The MetLife Federal Dental Insurance Program

http://www.federaldental.metlife.com

2007

A Nationwide Dental PPO Plan

Who may enroll in the 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 overseas; please see the end of this brochure to determine your region and corresponding rates

A.M. Best Co. E-Fusion Award 2004 in the Customer Web

Marketing Association's 2003 & 2004 Standard of Excellence Web Award Service and Benefits Management

Purdue University Certified Center of Excellence 2005 & 2006

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 Program 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.

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

Table of Contents

Program Highlights

A choice of plans and options	You can select from several national, 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 page 6 for more information.
Coverage effective date	If you sign up for a dental and/or vision plan during the 2006 Open Season, your coverage will begin on December 31, 2006. Premium deductions will start with the first full pay period beginning on/after January 1, 2007. 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 can enroll or change your dental and/or vision plan enrollment. This year the Open Season runs from November 13, 2006 through December 11, 2006. 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. See page 6 for more information.
Continued group coverage	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. See page 5 for more information.
Waiting period	The only waiting period is for orthodontic services. To meet this requirement, the person receiving the services must be enrolled in the same plan 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 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 can 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 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.

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 where you enter your name, personal information such as your address and Social Security Number, the agency you work for (or retirement system that pays your annuity), and the dental/vision plan you select. 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.

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

Open season

If you are an eligible employee or an eligible annuitant, you can enroll in a dental and/or vision plan during the November 13 through December 11, 2006 Open Season. Coverage is effective December 31, 2006.

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 survivor annuitant if not already covered under FEDVIP;

or within 60 days of a return 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 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 QLE's and the enrollment actions you may take.

Qualifying Life Event	**From Not Enrolledto 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
Return to pay status from active military duty	Yes	No	No	No	No
Annuity/compensation restored	Yes	No	No	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 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.

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.

Under FEDVIP, there is no 31-day extension of coverage, temporary continuation of coverage, spouse equity coverage, or right to convert to an individual policy.

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 2007. 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.

Section 3 How you get care

Identification cards / Enrollment confirmation	Upon enrollment into the MetLife Federal Dental Program, MetLife will provide you with a confirmation letter and identification card (ID). If you enroll, you will receive either an email or a paper confirmation letter along with an ID card. If you elected to enroll on line and requested email confirmation of your enrollment, 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 (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 Plan providers in the provider directory, which we update weekly. The list is on our website at: http://www.federaldental.metlife.com
• **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 dentist 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.
• **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.
• **Overseas**	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 an AXA number to find a local provider in their country. The employee pays the dentist directly then submits a claim to MetLife for reimbursement. We will pay benefits, subject to plan provisions, in an amount equal to the Covered Percentage for the charges incurred by you.
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 periodontal services, bridges, inlays/onlays (when performed together) veneers, implants (when a plan provides benefits for these procedures) and overdentures. Services performed by an in-network provider are subject to the discounted fee schedule that the provider agrees to accept as payment in full,; whether or not the services are covered by the plan. Note in MetLife's program, if the service is rendered in-network, the provider must accept the discounted fee schedule amount for any procedure subject to alternate benefit determinations as payment in full. This means that if the Plan determines that the restorative need to the rendered service was not established and the benefits are reduced, the patient's liability to the dentist is limited to the discounted fee for the service rendered.
Coordination of benefits	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 may request that you verify/identify your health insurance plan(s) annually or at time of service.
Rating areas	Your rates are determined based on where you live. This is called a rating area. If you move, you must update your address through BENEFEDS. Your rates might change because of the move.

Underserved areas	If you live in an underserved area and you receive covered services from an out-of-network provider, we will pay benefits based on our in network plan allowances.

Section 4 Your cost for covered services

This is what you will pay out-of-pocket for covered care:

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.

	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 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 plan are combined between in and out of network services. The total maximum annual benefit will never be greater than the in-network maximum annual benefit.

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

Lifetime benefit maximum

The Lifetime maximum for Orthodontic benefits is $3,000 in the High Option Plan whether or not an in-network provider delivers the services. The Lifetime maximum for the Standard Option Plan is $1,500 for in-network benefits and $1,000 for out-of-network. There are no other lifetime maximums under the Plans.

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. 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 dentist decides to terminate their 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 is 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 under the out–of- network plan. All benefits are payable based on the 80th percentile of MetLife's usual and customary charges for a dentist in your area.
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.
Overseas services	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 an AXA number to find a local provider in their country. The employee pays the dentist directly then submits a claim to MetLife for reimbursement. We will pay benefits, subject to plan provisions, in an amount equal to the Covered Percentage for the charges incurred by you.

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 following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.
- 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 as covered people must satisfy their own deductible. The calendar year deductible may apply 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.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.

You Pay:

- ***High Option***

  In-Network: Preventive and Diagnostic services – $0

  Out-of-Network: Preventive and Diagnostic services - 10% of the usual and customary charges

- ***Standard Option***

  In-Network: Preventive and Diagnostic Services - $0

  Out-of-Network: 40% of the usual and customary charges

Diagnostic and Treatment Services

D0120 Periodic oral evaluation - Limited to 1 every 6 months

D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months

D0150 Comprehensive oral evaluation - Limited to 1 every 6 months

D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months

D0210 Intraoral – complete series (including bitewings)

D0220 Intraoral - periapical first film

D0230 Intraoral - periapical - each additional film

D0240 Intraoral - occlusal film

D0270 Bitewing - single film – Adult – limited to 1 every calendar year – Children limited to 1 every 6 months

D0272 Bitewings - two films - Adult – limited to 1 every calendar year – Children limited to 1 every 6 months

D0274 Bitewings - four films Adult – limited to 1 every calendar year – Children limited to 1 every 6 months

D0277 Vertical bitewings – 7 to 8 films – Adults – limited to 1 every calendar year – Children limited to 1 every 6 months

D0330 Panoramic film – limited to 1 every 60 months

Preventative Services
D1110 Prophylaxis – adult - Limited to 1 every 6 months
D1120 Prophylaxis – child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – adult – Limited to 2 every 12 months
D1351 Sealant - per tooth - Limited to permanent molars through age 18. 1 sealant per tooth every 36 months
D1510 Space maintainer – fixed – unilateral - Limited to children under age 19
D1515 Space maintainer – fixed – bilateral - Limited to children under age 19
D1520 Space maintainer - removable – unilateral - Limited to children under age 19
D1525 Space maintainer - removable – bilateral - Limited to children under age 19
D1550 Re-cementation of space maintainer - Limited to children under age 19
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure

Not covered:

- *Plaque control programs*
- *Oral hygiene instruction*
- *Dietary instructions*
- *Sealants for teeth other than permanent molars*
- *Over-the-counter dental products, such as teeth whiteners, toothpaste, dental floss*

Class B Minor

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 following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.
- 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.

You Pay:

- ***High Option***

  In-Network: $0 deductible and then you pay 30% of the network allowance

  Out-of-Network: $50 deductible and then you pay 40% of the usual and customary charges

- ***Standard Option***

  In-Network: $0 deductible and then you pay 45% of the network allowance

  Out-of-Network: $100 deductible and then you pay 60% of the usual and customary charges

Minor Restorative Services

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

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 – Limited to 1 per tooth in 60 months

D2931 Prefabricated stainless steel crown - permanent tooth - Limited to 1per tooth in 60 months

D2951 Pin retention - per tooth, in addition to restoration

Not Covered:

- *Restorations, including veneers, which are placed for cosmetic purposes only*
- *Gold foil restorations*

Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration)
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - *Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is 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. - *Limited to primary incisor teeth for members up to age 6 and for primary molars andcuspids up to age 11 and is limited to once per tooth per lifetime.*
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
D4910 Periodontal maintenance – Limited to 4 in 12 months combined with the prophylaxis
Prosthodontic Services
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 - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture (chairside) - Limited to 1in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture (chairside) - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report

Oral Surgery
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

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 following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.
- 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.

You Pay:

- ***High Option***

  In-Network: $0 deductible and then you pay 50% of the network allowance

  Out-of-Network: $50 deductible and then you pay 60% of the usual and customary charges

- ***Standard Option***

  In-Network: $0 deductible and then you pay 65% of the network allowance

  Out-of-Network: $100 deductible and then you pay 80% of the usual and customary charges

Major Restorative Services

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 – Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic– Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months

Major Restorative Services - continued on next page

Major Restorative Services (cont.)

D2794 Crown – titanium– Limited to 1 per tooth every 60 months

D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months

D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months

D2980 Crown repair, by report

Not covered:

- *Gold foil restorations*
- *Restorations for cosmetic purposes only*

Endodontic Services

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

D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant – Limited to 1 every 36 months

D4211 Gingivectomy or gingivoplasty – one to three teeth, per quadrant – Limited to 1 every 36 months

D4240 Gingival flap procedure, including root planning, four of more contiguous teeth or bounded teeth spaces per quadrant – Limited to 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 – Limited to 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 – Limited to 1 per lifetime

Prosthodontic Services
D5110 Complete denture - maxillary – Limited to 1 every 60 months
D5120 Complete denture - mandibular – Limited to 1 every 60 months
D5130 Immediate denture - maxillary – Limited to 1 every 60 months
D5140 Immediate denture - mandibular – Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
D6212 Pontic - cast noble metal– Limited to 1 every 60 months
D6214 Pontic – titanium – Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
Prosthodontic Services (continued)
D6530 Inlay – metallic – three or more surfaces – Limited to 1 every 60 months
D6543 Onlay – metallic – three surfaces – Limited to 1 every 60 months
D6544 Onlay – metallic – four or more surfaces – Limited to 1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis – Limited to 1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis
D6740 Crown - porcelain/ceramic – Limited to 1 every 60 months
D6750 Crown - porcelain fused to high noble metal – Limited to 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6752 Crown - porcelain fused to noble metal – Limited to 1 every 60 months
D6780 Crown - 3/4 cast high noble metal – Limited to 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal – Limited to 1 every 60 months
D6782 Crown - 3/4 cast noble metal – Limited to 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic – Limited to 1 every 60 months
D6790 Crown - full cast high noble metal – Limited to 1 every 60 months
D6791 Crown - full cast predominately base metal – Limited to 1 every 60 months
D6792 Crown - full cast noble metal – Limited to 1 every 60 months
D6973 Core buildup for retainer, including any pins – Limited to 1 every 60 months
D9940 Occlusal guard, by report – Limited to 1 in 12 months for patients 13 and older

Prosthodontic Services (continued) - continued on next page

Prosthodontic Services (continued) (cont.)

Not covered:

- *Implantology and related services.*
- *Precision attachments, personalization, precious metal bases, and other specialized techniques*
- *Replacement of dentures that have been lost, stolen or misplaced*
- *Removable or fixed prostheses initiated prior to the effective date of coverage or inserted/cemented after the coverage ending date*

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 following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.

You Pay:

- ***High Option***

  In-Network: 50% of the network allowance

  Out-of-Network: 50% of the usual and customary charges

- ***Standard Option***

  In-Network: 50% of the network allowance

  Out-of-Network: 50% of the usual and customary charges

Orthodontic Services - limited to children up to age 19

D8010 Limited orthodontic treatment of the primary dentition

D8020 Limited orthodontic treatment of the transitional dentition

D8030 Limited orthodontic treatment of the adolescent dentition

D8050 Interceptive orthodontic treatment of the primary dentition

D8060 Interceptive orthodontic treatment of the transitional dentition

D8070 Comprehensive orthodontic treatment of the transitional dentition

D8080 Comprehensive orthodontic treatment of the adolescent dentition

D8210 Removable appliance therapy

D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit

D8670 Periodic orthodontic treatment visit (as part of contract)

D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)

Not covered:

- Orthodontic care for dependent children age 19 and over
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- Services to alter vertical dimension and/or restore or maintain the 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 following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services.
- 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.

You Pay:

- ***High Option***

  In-Network: $0 deductible and then you pay 30% of the network allowance

  Out-of-Network: $50 deductible and then you pay 40% of the usual and customary charges

- ***Standard Option***

  In-Network: $0 deductible and then you pay 45% of the network allowance

  Out-of-Network: $100 deductible and then you pay 60% of the usual and customary charges

Anesthesia Services

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

Miscellaneous Services

Not covered:

- Fabrication of athletic mouth guard
- Internal bleaching
- Nitrous oxide
- Oral sedation

Section 6 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.**

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, or similar person or group;
- Services and treatment performed prior to your effective coverage date including orthodontic treatment;
- Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
- Services and treatment which are not dentally necessary, or which are not recommended or approved by the treating dentist (Services determined to be unnecessary or which do not meet accepted standards of dental practice 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 not meeting accepted standards of dental practice;
- 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 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;
- Adjunctive dental care services that are covered by other medical insurance even when provided by a general dentist or oral surgeon.
- Services or treatment provided by a member of your immediate family or a member of the immediate family of your spouse.
- 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 incurred after the termination date of the member's coverage unless otherwise indicated.
- Those which are for unusual procedures and techniques.
- Those performed prior to the member's effective coverage date.
- Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
- Duplicate and temporary devices, appliances, and services.
- Plaque control programs, oral hygiene instruction, and dietary instructions.
- Implantology and related services.
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Restorations which are placed for cosmetic purposes only.
- 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).

Section 7 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 7998-1282

MetLife will make an international PPO network available to plan participants through a relationship with AXA Assistance. International plan participants will have access to a toll-free line with AXA, which will provide worldwide referrals to participating international dentists. The plan participant will be responsible for paying the dentist and submitting a claim to MetLife for reimbursement at the above address.

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 Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

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 no later than 31 days from the date of receipt of our decision.

2 Mail your appeal request 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 our benefit determination with 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 our 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.

Section 8 Definitions of terms we use in this brochure

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 and premium 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.
Annual benefit maximum	The maximum annual benefit that you can receive per person.
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, prefabricated stainless steel crowns, 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.
Enrollee	The Federal employee or annuitant enrolled in this Plan.
FEDVIP	Federal Employees Dental and 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.
Plan allowance	The amount we use to determine our payment for services. If services are provided by an in-network dentist 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 dentist the Plan Allowance is based on MetLife's determination of usual and customary charges for the procedure or procedures.
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.
Waiting period	The amount of time that you must be enrolled in this Plan before you can receive orthodontic services.
We / Us	The MetLife Federal Dental Insurance Program
Alternate Benefit	If we determine a service, less costly than the one preformed by your dentist could have been preformed by your dentist, we will pay benefits based upon the less costly services.
Usual and Customary Charge	The amount usually charged in your geographical area for a specific service. For purposes of the FEDVIP plan MetLife uses the 80th percentile of usual and customary charges in the payment of our claims for services rendered out-of-network.
You	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, 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 (888) 865-6854 and explain the situation, you will be required to state your complaint in writing to us.

Summary of benefits for MetLife Dental Plan - 2007

- **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%*	12
Class B (Intermediate) Services – includes minor restorative services	30%	40%	14
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	60%	17
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%	21

Standard Option Benefits	You Pay In-network	You Pay Out of network	Page
Class A (Basic) Services – preventive and diagnostic	Nothing	40%*	12
Class B (Intermediate) Services – includes minor restorative services	45%	60%*	14
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	80%*	17
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 benefits			
Class D Services – orthodontic $1,500 Lifetime Maximum for the In-network Or a $1,000 Lifetime Maxim for the Out-of-network	50%	50%	21

2007 Monthly Rate Information for The MetLife Federal Dental Program

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 option.

State	State/Zip (first 3)	MetLife High Option	MetLife Standard Plan
AK	entire state	5	5
AL	356-358	1	1
AL	rest of state	1	1
AR	entire state	1	1
AZ	entire state	1	1
CA	900-918, 922-935	5	5
CA	919-921	4	4
CA	939-941, 943-954	5	5
CA	rest of state	5	5
CA	942, 956-958	4	4
CO	entire state	4	4
CT	060-063	5	5
CT	064-069	5	5
DC	entire state	4	4
DE	entire state	3	3
FL	327-328, 347	1	1
FL	330-334	3	3
FL	rest of state	1	1
GA	300-303, 311	2	2
GA	rest of state	1	1
HI	entire state	4	4

IA	entire state	1	1
ID	entire state	1	1
IL	600-608	4	4
IL	620-622	1	1
IL	rest of state	1	1
IN	460-462	1	1
IN	463-464	4	4
IN	rest of state	1	1
KS	660-662	1	1
KS	rest of state	1	1
KY	410	1	1
KY	rest of state	1	1
LA	entire state	1	1
MA	010-013	5	5
MA	rest of state	5	5
MD	206-218	4	4
MD	219	3	3
ME	entire state	2	2
MI	480-485	3	3
MI	rest of state	2	2
MN	550-555	4	4
MN	rest of state	2	2

MO	630-633	1	1
MO	640-641	1	1
MO	rest of state	1	1
MS	entire state	1	1
MT	entire state	1	1
NC	entire state	1	1
ND	entire state	1	1
NE	entire state	1	1
NH	entire state	5	5
NJ	080-084	3	3
NJ	rest of state	5	5
NM	entire state	1	1
NV	rest of state	2	2
NV	897	4	4
NY	004, 005	5	5
NY	100-119, 124-126	5	5
NY	rest of state	2	2
OH	430-432	1	1
OH	440-443	1	1
OH	450-452	1	1
OH	453-455	1	1
OH	rest of state	1	1

OK	entire state	1	1
OR	970-973	4	4
OR	rest of state	3	3
PA	150-154,156,160	1	1
PA	183	5	5
PA	189-194	3	3
PA	rest of state	1	1
PR	entire state	1	1
RI	entire state	5	5
SC	entire state	1	1
SD	entire state	1	1
TN	entire state	1	1
TX	750-753,760-762	1	1
TX	770-775	1	1
TX	rest of state	1	1
UT	entire state	1	1
VA	201, 220-226	4	4
VA	230-232,238	1	1
VA	rest of state	1	1
VT	entire state	2	2
WA	980-985	5	5
WA	986	4	4

WA	rest of state	4	4
WI	530-534	2	2
WI	540	4	4
WI	rest of state	2	2
WV	entire state	1	1
WY	entire state	1	1
OVERSEAS	All	6	6

2007 Monthly Rate Information for The MetLife Federal Dental Program

Monthly Rates

How to find your monthly rate

- In the chart below, look up your state or zip code to determine your Rating Area.

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**
1	$25.94	$51.87	$77.81	$15.80	$31.59	*$47.41*
2	$28.99	$57.98	$86.99	$17.05	$34.10	*$51.16*
3	$31.53	$63.05	$94.58	$18.83	$37.68	*$56.51*
4	$34.08	$68.14	$102.22	$20.89	$41.75	*$62.64*
5	$38.11	$76.25	$114.36	$22.90	$45.80	*$68.71*
Overseas	*$38.11*	*$76.25*	*$114.36*	*$22.90*	*$45.80*	*$68.71*

How to find your bi-weekly rate

- In the chart below, look up your state or zip code to determine your Rating Area.

Bi-weekly Rates

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
1	$11.97	$23.94	$35.91	$7.29	$14.58	*$21.88*
2	$13.38	$26.76	$40.15	$7.87	$15.74	*$23.61*
3	$14.55	$29.10	$43.65	$8.69	$17.39	*$26.08*
4	$15.73	$31.45	$47.18	$9.64	$19.27	*$28.91*
5	$17.59	$35.19	$52.78	$10.57	$21.14	*$31.71*
Overseas	*$17.59*	*$35.19*	*$52.78*	*$10.57*	*$21.14*	*$31.71*