MetLife | THE MBA Manufacturer & Business Association

Crafting Smiles, Building Success.

2026 | Dental Benefit Summaries

TABLE OF CONTENTS

TOC

You will benefit from…

Simplified
Benefits Administration

Access to a large,
high-quality dental network

Exceptional Service
from a Dedicated Team

Member
Centered Approach

Why MetLife Dental?

BY THE NUMBERS:

20M+
Individuals covered[1]

98%
Claims processed within 10 business days[1]

60+ years
Providing dental insurance[1]

94
of the top 100 FORTUNE 500® companies[4]

96%
Claimant satisfaction[2]

95%
Customer satisfaction[3]

487,000+
true PPO network access points[5]

43.1%
Average PPO network deep discount

4.6% in 2024[6]
Faster network growth than industry peers

1.7% in 2024
Low voluntary network turnover

TOC

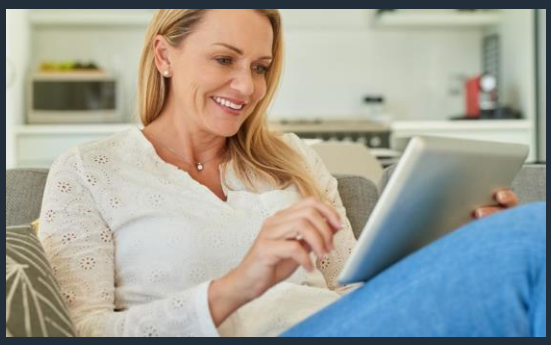
MetLife Dental Features

MetLife SpotLite on Oral Health℠[7]

Value-based healthcare rewards providers for quality outcomes rather than quantity of care delivered.

Teledentistry[8]

Partnership with **Dental.com** to connect members with a licensed dentist, through a video call, to help address urgent dental situations from anywhere.



TOC

Smart Scan[9]

AI-powered digital technology that detects suspected dental issues through images on a mobile phone. Generates an oral health report that can be shared with a provider.

I. UNDERWRITING REGULATIONS

A. Initial Enrollment Procedures

New Members - New members may enroll for the MetLife Dental group programs on the **first day of the month following membership approval by the Board of Governors.**

B. Enrollment/Open Enrollment Procedures

MetLife Dental offers an **open enrollment period** for employees who want to become part of the plan after their standard eligibility waiting period. This open enrollment will occur each year, two months prior to the January 1 renewal of the products (**January 1 through December 31**).

2. The standard eligibility waiting period is the employee's hire date. Eligibility is within the purview of the employer. Possible eligibility waiting periods are the first of the month following the employee's date of hire, the first of the month following 30 days of employment, the first of the month following 60 days of employment, or the first of the month following 90 days of employment. Eligibility waiting periods vary by employer.
3. If an employee would like to request insurance coverage, they must complete an enrollment form (supplies can be received by contacting Manufacturer & Business Association at (800) 815-2660 or your insurance agent). Have the employee sign the form and mail it to the billing office:

   Manufacturer & Business Association Insurance Plan
   Three Gateway Center, STE 1625
   Pittsburgh, PA 15222

Please Note: If an employee declines to enroll himself and/or his dependents for dental coverage when first eligible, the employee and/or his dependents must wait until the next open enrollment period to enroll.

C. Eligibility

Association member firms with two or more full-time employees.

D. Change of Option Procedures

Existing members currently enrolled should notify their broker or the Manufacturer & Business Association (800) 815-2660 if a change in benefit is desired.

E. Contributions

Employee dental coverage is considered non-contributory and must be employer paid with 100% participation. Spousal coverage opt-outs will be considered but the participation requirement must not be less than 75% of eligible employees. Dependent coverage may be contributory (but not to exceed 50% of the actual cost).

TOC

II. MANUFACTURER & BUSINESS ASSOCIATION INSURANCE PROGRAM BILLING, ADMINISTRATIVE FEES AND PROCEDURES

Billing and administrative services for the Manufacturer & Business Association Insurance Plan are provided through CW Breitsman Associates. The schedule of fees applied to the monthly premium billings is as follows:

A. Service Charge
A basic charge per group of $4.00.
$0.35 per participating employee.

B. Premium Due Date - Premium payments are due and payable by the **25th day of the month of billing**.

C. Checks are to be made payable to:
Manufacturer & Business Association Insurance Plan

And mailed to:
Manufacturer & Business Association Insurance Plan
Three Gateway Center, STE 1625
Pittsburgh, PA 15222

A $35.00 charge for returned checks will be applied.

D. Member firms must submit, in writing, all requests for administrative changes regarding company name, address, telephone number, ownership and billing correspondence to: Manufacturer & Business Association 2171 West 38th Street Erie, Pa. 16508

E. Premium invoices will be mailed to member companies **only**.

Any problems or questions relating to billing should be directed to CW Breitsman Associates at **(833) 530-9675**.

F. Eligible Members

- Employee/subscriber
- Employee's spouse
- Unmarried children up to the end of the month they attain age twenty- six (26)
- Unmarried children who become mentally or physically disabled and incapable of self-support before age twenty-six (26) while covered by this Contract or another contract
- Children who are subject to a Qualified Domestic Relations Order
- Newborn children of any covered person for thirty-one (31) days after birth.

G. Enrollment/Change Procedures

1. To add a new employee, complete an enrollment form (supplies can be received by contacting the Manufacturer & Business Association at (800) 815-2660 or your insurance agent). Have the employee sign the form and return it to the billing office.

CW Breitsman Associates
Three Gateway Center, STE 1625
Pittsburgh, PA 15222

Main Contact: Aimee Ripley - aripley@cwb-a.com

TOC

2. To delete an employee, cross the name from the billing invoice and provide a termination date.

3. To change dependent status, complete a revised enrollment card and return it to the billing office.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

Participating Dentists

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program (PDP). Dentists participating in the PDP have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the PDP, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges.
You are always free to receive services from any Dentist.
You do not need any authorization from Us to choose a Dentist

Filing a Claim

Whether you see an In-Network or Out-of-Network dentist, your dentist should submit the claim on your behalf. However, if you need to file a claim please follow the instructions below.

CLAIMS FOR DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental Insurance benefits described in this certificate, both the notice of claim form and the required Proof should be sent to us within 90 days of the date of a loss.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1- A claimant can request a claim form by calling us at 1-800-942-0854.

Step 2- We will send a claim form to the claimant within 15 days of the request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

Step 3- When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form.

Step 4-The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

PAYMENT FOR SERVICES

In-Network

If a covered service is performed by an In-Network Dentist, MetLife will base the benefit on the covered percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a covered service, the member will be responsible for paying:

- the deductible; and
- any other part of the Maximum Allowed Charge for which MetLife does not pay benefits.

Out-of-Network

If a covered service is performed by an Out-of-Network Dentist, MetLife will base the benefit on the 90th percentile of the reasonable and customary Charge.

Out-of-Network Dentists may charge the member more than the 90th percentile of the reasonable and customary charge. If an Out-of-Network Dentist performs a covered service, the member will be responsible for paying:

- the deductible;
- any other part of the 90th percentile of the reasonable and customary charge for which MetLife does not pay benefits; and
- any amount in excess of the 90th percentile of the reasonable and customary charge charged by the Out-of-Network Dentist.

TOC

Coordination of Benefits

Coordination of benefits allows claims to be processed fairly when more than one coverage is available. To eliminate a chance of more than 100% reimbursement, the charges are coordinated between the multiple plans.

MetLife pays the difference between what the primary carrier paid and the allowable fee. Standard/Regular Coordination of Benefits is a cooperative claim payment between two or more insurance carriers that applies when a member is covered under more than one plan. Reimbursement between the carriers can result in a 100% reimbursement of benefit. However, the member will not realize a profit above the 100% reimbursement. If the Plan has a Standard/Regular COB Provision with a Bank, expenses are reviewed during every claim process for the entire year's expenses. This calculation may result in a payment to the employee for expenses incurred earlier in the year.

Work In Progress

Rules if You or You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;
2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:
   - the loss of a tooth; and
   - the accumulation of amounts toward Annual Deductibles and Lifetime Deductibles;
3. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:
   - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
   - the date this Dental Insurance ends.

TOC

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be based on the lower of:

- the amount charged by the Dentist; and
- the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment if:

- Dental Insurance is in effect for the person receiving the orthodontic treatment; and
- proof is given to Us that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Alternate Benefit

If We determine that a service, less costly 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; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- 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 partial denture which is the less costly service.

TOC

Manufacturer and Business Association
Rate Summary: January 1, 2026, through December 31, 2027

Dental insurance may be purchased by Association member companies if the total number of employees to be covered is 2 or more. (Please refer to Underwriting Regulations Sec. II A)

Coverage	Monthly Rates
Employer Sponsored Dental ***(per Employee Per Month)***	
Option 1	
Employee Only	$21.25
Employee + Family	$55.45
Option 2	
Employee Only	$21.25
Employee + Family	$58.95
Option 3	
Employee Only	$24.14
Employee + Family	$70.86
Option 4	
Employee Only	$27.85
Employee + Family	$81.63
Option 7	
Employee Only	$21.68
Employee + Family	$56.56
Option 8	
Employee Only	$30.08
Employee + Family	$88.15
Option 9	
Employee Only	$25.02
Employee + Family	$69.34
Option 10	
Employee Only	$25.02
Employee + Family	$63.85

TOC

Option 1		
Coverage Type	**In-Network**[1] %of **PDP** Fee[2]	**Out-of-Network**[1] % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	80%
Type C – Major Restorative	50%	50%
Deductible		
Individual	$25	$25
Family	$75	$75
Annual Maximum Benefit		
Per Individual	$1,000	$1,000
Orthodontia	Not Covered	Not Covered
Orthodontia Lifetime Maximum	Not Covered	Not Covered

TOC

Rates	
Employee Only	$21.25
Employee + Family	$55.45

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 2		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	80%
Type C – Major Restorative	50%	50%
Type D – Orthodontia	50%	50%
Deductible		
Individual	$25	$25
Family	$75	$75
Annual Maximum Benefit		
Per Individual	$1,000	$1,000
Orthodontia Lifetime Maximum – Ortho applies to Child Only	Up to dependent age limit	
	$600 per person	$600 per person

TOC

Rates	
Employee Only	$21.25
Employee + Family	$58.95

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 3		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	80%
Type C – Major Restorative	50%	50%
Type D – Orthodontia	50%	50%
Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Individual	$1,000	$1,000
Orthodontia Lifetime Maximum – Ortho applies to Child Only	Up to dependent age limit	
	$600 per person	$600 per person

TOC

Rates	
Employee Only	$24.14
Employee + Family	$70.86

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 4		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	100%	100%
Type C – Major Restorative	50%	50%
Type D – Orthodontia	50%	50%
Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Individual	$1,000	$1,000
Orthodontia Lifetime Maximum – Ortho applies to Child Only	Up to dependent age limit	
	$600 per person	$600 per person

TOC

Rates	
Employee Only	$27.85
Employee + Family	$81.63

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 7		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	1000%
Type C – Major Restorative	50%	50%
Deductible		
Individual	$25	$25
Family	$75	$75
Annual Maximum Benefit		
Per Individual	$1,000	$1,000
Orthodontia	Not Covered	Not Covered
Orthodontia Lifetime Maximum	Not Covered	Not Covered

TOC

Rates	
Employee Only	$21.68
Employee + Family	$56.56

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 8		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	100%	100%
Type C – Major Restorative	50%	50%
Type D – Orthodontia	50%	50%
Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Individual	$1,500	$1,500
Orthodontia Lifetime Maximum – Ortho applies to Child Only	Up to dependent age limit	
	$1000 per person	$1000 per person

TOC

Rates	
Employee Only	$30.08
Employee + Family	$88.15

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 9		
Coverage Type	**In-Network[1]** %of **PDP** Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	80%
Type C – Major Restorative	50%	50%
Type D – Orthodontia	50%	50%
Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Individual	$1,500	$1,500
Orthodontia Lifetime Maximum – Ortho applies to Child Only	Up to dependent age limit	
	$1500 per person	$1500 per person

TOC

Rates	
Employee Only	$25.02
Employee + Family	$69.34

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Option 10		
Coverage Type	**In-Network**[1] %of **PDP** Fee[2]	**Out-of-Network**[1] % of R&C Fee[4]
Type A – Preventive	100%	100%
Type B – Basic Restorative	80%	1000%
Type C – Major Restorative	50%	50%
Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum Benefit		
Per Individual	$1,500	$1,500
Orthodontia	Not Covered	Not Covered
Orthodontia Lifetime Maximum	Not Covered	Not Covered

TOC

Rates	
Employee Only	$25.02
Employee + Family	$63.85

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist. Utilizing an out-of-network dentist for care may cost you more than using an in network dentist.
2. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
3. Applies to Type Band C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.
5. Savings from enrolling in a dental benefits plan [featuring the MetLife Preferred Dentist Program] will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

Manufacturer and Business Association
Selected Covered Services and Frequency Limitations*: Options 1, 2, 3, 4, 7, 8

Benefits are payable immediately from the start date of an individual's benefits

Type A	
Preventative	**Frequency**
Oral Examinations	2 in 12 months
Problem Focused Examinations	1 in 12 months
Full Mouth X-Rays	1 in 36 months
Bitewing X-Rays (Adult/Child)	2 in 12 months
Prophylaxis: Cleanings	2 in 12 months
Topical Fluoride Applications	2 in 12 months – Children to age 19
Sealants	1 in 60 months - Children up to age 14
Space Maintainers	1 per lifetime per tooth area - Children up to age 14
Type B	
Basic Restorative	**Frequency**
Amalgam and Composite Fillings	1 in 24 months. All teeth
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 36 months per quadrant
Periodontal Scaling & Root Planing	1 in 24 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery: Simple Extractions	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	
Type C	
Major Restorative	**Frequency**
Crown/ Inlays / Onlays	1 per tooth in 84 months
Prefabricated Crowns	1 in 84 months
Repairs	1 in 12 months
Bridges	1 in 84 months
Dentures	1 in 84 months
Consultations	1 in 12 months

TOC

***Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

Selected Covered Services and Frequency Limitations*: Options 9, 10

Benefits are payable immediately from the start date of an individual's benefits

Type A	
Preventative	**Frequency**
Oral Examinations	2 in 12 months
Problem Focused Examinations	1 in 12 months
Full Mouth X-Rays	1 in 36 months
Bitewing X-Rays (Adult/Child)	2 in 12 months
Prophylaxis: Cleanings	2 in 12 months
Topical Fluoride Applications	2 in 12 months – Children to age 19
Sealants	1 in 60 months - Children up to age 14
Space Maintainers	1 per lifetime per tooth area - Children up to age 14
Type B	
Basic Restorative	**Frequency**
Amalgam and Composite Fillings	1 in 24 months. All teeth
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 36 months per quadrant
Periodontal Scaling & Root Planing	1 in 24 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery: Simple Extractions	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	
Type C	
Major Restorative	**Frequency**
Crown/ Inlays / Onlays	1 per tooth in 84 months
Prefabricated Crowns	1 in 84 months
Repairs	1 in 12 months
Bridges	1 in 84 months
Dentures	1 in 84 months
Consultations	1 in 12 months

TOC

***Alternate Benefits**: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

.

Selected Covered Services and Frequency Limitations*: Options 2, 3, 4, 8, 9 only

Orthodontics

Benefits are payable immediately from the start date of an individual's benefits

Dependent children up to age 26. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary. Orthodontic benefits end at cancellation of coverage

TOC

***Alternate Benefits**: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

.

Exclusions - Options 1, 2, 3, 4, 7 & 8

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.
   - **For NY Sitused Groups, this exclusion does not apply.**
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
    - **For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.
    - **This exclusion only applies for North Carolina Sitused Groups.**
15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
    - **This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
    - **This exclusion only applies for Virginia Sitused Groups.**
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.
    - **This exclusion only applies for Virginia Sitused Groups.**
18. Services covered under other coverage provided by the Employer.

TOC

Exclusions - Options 1, 2, 3, 4, 7 & 8 (continued)

19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
    - **For NY Sitused Groups, this exclusion does not apply.**
25. Caries susceptibility tests.
26. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments.
29. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
30. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Fixed and removable appliances for correction of harmful habits.[1]
33. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
34. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
35. Orthodontic services or appliances.[1]
36. Repair or replacement of an orthodontic device.[1]
37. Duplicate prosthetic devices or appliances.
38. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
39. Intra and extraoral photographic images.
40. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article. **This exclusion only applies for Maryland Sitused Groups.**

[1]Some of these exclusions may not apply. Please see your Certificate of Insurance.

TOC

Exclusions - Options 9

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.

   For NY Situsd Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    For North Carolina and Virginia Situsd Groups, this exclusion does not apply.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    This exclusion only applies for North Carolina Situsd Groups.
15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for North Carolina Situsd Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.

    This exclusion only applies for Virginia Situsd Groups.
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual ben¹efit association, or VA hospital.

    This exclusion only applies for Virginia Situsd Groups.

TOC

Exclusions - Options 9 (continued)

18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.

    For NY Situsd Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. Other fixed Denture prosthetic services not described elsewhere in this certificate.
27. Precision attachments, except when the precision attachment is related to implant prosthetics.
28. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
29. Fixed and removable appliances for correction of harmful habits.[1]
30. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
31. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
32. Repair or replacement of an orthodontic device.[1]
33. Duplicate prosthetic devices or appliances.
34. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
35. Intra and extraoral photographic images.
36. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article. **This exclusion only applies for Maryland Situsd Groups**

[1]Some of these exclusions may not apply. Please see your Certificate of Insurance

TOC

Exclusions - Options 10

1. Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
   - scaling and polishing of teeth; or
   - fluoride treatments.

   For NY Situsued Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    For North Carolina and Virginia Situsued Groups, this exclusion does not apply.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law. **This exclusion only applies for North Carolina Situsued Groups.**
15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for North Carolina Situsued Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
    This exclusion only applies for Virginia Situsued Groups.

TOC

Exclusions - Options 10 (continued)

17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. The following when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
24. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.

    For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. Other fixed Denture prosthetic services not described elsewhere in this certificate.
27. Precision attachments, except when the precision attachment is related to implant prosthetics.
28. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
29. Fixed and removable appliances for correction of harmful habits.[1]
30. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
31. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
32. Orthodontic services or appliances.[1]
33. Repair or replacement of an orthodontic device.[1]
34. Duplicate prosthetic devices or appliances.
35. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
36. Intra and extraoral photographic images.
37. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

    This exclusion only applies for Maryland Sitused Groups.

[1]Some of these exclusions may not apply. Please see your Certificate of Insurance

TOC

REFERENCE PAGE

Mailing Addresses:

Dental Claims
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
Fax: 1-859-389-6505

Company Name/Address Changes
Manufacturer & Business Association
2171 West 38th Street
Erie, PA 16508
Phone: (800) 815-2660

Monthly Premium Billing
Manufacturer & Business Association Insurance Plan
Three Gateway Center, STE 1625
Pittsburgh, PA 15222
Phone (833) 530-9675

Enrollments/Adds/Terms
Manufacturer & Business Association Insurance Plan
Three Gateway Center, STE 1625
Pittsburgh, PA 15222

Phone Numbers:

Claim Forms
1-800-275-4638

Supplies/ Claim Forms
1-800-275-4638

Billing Questions
1-833-530-9675

Dental Coverage Verification/Claim Questions
1-800-275-4638

Other Dental Questions
1-800-275-4638

Membership Issues
1-800-815-2660

TOC

COBRA Continuation for Dental Insurance

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Please refer to the COBRA section of Your summary plan description or contact the Employer for information regarding continuation of insurance under COBRA.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff up to 2 months.
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 9 months.
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence up to 2 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS:

INSURANCE FOR YOUR DEPENDENTS.

TOC

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.
Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

[1]MetLife internal data, 2023.

[2]Dental In-Network Plan Participant 2023 VOC Satisfaction Results, MetLife book of business.

[3]Dental In-Network Plan Participant 2023 VOC Satisfaction Results – Book of Business. Results based on MetLife plan participants who visited a dentist and responded to the survey.

[4]National Accounts Service and Operations Metrics, year-end 2023.

[5]Network access point data as of December 2024.

[6]Network access point data as of December 2024. 2 Based on unique providers from October 2023 to October 2024, Network360. Industry peer group is Delta, Cigna, Aetna and UHC.

[7]MetLife's SpotLite on Oral HealthSM is a special designation intended to identify certain PDP providers who have demonstrated a focus on improved health outcomes and have met qualifying criteria. This designation may be used by plan participants to find providers that better align with their healthcare needs. MetLife is not endorsing or otherwise recommending the use of a particular PDP provider.

[8]Dental benefits are provided by Metropolitan Life Insurance Company (MetLife). Virtual dental services are provided by Teledentistry Network, Inc. (TNI). Dental.com (Website) is developed, provided, and maintained by TNI and not MetLife. Use of the Website is subject to all the terms and conditions stated therein. TNI is not affiliated with MetLife or its affiliates.

[9]Smart Scan is made available at Dental.com (Website), which is developed, provided, and maintained by Teledentistry Network, Inc. and not MetLife. All content on the Website, including Smart Scan, is intended for your general knowledge only and is not a substitute for obtaining medical or dental advice for specific medical or dental conditions or other advice from your dentists or doctors.