retainer for cast high noble metal fixed partial denture	1 every 60 months
D6073	Abutment supported retainer for predominately base metal fixed partial denture	1 every 60 months
D6074	Abutment supported retainer for cast noble metal fixed partial denture	1 every 60 months
D6075	Implant supported retainer for ceramic fixed partial denture	1 every 60 months
D6076	Implant supported retainer for porcelain fused to high noble metal fixed partial denture	1 every 60 months
D6077	Implant supported retainer for cast metal fixed partial denture	1 every 60 months
D6078	Implant/abutment supported fixed partial denture for completely edentulous arch	1 every 60 months

Prosthodontic Services continued on next page

Prosthodontic Services (continued)		
D6079	Implant/abutment supported fixed partial denture for partially edentulous arch	1 every 60 months
D6210	Pontic - cast high noble metal	1 every 60 months
D6211	Pontic - cast predominately base metal	1 every 60 months
D6212	Pontic - cast noble metal	1 every 60 months
D6214	Pontic – titanium	1 every 60 months
D6240	Pontic - porcelain fused to high noble metal	1 every 60 months
D6241	Pontic - porcelain fused to predominately base metal	1 every 60 months
D6242	Pontic - porcelain fused to noble metal	1 every 60 months
D6245	Pontic - porcelain/ceramic	1 every 60 months
D6519	Inlay/onlay – porcelain/ceramic	1 every 60 months
D6520	Inlay – metallic – two surfaces	1 every 60 months
D6530	Inlay – metallic – three or more surfaces	1 every 60 months
D6543	Onlay – metallic – three surfaces	1 every 60 months
D6544	Onlay – metallic – four or more surfaces	1 every 60 months
D6545	Retainer - cast metal for resin bonded fixed prosthesis	1 every 60 months
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	1 every 60 months
D6740	Crown - porcelain/ceramic	1 every 60 months
D6750	Crown - porcelain fused to high noble metal	1 every 60 months
D6751	Crown - porcelain fused to predominately base metal	1 every 60 months
D6752	Crown - porcelain fused to noble metal	1 every 60 months
D6780	Crown - 3/4 cast high noble metal	1 every 60 months
D6781	Crown - 3/4 cast predominately base metal	1 every 60 months
D6782	Crown - 3/4 cast noble metal	1 every 60 months
D6783	Crown - 3/4 porcelain/ceramic	1 every 60 months
D6790	Crown - full cast high noble metal	1 every 60 months
D6791	Crown - full cast predominately base metal	1 every 60 months
D6792	Crown - full cast noble metal	1 every 60 months
D6973	Core buildup for retainer, including any pins	1 every 60 months
D9940	Occlusal guard, by report	1 in 12 months for patients 13 and older

Services Not Covered:
(Please refer to Section 7 for a list of General Exclusions)

ADA Codes	Description of Service	
D2410	Gold Foil 1 surface	
D2420	Gold Foil 2 surface	
D2430	Gold Foil 3 surface	
D2799	Provisional Crown	
D2955	Post Removal	
D2970	Temporary Crown	
D2975	Coping	
D3460	Endodontic Implant	
D3470	Intentional reimplantation	
D3910	Surgical procedure for isolation of tooth	
D3950	Canal preparation	
D4230	Anatomical crown exposure 4 or more teeth	
D4231	Anatomical crown exposure 1-3 teeth	
D4320	Splinting intracoronal	
D4321	Splinting extracoronal	
D5810	Complete denture upper (interim)	
D5811	Complete denture lower (interim)	
D5820	Partial denture upper (interim)	
D5821	Partial denture lower (interim)	

D5862	Precision Attachment	
D5867	Replacement Precision Attachment	
D5986	Fluoride Gel Carrier	
D6010	Endosteal Implant	
D6012	Interim endosteal Implant	
D6040	Eposteal Implant	
D6050	Transosteal Implant	
D6055	Implant connecting bar	
D6056	Prefabricated abutment	
D6057	Custom abutment	
D6253	Provisional Pontic	
D6920	Connector bar	
D6940	Stress breaker	
D6950	Precision Attachment	
D6975	Coping - metal	

Class D Orthodontic

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet Generally Accepted Dental Protocols.
- The calendar year deductible is $0 per person.
- The waiting period for orthodontic services is 24 months. The person receiving services must be covered under the same Option for the entire waiting period.
- The lifetime maximum for orthodontic services depends on the option in which you enroll and if you chose to receive services from a network provider. For example, if you are covered by the High Option, the lifetime maximum is $3,000 regardless of the participating status of the provider. In the Standard Option services rendered by an In-Network provider will be subject to a $1,500 lifetime maximum and services rendered by an Out-of-Network provider will be subject to a $1,000 lifetime maximum.
- The benefit payable for the initial placement will not exceed 25% of the Lifetime Maximum Benefit Amount for the appliance. All supplemental payments will be made in equal installments pro-rated over the balance of a maximum period of 24 months.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

- ***High Option***
  - **In-Network: 50% of the Network Allowance (PDP fee) up to the Lifetime Benefit Maximum. You are responsible for all charges that exceed the Lifetime Benefit Maximum.**
  - **Out-of-Network: 50% of the Usual and Customary charges up to the Lifetime Benefit Maximum. You are responsible for all charges that exceed the Lifetime Benefit Maximum.**
- ***Standard Option***
  - **In-Network: 50% of the Network Allowance (PDP fee) up to the Lifetime Benefit Maximum. You are responsible for all charges that exceed the Lifetime Benefit Maximum.**
  - **Out-of-Network: 50% of the Usual and Customary charges up to the Lifetime Benefit Maximum. You are responsible for all charges that exceed the Lifetime Benefit Maximum**

Orthodontic Services - limited to children up to age 19

ADA Codes	Covered Services	Limitations
D8010	Limited orthodontic treatment of the primary dentition (including retention)	
D8020	Limited orthodontic treatment of the transitional dentition (including retention)	
D8030	Limited orthodontic treatment of the adolescent dentition (including retention)	
D8050	Interceptive orthodontic treatment of the primary dentition (including retention)	
D8060	Interceptive orthodontic treatment of the transitional dentition (including retention)	
D8070	Comprehensive orthodontic treatment of the transitional dentition (including retention)	
D8080	Comprehensive orthodontic treatment of the adolescent dentition (including retention)	

D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	

Services Not Covered:
(Please refer to Section 7 for a list of General Exclusions)

Not covered:

- Orthodontic care for dependent children age 19 and over
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- Orthodontic services provided to dependent of an enrolled member who has not met the 24 month waiting period requirement.
- Services to alter vertical dimension and/or restore or maintain occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth

General Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, minor restorative care or treatment of a covered condition and meet Generally Accepted Dental Protocols.
- The calendar year deductible is $0 if you use an In-Network provider. Should you elect to use an Out-of-Network provider the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy his or her own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontic services is $3,000, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontic services is $1,200 for In-Network services and $600 for Out-of-Network services. In no instance will MetLife allow more than $1,200 in combined benefits under the Standard Option in any plan year.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7.

You Pay:

High Option

- **In-Network: $0 deductible and then you pay 30% of the Network Allowance (PDP Fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: $50 deductible and then you pay 40% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums.**

Standard Option

- **In-Network: $0 deductible and then you pay 45% of the Network Allowance (PDP Fee) for covered services as defined by the Plan, subject to Plan deductibles and maximums.**
- **Out-of-Network: $100 deductible and then you pay 60% of the Usual and Customary charges for covered services as defined by the Plan, subject to Plan deductibles and maximums.**

Anesthesia Services

ADA Codes		Limitations
D9220	Deep sedation/general anesthesia - first 30 minutes	
D9221	Deep sedation/general anesthesia - each additional 15 minutes	

Intravenous Sedation

D9241	Intravenous conscious sedation/analgesia - first 30 minutes	
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	

Consultations

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	

Medications

D9610	Therapeutic drug injection, by report	

Post Surgical Services		
D9930	Treatment of complications (post-surgical) unusual circumstances, by report	

Services Not Covered:

(Please refer to Section 7 for a list of General Exclusions)

ADA Codes	Description of Service	
D9210	Local Anesthesia not in conjunction with operative or surgical procedures	
D9211	Regional Block Anesthesia	
D9212	Trigeminal Division Block Anesthesia	
D9215	Local Anesthesia	
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	
D9248	Non-intravenous conscious sedation	
D9410	House / extended care facility call	
D9420	Hospital Call	
D9450	Case presentation	
D9630	Other drugs and or medicaments	
D9920	Behavior Management	
D9941	Fabrication of athletic mouthguard	
D9950	Occlusion analysis - mounted case	
D9951	Occlusal adjustment - limited	
D9952	Occlusal adjustment - complete	
D9970	enamel microabrasion	
D9971	odontoplasty 1-2 teeth	
D9972	External bleaching - per arch	
D9973	External bleaching - per tooth	
D9974	Internal bleaching - per tooth	
D0310	Sialography	
D0472	Oral Pathology lab	
D0473	Oral Pathology lab	
D0474	Oral Pathology lab	
D0480	Oral Pathology lab	
D0502	Oral Pathology lab	
D5911	Facial Moulage (sectional)	
D5912	Facial Moulage (complete)	
D5913	Nasal Prosthesis	
D5914	Auricular Prosthesis	
D5915	Orbital Prosthesis	
D5916	Ocular Prosthesis	
D5919	Facial Prosthesis	
D5922	Nasal Septal Prosthesis	
D5923	Ocular Prosthesis (interim)	
D5924	Cranial Prosthesis	
D5925	Facial Augmentation implant	
D5926	Nasal Prosthesis (replacement)	
D5927	Auricular Prosthesis (replacement)	
D5928	Orbital Prosthesis (replacement)	
D5929	Facial Prosthesis (replacement)	
D5931	Obturator Prosthesis (surgical)	
D5932	Obturator Prosthesis (definitive)	
D5933	Obturator Prosthesis (modification)	
D5934	Mandibular resection Prosthesis w/guide flange	

Additional Services Not Covered continued on next page

Additional Services Not Covered: (continued) *(Please refer to Section 7 for a list of General Exclusions)*		
ADA Codes	Description of Service	
D5935	Mandibular resection Prosthesis w/out guide flange	
D5936	Obturator Prosthesis (interim)	
D5937	Trismus Appliance	
D5951	Feeding Aid	
D5952	Speech Aid prosthesis (pediatric)	
D5953	Speech Aid prosthesis (adult)	
D5954	Palatal Augmentation Prosthesis	
D5955	Palatal Lift Prosthesis (definitive)	
D5958	Palatal Lift Prosthesis (interim)	
D5959	Palatal Lift Prosthesis (modification)	
D5960	Speech Aid Prosthesis (modification)	
D5982	Surgical Stent	
D5983	Radiation Carrier	
D5984	Radiation Shield	
D5985	Radiation Cone locator	
D5987	Commissure Splint	
D5988	Surgical Splint	
D7285	Biopsy of oral tissue (hard)	
D7286	Biopsy of oral tissue (soft)	
D7410	Lesion up to 1.25 (benign)	
D7411	Lesion greater than 1.25 (benign)	
D7412	Complicated lesion (benign)	
D7413	Lesion up to 1.25 (malignant)	
D7414	Lesion greater than 1.25 (malignant)	
D7415	Complicated lesion (malignant)	
D7440	Lesion diameter up to 1.25 (malignant)	
D7441	Lesion diameter greater than 1.25 (malignant)	
D7460	Removal of Benign lesion up to 1.25	
D7461	Removal of Benign lesion greater than 1.25	
D7465	Destruction of lesion (by report)	
D7490	Radical resection upper/lower	
D7530	Removal of foreign body	
D7540	Removal of reaction producing the foreign body	
D7550	Partial Ostectomy	
D7560	Maxillary Sinusotomy	
D7610	Upper open reduction	
D7620	Upper closed reduction	
D7630	Lower open reduction (simple)	
D7640	Lower closed reduction (simple)	
D7650	Open reduction (simple)	
D7660	Closed reduction (simple)	
D7670	Alveolus closed reduction (simple)	
D7671	Alveolus open reduction (simple)	
D7680	Facial bones (simple)	
D7710	Upper open reduction (compound)	
D7720	Upper closed reduction (compound)	
D7730	Lower open reduction (compound)	
D7740	Lower closed reduction (compound)	
D7750	Malar and/or zygomatic arch open red.(compound)	
D7760	Malar and/or zygomatic arch closed red.(compound)	
D7770	Alveolus open red.(compound - stabilization of teeth)	
D7771	Alveolus closed red. (compound – stabilization of teeth)	

Additional Services Not Covered continued on next page

Additional Services Not Covered: (continued) *(Please refer to Section 7 for a list of General Exclusions)*		
ADA Codes	Description of Service	
D7780	Facial bones (compound)	
D7810	TMJ open reduction	
D7820	TMJ closed reduction	
D7830	TMJ manipulation	
D7840	Condylectomy	
D7850	Surgical discectomoy	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-Arthroscopic	
D7872	Arthroscopy with or without a biopsy	
D7873	Arthroscopy surgical adhesions	
D7874	Arthroscopy surgical disc	
D7875	Arthroscopy surgical synovectomy	
D7876	Arthroscopy surgical discectomy	
D7877	Arthroscopy surgical debridement	
D7911	Complicated sutures up to 5 cm.	
D7912	Complicated sutures greater than 5 cm.	
D7920	Skin graft	
D7940	Osteoplasty deformities	
D7941	Osteotomy lower rami	
D7943	Osteotomy lower rami with bone graft	
D7944	Osteotomy segmented	
D7945	Osteotomy body of mandible	
D7946	Lefort I upper total	
D7947	Lefort I upper segmented	
D7948	Lefort II or Lefort III without bone graft	
D7949	Lefort II or Lefort III with bone graft	
D7955	Repair of Maxillofacial soft or hard tissue	
D7980	Sialolithotomy	
D7981	Excision of salivary gland	
D7982	Sialodochoplasty	
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft	
D7996	Implant lower for augmentation purposes	

Section 6 International Services and Supplies Provided

International Claims Payment

We will pay benefits, subject to plan provisions, in an amount equal to the covered percentage for the charges incurred by you. All payments will be made in US currency.

Finding an International Provider

International employees and their dependents may contact AXA Assistance USA (AXA) for referral to dental providers outside of the continental United States or may use the dentist of their choice. The process involves a plan participant calling AXA at 312 935-9210 collect or 1 (866) 384-2771 to find a local provider in their country. .

Filing International Claims

The Plan participant will be responsible for paying the dentist and submitting the claims to MetLife for reimbursement at the following address:

Mail completed claim form to:

MetLife Dental Claims

P.O. Box 981282

El Paso, TX 79998-1282

International Rates

There is one international region. Please see the Rate table for the actual premium amount

Section 7 General Exclusions – Things We Don't Cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition. Section 5 contains lists of excluded ADA codes categorized by type of service.**

We do not cover the following:

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
- Services and treatment performed prior to your effective coverage date;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice. Such services are not billable to you by a participating dentist unless the dentist notifies you of your liability prior to treatment and you choose to receive the treatment. Participating dentists should document such notification in their records;
- Services and treatment resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- Services or treatment provided as a result of intentionally self-inflicted injury or illness;
- Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Those which are for specialized procedures and techniques;
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;

- Dental Implants and related services;
- Services to alter vertical dimension and/or restore or maintain occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement;
- Orthodontic care for dependent children age 19 and over;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non benefited service) as determined by MetLife.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by MetLife.
- All Out-of-Network services listed in Section 5 are subject to the Usual and Customary maximum allowable fee charges as defined by MetLife. The member is responsible for all remaining charges that exceed the allowable maximum.

Section 8 The Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

MetLife's dental providers may submit their claims directly to MetLife by accessing MetDental.com where we provide them with real-time results. However, should you wish to send in a paper claim you may download a claim form from the website http://www.federaldental.metlife.com.

Mail completed claim form to:

MetLife Dental Claims

P.O. Box 981282

El Paso, TX 79998-1282

Deadline for Filing Your Claim

You must submit your claim to us within 13 months following the delivery of the services in order for them to be considered for plan benefits

Disputed Claim Process

Follow this disputed claims process if you disagree with our decision on your claim or request f

Step	Description
1	Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and mail your additional proof to us within 180 days from the date of receipt of our decision.
2	Send your request for reconsideration to: MetLife Dental Claims Appeals P.O. Box 14589 Lexington, KY 40512 We will review your request and provide you with a written or electronic explanation of benefit determination within 30 days of the receipt of your request.
3	If the dispute is not resolved through the reconsideration process, you may request a review of the denial. You must submit your request to us in writing along with any additional information you or your dentist can provide to substantiate your claim so that we can reconsider our decision. Failure to do so will disqualify the appeal of your claim.
4	If you do not agree with our final decision, you may request an independent third party review. To qualify for this independent third party review the charge for the procedure in question must be in excess of $1,000 and the reason for denial must be based on our determination that the rationale for the procedure did not meet out dental necessity criteria or our administration of the plans Alternate Benefit provision. The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review. If the matter is not eligible for this third level of review, the second level of review is binding and is the final remedy available to you. This decision is not subject to judicial review.

Initial Determination

MetLife will review your claim and notify you of its decision to approve or deny your claim Such notification will be provided to you within a 30-day period from the date you submitted your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of the Plan. If MetLife needs such an extension, MetLife will notify you prior to the expiration of the initial 30 day period, state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Overpayments

We have the right to recover any amount that we determine to be an overpayment, whether for services received by you or your dependents.

An overpayment occurs if we determine that:

- the total amount paid by us on a claim for dental benefits is more than the total of the benefits due to you under this brochure; or
- payment we made should have been made by another group plan.

If such overpayment occurs, you have an obligation to reimburse us.

Recovery of Dental Insurance Overpayments

We may recover the overpayment from you by: stopping or reducing any future benefits payable under the MetLife Federal Dental Plan; demanding an immediate refund of the overpayment from you; and/or taking legal action.

We may recover such overpayment in accordance with that agreement. If the overpayment results from MetLife having made a payment to you that should have been made under another group plan, we may recover such overpayment from one or more of the following:

- any other insurance company; or
- any other organization.

If such overpayment occurs, you have an obligation to reimburse us.

HIPAA Privacy Practices for Personal for Health Information

This section describes how medical information about you may be used and disclosed and how you can get information. Please review this section carefully.

MetLife and each member of the MetLife family of companies (an "Affiliate") strongly believe in protecting the confidentiality and security of information we collect about you. This section refers to MetLife by using the terms "us," "we," or "our."

This section describes how we protect the personal health information we have about you which relates to your coverage under the MetLife Federal Dental Plan ("Personal Health Information"), and how we may use and disclose this information. Personal Health Information includes individually identifiable information, which relates to your past, present or future health, treatment or payment for health care services. This section also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide notice of our privacy practices for Personal Health Information to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy

policies, please see the privacy notices contained at our website, www.MetLife.com. You may submit questions to us there or you may write to us directly at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898 Bridgewater, New Jersey 08807-6896. We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of our HIPAA privacy practices as explained in this section.

We protect your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your insurance coverage under the MetLife Federal Dental Plan, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will not disclose your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your dental insurance coverage.

The main reasons for which we may use and may disclose your Personal Health Information are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

For Payment

We may use and disclose Personal Health Information to pay for benefits under the MetLife Federal Dental Plan. For example, we may review Personal Health Information contained on claims to reimburse providers for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.

For Health Care Operations

We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for dental insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Personal Health Information to provide a service to us and will agreed to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

Where Required by Law or for Public Health Activities

We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

To Avert a Serious Threat to Health or Safety

We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

For Health-Related Benefits or Services

We may use Personal Health Information to provide you with information about benefits available to you under your current coverage and, in limited situations, about health-related products or services that may be of interest to you.

For Law Enforcement or Specific Government Functions

We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

When Requested as Part of a Regulatory or Legal Proceeding

If you or your estate is involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

Other Uses of Personal Health Information

Other uses and disclosures of Personal Health Information not covered by this section and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your dental insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Personal Health Information We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your Personal Health Information. Should you have questions about a specific right, please write to us at the location listed in our discussion of that right.

Right to Inspect and Copy your Personal Health Information

In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to Amend Your Personal Health Information

If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to MetLife P.O. Box 14587, Lexington, KY 40512. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
- is not part of the Personal Health Information kept by or for us; or

is not part of the Personal Health Information, which you would be permitted to inspect and copy.

Right to a List of Disclosures

You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (For example, on paper or electronically). The first list you request within a 12 month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications

You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to MetLife P.O. Box 14587, Lexington, KY 40512 and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to File a Complaint

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6896 Bridgewater NJ 08807-6896. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions regarding how to file a complaint please contact us at (908) 253-2706 or at HIPAAprivacyInst@metlife.com.

Changes to our HIPAA Privacy Practices for Personal Health Information

We reserve the right to change the terms of our HIPAA privacy practices for Personal Health Information at any time. We reserve the right to make the revised or changed practices effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. You will receive a copy of any revised notice from MetLife by mail or by e-mail, but only if e-mail delivery is offered by MetLife and you agree to such delivery.

Further Information

You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact us at HIPAAprivacyInst@metlife.com, (908) 253-2706 or write to us at MetLife, Institutional Business HIPAA Privacy Office, P.O. Box 6898 Bridgewater, New Jersey 08807-6896.

Section 9 Definitions of Terms We Use in this Brochure

Alternate Benefit — If we determine a service less costly than the one preformed by your dentist could have been performed by your dentist, we will pay benefits based upon the less costly services. See Section 3 How You Obtain Care for a definition of Alternate Benefit.

Annual Benefit Maximum — The maximum annual benefit that you can receive per person.

Annuitants — Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.

BENEFEDS — The enrollment, premium, direct billing in certain situation, administration system for FEDVIP.

Benefits — Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.

Calendar Year — From January 1, 2008 through December 31, 2008. Also refer to Plan year.

Class A Services — Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

Class B Services — Intermediate services, which include restorative procedures such as fillings, periodontal scaling, tooth extractions, and denture adjustments.

Class C Services — Major services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D Services — Orthodontic services.

Date of Service — The date a dental service is completed. In cases when more than one visit is necessary to complete a dental procedure, the date the actual dental procedure is completed is considered the date of service. This is the date your dentist should use on the claim form when submitting services for payment.

Enrollee — The Federal employee or annuitant enrolled in this plan.

FEDVIP — Federal Employees Dental & Vision Insurance Program.

Generally Accepted Dental Protocols — Dental necessity means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by us and is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.

Maximum Allowed Charge — Maximum Allowed Charge means the contracted or billed amount of the dental charge whichever is the lesser.

Network Allowance — Network Allowance means the allowance per procedure that MetLife has negotiated with the provider and they have agreed to accept as payment in full for his/her services.

Plan — The MetLife Federal Dental Plan.

Plan Allowance — The amount we use to determine our payment for services. If services are provided by an In-Network provider, the Plan Allowance is based on the discounted fee he or she accepts as

payment in full for the procedure or procedures. If services are provided by an Out-of-Network provider, the plan allowance is based on MetLife's determination of Usual and Customary charges for the procedure or procedures.

Usual and Customary Charge

Usual and Customary Charges are the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies; or
- the usual allowance for an area is the usual charge made by most dentists in the same geographic area for the same or similar service or supply. MetLife's claim payment system uses data accumulated through internal claim processing to establish procedure code specific customary allowance within a geographic area. We use the 80th percentile charge to establish a customary allowance. Using the 80th percentile recognizes that even within a geographically contiguous area, charges for a procedure may vary based on location, provider qualifications, or the nature of the specific case. At the same time, payment for charges far in excess of the prevailing fee will be reduced to the 80th percentile amount for benefit payment purposes. The 80th percentile is felt to be a fair level since full payment is allowed not only for average charges, but also for fees somewhat about the average rate.

An example, of how the 80th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Usual and Customary charge records. These 100 hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 80th percentile of charges is the charge that is equal to the charge numbered 80.

Waiting period

The amount of time that You must be enrolled in this Plan before you can receive orthodontic services.

We / Us / Our

The MetLife Federal Dental Insurance Program

You/Your

Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, the MetLife Federal Dental Plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1 (888) 865-6854 and explain the situation, you will be required to state your complaint in writing to us.
- Do not maintain as a family member on your policy:
    - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - Your child over age 22 (unless he/she is disabled and incapable of self- support).

If you have any questions about the eligibility of a dependent, check with BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Summary of Benefits

- **Do not rely on this chart alone.** On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.
- Below, an asterisk (*) means the item is subject to a deductible of $50 for the High Option or $100 for the Standard Option per calendar year.

High Option Benefits	You Pay In-Network	You Pay Out-of-Network	Page
Class A (Basic) Services – preventive and diagnostic	Nothing	10%*	17
Class B (Intermediate) Services – includes minor restorative services	30%	40%*	20
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	60%*	24
Class A, B, and C Services are subject to a $3,000 annual maximum benefit			
Class D Services – orthodontic $3,000 Lifetime Maximum	50%	50%	29

Standard Option Benefits	You Pay In-Network	You Pay Out -of - Network	Page
Class A (Basic) Services – preventive and diagnostic	Nothing	40%*	17
Class B (Intermediate) Services – includes minor restorative services	45%	60%*	20
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	80%*	24
Class A, B, and C Services are subject to a $1,200 annual maximum benefit for the In-Network benefits and $600 for the Out-of-Network benefit			
Class D Services – orthodontic $1,500 Lifetime Maximum for the In-Network Or a $1,000 Lifetime Maximum for the Out-of-Network	50%	50%	29

Rate Information

How to find your monthly rate

- In the first chart below, look up your state or zip code to determine your Rating Area.
- In the second chart below, match your Rating Area to your enrollment type and plan options.

State	State/Zip (first 3)	MetLife High/Standard Options Premium Rating Area	State	State/Zip (first 3)	MetLife High/Standard Options Premium Rating Area
AK	entire state	5	MO	rest of state	1
AL	356-358	1	MS	entire state	1
AL	rest of state	1	MT	entire state	1
AR	entire state	1	NC	entire state	1
AZ	entire state	1	ND	entire state	1
CA	900-918, 922-935	5	NE	entire state	1
CA	919-921	4	NH	entire state	5
CA	939-941, 943-954	5	NJ	080-084	3
CA	rest of state	5	NJ	rest of state	5
CA	942, 956-958	4	NM	entire state	1
CO	entire state	4	NV	rest of state	2
CT	060-063	5	NV	897	4
CT	064-069	5	NY	004, 005	5
DC	entire state	4	NY	100-119, 124-126	5
DE	entire state	3	NY	rest of state	2
FL	327-328, 347	1	OH	430-432	1
FL	330-334	3	OH	440-443	1
FL	rest of state	1	OH	450-452	1
GA	300-303, 311	2	OH	453-455	1
GA	rest of state	1	OH	rest of state	1
HI	entire state	4	OK	entire state	1
IA	entire state	1	OR	970-973	4
ID	entire state	1	OR	rest of state	3
IL	600-608	4	PA	150-154,156,160	1
IL	620-622	1	PA	183	5
IL	rest of state	1	PA	189-194	3
IN	460-462	1	PA	rest of state	1
IN	463-464	4	PR	All	1
IN	rest of state	1	RI	entire state	5
KS	660-662	1	SC	entire state	1
KS	rest of state	1	SD	entire state	1
KY	410	1	TN	entire state	1
KY	rest of state	1	TX	750-753,760-762	1
LA	entire state	1	TX	770-775	1
MA	010-013	5	TX	rest of state	1
MA	rest of state	5	UT	entire state	1
MD	206-218	4	VA	201, 220-226	4
MD	219	3	VA	230-232,238	1
MD	rest of state	2	VA	rest of state	1
ME	entire state	2	VT	entire state	2
MI	480-485	3	WA	980-985	5
MI	rest of state	2	WA	986	4
MN	550-555	4	WA	rest of state	4
MN	rest of state	2	WI	530-534	2

State	State/Zip (first 3)	MetLife High/Standard Options Premium Rating Area	State	State/Zip (first 3)	MetLife High/Standard Options Premium Rating Area
MO	630-633	1	WI	540	4
MO	640-641	1	WI	rest of state	2
WV	entire state	1	VI	All	0
WY	entire state	1	GU	All	0
			INTERNATIONAL	All	0

Rate Information

Monthly Rates

How to find your monthly rate

- In the chart below, match your Rating Area to your enrollment type and Plan Option.

Rating Areas	High option Self Only	High option Self Plus One	High option Self and Family	Standard option Self Only	Standard option Self Plus One	Standard option Self and Family
0	$41.51	$82.98	$124.50	$24.90	$49.83	$74.73
1	$28.23	$56.44	$84.65	$17.16	$34.34	$51.50
2	$31.55	$63.12	$94.66	$18.53	$37.07	$55.60
3	$34.32	$68.62	$102.92	$20.48	$40.95	$61.43
4	$37.09	$74.17	$111.26	$22.71	$45.41	$68.12
5	$41.51	$82.98	$124.50	$24.90	$49.83	$74.73

Bi-weekly Rates

How to find your bi-weekly rate

- In the chart below, match your Rating Area to your enrollment type and Plan Option

Rating Area	High option Self Only	High option Self Plus One	High option Self and Family	Standard option Self Only	Standard option Self Plus One	Standard option Self and Family
0	$19.16	$38.30	$57.46	$11.49	$23.00	$34.49
1	$13.03	$26.05	$39.07	$7.92	$15.85	$23.77
2	$14.56	$29.13	$43.69	$8.55	$17.11	$25.66
3	$15.84	$31.67	$47.50	$9.45	$18.90	$28.35
4	$17.12	$34.23	$51.35	$10.48	$20.96	$31.44
5	$19.16	$38.30	$57.46	$11.49	$23.00	$34.49