The MetLife Federal Dental Plan

www.MetLife.com/FederalDental

(888) 865-6854

MetLife

2027

A Nationwide Dental PPO Plan

MetLife Dental is available nationwide and overseas.

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 6
- Summary of Benefits: Page 61

Who may enroll in this Plan: All Federal and U.S. Postal Service (USPS) employees, DC Court employees, certain seasonal, intermittent, and temporary employees, annuitants, survivor annuitants, compensationers, certain firefighters and emergency response personnel, and uniformed service retirees.

Enrollment Options:

- 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

This Plan has 5 enrollment regions, including international; please see the end of this brochure to determine your region and corresponding rates.

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
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 law 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. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-328, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of The MetLife Federal Dental Plan under Metropolitan Life Insurance Company (MetLife) contract OPM02-FEDVIP-02AP-11 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

MetLife
400 Warren Corporate Center Drive
Warren, NJ 07059

(888) 865-6854*
MetLife.com/FederalDental

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, if they are also listed on the coverage. **You and your family members do not have a right to benefits that were available before January 1, 2027 unless those benefits are also shown in this brochure.**

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

The MetLife Federal Dental Insurance Plan is responsible for the selection of In-Network providers in your area. Contact us at (888) 865-6854* for the names of participating providers or to request a provider directory. You may also view current In-Network providers via our web website at MetLife.com/FederalDental. Continued participation of any specific provider cannot be guaranteed. Thus, you should make coverage decisions based on the plan benefits, not based on a specific provider. When you phone for an appointment, please remember to verify that the provider is currently in the MetLife network. If your provider is not currently participating in the provider network, you can ask them to join; or ask your dentist to visit https://dentalprovider.metlife.com/presignin or call (877) MET-DDS9. Note this website and phone number are specifically for dentists and not accessible to employees/annuitants. You cannot change plans, outside of open season, because of changes to the provider network.

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

*Hearing and Speech impaired individuals may communicate using a text telephone device and Relay Services by dialing the MetLife Federal Dental number of “888-865-6854”. Relay Services is immediate assistance. The Message Relay Service enables customers who are deaf, hard of hearing, or speech impaired, and who use a Teletypewriter (TTY), to communicate with others via the telephone. You simply type your conversation to a Relay Agent who then reads the typed conversation to the other party. The text telephone is used through a caller's wireless provider as long as they have a TTY compatible phone.

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

We want you to know that protecting the confidentiality of your individually identifiable health information is of the utmost importance to us. To review full details about our privacy practices, our legal duties, and your rights, please visit our website at MetLife.com/FederalDental and link to the "Privacy Policy" at the bottom MetLife Federal Dental's home page. If you do not have access to the internet or would like further information, please contact us by calling 1-888-865-6854. Furthermore, you may view the HIPAA information and other Personal Health Information beginning on page 52 of this document.

Discrimination is Against the Law

The MetLife Federal Dental Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, MetLife does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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How We Have Changed for 2027

Now covering the following CDT (Current Dental Terminology) procedure codes, for both Standard and High plan options, for eligible services incurred on or after January 1, 2027:

- D1209 Application of caries preventive medicament - topical non-fluoride; full mouth (Class A)
- D5521 Replace all teeth on complete denture - maxillary (Class B)
- D5522 Replace all teeth on complete denture - mandibular (Class B)
- D5859 Placement of semi-precision abutment - natural tooth (Class C)
- D6126 Replace all teeth and acrylic on hybrid prosthesis - per arch (Class C)
- D8689 Re-cement or re-bond orthodontic fixed appliance (Class D)
- D9937 Cleaning and inspection of occlusal orthotic device - per appliance (Class C)

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, 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. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.gov. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members are enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2026 Open Season, your coverage will begin on January 1, 2027. Premium deductions will start with the first full pay period beginning on/after January 1, 2027. You may use your benefits as soon as your enrollment is confirmed.
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. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Annual Enrollment Opportunity	Each year, an open season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, open season runs from November 9, 2026, through midnight EST December 14, 2026. You do not need to re-enroll each open season, unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual open season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.
Compliance with the American Dental Association (ADA)	FEDVIP abides by the Current Dental Terminology (CDT) codification system in accordance with standards set by the American Dental Association (ADA). *Current Dental Terminology (CDT)*, Copyright © American Dental Association. All rights reserved.

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, the Postal Service Health Benefits (PSHB) Program, or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation, you are eligible to enroll in FEDVIP. Enrollment in the FEHB Program, PSHB Program, or a Health Insurance Marketplace (Exchange) plan is not required.

Temporary / Seasonal Employees

Certain temporary, intermittent, and seasonal Federal and U.S. Postal Service employees are now eligible to enroll in FEDVIP. To be eligible, these employees must be expected to work 130 hours per calendar month for at least 90 days. In addition, certain firefighters hired under a temporary appointment and intermittent emergency response personnel are eligible to enroll in FEDVIP. The employing agency must determine and notify these employees of their eligibility.

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.

Your FEDVIP enrollment will continue 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 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB/PSHB Program.

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

Survivor Annuitants

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

Compensationers

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

TRICARE-eligible individual

An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan.

Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage.

Family Members

Except with respect to TRICARE-eligible individuals, 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/PSHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

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

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB/PSHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member.
- Active-duty uniformed service members. **Note:** If you are an active-duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).
- Temporary/seasonal employees who does not meet the 130 hours per calendar month for 90 days.

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.gov) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 711, International 1-571-730-5942 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans your enrollment will continue automatically. Please Note: your plan(s) premiums may change for 2027.

Note: You cannot enroll or change enrollment 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.

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

Dual Enrollment

If you or one of your family members are enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during the November 9, 2026 through midnight EST December 14, 2026, Open Season. Coverage is effective January 1, 2027.

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 may 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
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

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

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

The following chart lists the QLE's and the enrollment actions you may take:

Qualifying Life Event: Marriage
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Acquiring an eligible family member (non-spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing a covered family member
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: Yes
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Losing other dental/vision coverage (eligible or covered person)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: Yes
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Moving out of regional plan's service area
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes

Qualifying Life Event: Going on active military duty, non- pay status (enrollee or spouse)
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from active military duty (enrollee or spouse)
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Returning to pay status from Leave without pay
From Not Enrolled to Enrolled: Yes (if enrollment cancelled during LWOP)
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: Yes (if enrollment cancelled during LWOP)

Qualifying Life Event: Annuity/ compensation restored
From Not Enrolled to Enrolled: Yes
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: No
Change from One Plan to Another: No

Qualifying Life Event: Transferring to an eligible position*
From Not Enrolled to Enrolled: No
Increase Enrollment Type: No
Decrease Enrollment Type: No
Cancel: Yes
Change from One Plan to Another: No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium and you elect to enroll.

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, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

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.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either plan, you cannot change or cancel that particular enrollment until the next open season, unless you experience a QLE that allows such a change or cancellation.

VA Exception for Cancellation

Generally, you may cancel your enrollment only during the annual open season. However, if you are a FEDVIP enrollee paying premiums on a **post-tax basis**, and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may** change your enrollment type or cancel your enrollment within 60 days of receiving notification of VA dental or vision eligibility. This 60-day period may fall outside of open season. VA dental or vision eligibility documentation must be submitted to OPM via the BENEFEDS mailbox (benefedsportal@opm.gov) within 60 days of notification to support the FEDVIP enrollment change or cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the open season effective date. An eligible family member's coverage also ends upon the effective date of the cancellation.

If you are a FEDVIP enrollee paying premiums on a **pre-tax basis,** and you, your family member, or TEI family member becomes eligible for VA dental or vision benefits, then you **may not** change or cancel your FEDVIP enrollment until the next open season.

FEDVIP enrollees can verify if they are paying their premiums on a pre- or post- tax basis by contacting BENEFEDS at 1-877-888-3337, TTY number 711, International 1-571-730-5942.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- 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;
- cancel the enrollment during open season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

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

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

Continuation of Coverage

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

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

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

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

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in a FSAFEDS HealthCare Flexible Spending Account (HCFSA), Limited Expense Health Care Flexible Spending Account (LEX HCFSA), or any flexible spending account, 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.

Please review IRS - Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans (https://www.irs.gov/forms-pubs/about-publication-969) for additional information about carryover and contribution amounts for the upcoming tax year. If you have an HCFSA or LEX HCFSA FSAFEDS account and you have not exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over a set maximum amount of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st. You must also actively re-enroll in a health care or limited expense account during the next open season to be carryover eligible. Your re-enrollment must meet the minimum contribution amount for the plan year. If you do not re-enroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

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 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 the program next year. See https://www.fsafeds.gov or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058.**Note: FSAFEDS is not open to retired employees or to TRICARE eligible individuals.**

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB/PSHB and/or FEDVIP plans.

Section 3 How You Obtain Care

Identification Cards / Enrollment Confirmation

When you enroll for the first time, you will receive a welcome letter along with an identification card ("ID Card"). It is important to bring your FEDVIP and FEHB/PSHB ID card to every dental appointment because most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both ID cards can ensure that you receive the maximum allowable benefit under each Program. If you require a replacement ID card, you will be able to view and print your ID card via MyBenefits after entering www.MetLife.com/FederalDental. An 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.

If you were enrolled in the MetLife Federal Dental Plan in 2026 and continue coverage for 2027, MetLife will provide you with a confirmation letter only.

Where You Get Covered Care

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

Plan Providers

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

In-Network

Care that you receive from a MetLife Preferred Dentist Program (PPO) provider is considered In-Network. Plan participants are not required to select a primary care dentist and are free to select the dentist of their choice. MetLife's PPO network consists of independently credentialed and contracted providers. To find a dentist in your area go to: www.MetLife.com/FederalDental. You may also contact customer service at (888) 865-6854.

Out-of-Network

Care that you receive from a licensed provider that does not participate in the MetLife Preferred Dentist Program (PPO) is considered Out-of-Network. You are responsible for any difference between the plan payment and the amount billed.

Emergency Services

All expenses for emergency services are payable as any other expense and are subject to plan limitations such as frequencies, deductibles, and maximums. If you utilize the services of an Out-of-Network dentist for emergency services, benefits will be paid under the Out-of-Network Plan provisions. You are responsible for the difference between the Plan payment and billed charges.

Plan Allowance

The plan allowance is the maximum amount we will consider for payment for a specific procedure. The actual benefit will be a specified percentage of the plan allowance. When you use a participating (in-network) provider, your out-of-pocket cost is limited to the difference between the plan allowance and our payment. When you use services provided by a provider that does not participate in our network of providers, they are considered out-of-network services.

The Plan Allowance for Out-of-Network services will be equal to the In-Network Plan Allowance for the covered service (see page 61 for further details). When you use an Out-of-Network provider, you are responsible for the difference between the Plan Allowance and our payment plus the difference between the amount the provider bills and the Plan Allowance. Out-of-Network providers may charge their normal fees which may be greater than the Plan Allowance.

The Plan Allowance may vary by geographic location and/or a participating provider's contracted fee schedule.

Pre-Treatment Estimate

A pre-treatment estimate of benefits is recommended for any procedure which is anticipated to cost at least $300 or which involves mandatory consultant review. Mandatory consultant review applies to services such as but not limited to, periodontal services, crowns, bridges, inlays/onlays (when performed together) veneers, implants (when a plan provides benefits for these procedures) and overdentures, among other services. When your dentist suggests treatment, have them send a claim form, along with the proposed treatment plan and supporting documentation to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pre-treatment estimate depending upon annual maximums, deductibles, plan frequency limits and other plan provisions at time of payment.

Alternate Benefit

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

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

For example, when both a removable partial denture and fixed bridgework are professionally acceptable options for replacing multiple missing teeth in the same arch, the plan may base payment on the less costly treatment, which is the removable partial denture.

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

Dental Review

MetLife's claim review is conducted by licensed dentist consultants who review the clinical documentation submitted by your treating dentist. These dentist consultants review this material checking for dental necessity for certain procedures such as crowns, bridges, onlays, implants, periodontal treatments, as well as other services. The dentist consultants may also recommend that an alternate benefit be applied to a service in accordance with the terms of the plan. Therefore, we strongly recommend that you or your dentist request a pre-treatment estimate for services that are expected to cost at least $300, so that, you and your dentist are aware of the coverage terms and benefits before services are performed.

FEHB/PSHB First Payor

If you have dental coverage through your FEHB/PSHB plan and coverage under FEDVIP, your FEHB/PSHB plan will be the first payor of any benefit payments. When services are rendered by a provider, who participates with both your FEHB/PSHB and your FEDVIP plan, the FEDVIP Plan Allowance will prevail. We are responsible for facilitating the process with the primary FEHB/PSHB payor. You are responsible for the difference if any between the FEHB/PSHB and FEDVIP benefit payments and the FEDVIP Plan Allowance subject to any deductibles and benefits maximums. See examples 1 and 2 below.

It is important to bring your FEDVIP and FEHB/PSHB identification cards to every dental appointment because most FEHB/PSHB plans offer some level of dental benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Example 1: High Option coverage when services are provided by an In-Network provider.

When the covered individual has FEHB/PSHB coverage that offers dental benefits, FEHB/PSHB is always First Payor.

Services are provided by an In-Network Provider

Provider submitted charge for a one surface amalgam filling*: $108.00
In-Network fee: $60.00
FEHB/PSHB paid as first-payor (or MetLife's estimate): $16.00
MetLife benefits payable in the absence of FEHB/PSHB coverage: $42.00 ($60.00 at 70%).
Payment by MetLife: $42.00

Patient's responsibility to the provider: $2.00 ($60.00-$16.00-$42.00=$2.00).

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

Example 2: High Option coverage when services are provided by an Out-of-Network provider.

When the covered individual has FEHB/PSHB coverage that offers dental benefits, FEHB/PSHB is always First Payor.

Services are provided by an Out-of-Network Provider

Provider submitted charge for one surface amalgam filling*: $108.00
Plan Allowance**: $90.00
FEHB/PSHB payment as first payor (or MetLife's estimate): $16.00
MetLife benefits payable in the absence of FEHB/PSHB coverage: $54.00 ($90.00 x 60%).
Payment by MetLife**: $54.00

Patient's responsibility to the provider**: $38.00 ($108.00-$16.00-$54.00=$38.00)

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

**Assumes the provider charge is higher than MetLife's plan allowance. The plan allowance may vary by geographic location and/or a participating provider's contracted fee schedule.

Coordination of Benefits

If you are covered under a non-FEHB/non-PSHB plan, your MetLife Federal Dental benefits will be coordinated using traditional COB provisions for determining payment. Please see examples 1 and 2 below.

When benefits are coordinated between MetLife and a non-FEHB/non-PSHB carrier, the maximum allowable charge may vary depending upon the contractual relationship and contracted fee between MetLife and non-FEHB/non-PSHB carrier. The participant may be responsible for the difference between the combined non-FEHB/non-PSHB and MetLife benefit payment and the providers' allowable charge.

Example 1: Coordination of Benefits with High Option coverage when services are performed by an In-Network provider.

When MetLife is secondary to a non-FEHB/non-PSHB dental carrier.

Services are provided by an In-Network Provider

Provider submitted charge for two surface amalgam filling: $121.00
In-Network Fee: $73.00
Payable by Primary Carrier: $60.50
MetLife benefits payable in the absences of other insurance*: $51.10 ($73.00 at 70%)
Payment by MetLife: $12.50
Patient's responsibility to the provider **: $0 ($73.00 - $60.50 - $12.50 = $0.00)

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

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

Example 2: Coordination of Benefits with High Option coverage where services are provided by an Out-of-Network provider.

When MetLife is secondary to a non-FEHB/non-PSHB carrier

Services are provided by an Out-of-Network Provider

Provider submitted charge for 2 surface amalgam fillings: $113.00
Plan Allowance** $113.00:
Payment of Primary Carrier: $96.80
MetLife benefits payable in the absence of other insurance*: $67.80 ($113.00 x 60%)
Payment by MetLife: $16.20
Patient's responsibility to the provider **: $0 ($113.00 - $96.80 - $16.20 = $0)

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

**Assumes the provider charge is within MetLife's plan allowance. The plan allowance may vary be geographic location and/or a participating provider's contracted fee schedule.

Right of Recovery

If the amount we pay is more than we should have paid under the First Payor provision or when benefits are coordinated we may recover the excess from one or more of:

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

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services. However, in no circumstance will the member be responsible for a greater out of pocket amount then they would have been responsible for had there been no overpayment.

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. Your rates will not be impacted if you temporarily reside at another location

Limited Access Area

If you live in a limited access area and you receive covered services from an Out-of-Network provider, we will pay benefits based on our In-Network Plan Allowances. The determination of network adequacy is based on a ratio of Federal eligibles to network and general dentistry providers in a particular area. To determine if you are in a limited access area or specialty services are needed, please contact MetLife at (888) 865-6854*. MetLife reviews the limited access areas quarterly to ensure you have adequate access to our general dentistry In-Network providers. Therefore, we recommend you call (888) 865-6854 to confirm if you are still in a limited access area as your claim payment may be impacted. The limited access rule applies to general dentistry providers and specialty services. If the services must be provided by a specialist and one is not available in your area, please call us for assistance. If an In-Network provider (general or specialist) can perform a specialty service, then that service will be covered at the In-Network benefit. Please contact MetLife at (888) 865-6854 or visit our website at www.MetLife.com/FederalDental to obtain a list of In-Network general dentists in your area, who may be able to perform specialty services.

*Hearing and Speech impaired individuals may communicate using a text telephone device and Relay Services by dialing the MetLife Federal Dental number of "888-865-6854". Relay Services is immediate assistance. The Message Relay Service enables customers who are deaf, hard of hearing, or speech impaired, and who use a Teletypewriter (TTY), to communicate with others via the telephone. You simply type your conversation to a Relay Agent who then reads the typed conversation to the other party. The text telephone is used through a callers wireless provider as long as they have a TTY compatible phone.

Claim Determination Period

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

Should you experience a lapse in coverage during the calendar year, any benefits paid after reinstatement will be accrued to the maximums applicable to that same calendar year.

Section 4 Your Cost For Covered Services

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

Deductible

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

Class A
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $100

Class B
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $100

Class C
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $50
Out-of-Network Standard Option: $100

Orthodontics
In-Network High Option: $0
In-Network Standard Option: $0
Out-of-Network High Option: $0
Out-of-Network Standard Option: $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.

Class A
In-Network High Option: 0%
In-Network Standard Option: 0%
Out-of-Network High Option: 10%
Out-of-Network Standard Option: 40%

Class B
In-Network High Option: 30%
In-Network Standard Option: 45%
Out-of-Network High Option: 40%
Out-of-Network Standard Option: 60%

Class C
In-Network High Option: 50%
In-Network Standard Option: 65%
Out-of-Network High Option: 60%
Out-of-Network Standard Option: 80%

Orthodontics
In-Network High Option: 50%
In-Network Standard Option: 50%
Out-of-Network High Option: 50%
Out-of-Network Standard Option: 50%

Annual Benefit Maximum	Once you reach this amount, you are responsible for all additional charges. The Annual Benefit Maximums within each option are combined between In and Out-of-Network services. The total Annual Benefit Maximum will never be greater than the In-Network Annual Benefit Maximum. **Annual Benefits Maximum** In-Network High Option: Unlimited In-Network Standard Option: $2,000 Out-of-Network High Option: Unlimited Out-of-Network Standard Option: $2,000
Orthodontia Lifetime Benefit Maximum	The Orthodontia Lifetime Benefit Maximum is applicable to Orthodontia benefits only. There are no other lifetime maximums under this Plan. **Lifetime Orthodontia Maximum** In-Network High Option: $3,500 (child)/ $3,000 (adult) In-Network Standard Option: $1,500 Out-of-Network High Option: $3,500 (child)/ $3,000 (adult) Out-of-Network Standard Option: $1,500
In-Network Services	Care that you receive from a MetLife Preferred Dentist Program (PPO) provider is considered In-Network. Plan participants are not required to select a primary care dentist and are free to select the dentist of their choice. No referral process is needed for access to specialty care. In most cases, use of In-Network providers results in a lower out-of-pocket expense to you. If you reside in a limited access area your benefits will be paid at the In-Network benefit level. For additional information on limited access areas, please see Section 3, How You Obtain Care. Remember, for In-Network services you only pay the difference between the Plan Allowance for the covered service and the plan's benefit payment subject to any deductibles and benefits maximums.
Out-of-Network Services	All services rendered by an Out-of-Network dentist will be paid as Out-of-Network benefits. except for limited access benefits. The plan allowance for Out-of-Network services will be equal to the In-Network Plan Allowance for the covered service. The Out-of-Network Plan Allowance may vary be geographic location and/or a participating provider's contracted fee schedule. When you use an Out-of-Network provider, you are responsible for the difference between the Plan Allowance and our payment plus the difference between the amount the provider bills and the Plan Allowance
Calendar Year	The calendar year refers to the plan year, which is defined as January 1, 2027, to December 31, 2027.
Prorated Orthodontia Benefits	If orthodontia services are initiated prior to the effective date of coverage, we will prorate benefits. Twenty-five percent (25%) of the Plan Allowance is considered as the fee for initial placement of the appliance. Because this occurred prior to the effective date of coverage, it is considered a non- covered expense. The balance of the Plan Allowance, 75%, will be divided by the total number of monthly visits provided in the orthodontist's treatment plan. Benefits are payable at 50% of the Plan Allowance.
• **Standard Option Benefits**	**Actual Fee: $6,400**

Treatment Plan: 24 visits
Number of monthly visits (not covered): 14, Provided prior to being eligible for orthodontia benefits.
Number of monthly visits (covered): 10, 24 total visits minus 14 provided prior to being eligible for orthodontia benefits.
Plan Allowance for initial placement: $1,600, $6,400 x 25% = $1,600 (This is a non-covered expense as it occurred prior to being eligible for orthodontia benefits
Plan Allowance for monthly visits: $4,800, $6,400 - $1,600 = $4,800
Plan Allowance per visit: $200, $4,800 divided by 24
Total Plan Allowance for covered visits: $2,000, $200 times 10 covered visits
Total plan payment: $1,000, Benefit is 50% of Plan Allowance for covered services

- **High Option Benefits**

Actual Fee: **$6,400**

Treatment Plan: 24 visits
Number of monthly visits (not covered): 14, Provided prior to being eligible for orthodontia benefits.
Number of monthly visits (covered): 10, 24 total visits minus 14 provided prior to being eligible for orthodontia benefits.
Plan Allowance for initial placement: $1,600, $6,400 x 25% = $1,600. (This is a non-covered expense as it occurred prior to being eligible for orthodontia benefits)
Plan Allowance for monthly visits: $4,800, $6,400 - $1,600 = $4,800
Plan Allowance per visit: $200, $4,800 divided by 24
Total Plan Allowance for covered visits: $2,000, $200 x 10 covered visits
Total Plan Payment: $1,000, Benefit is 50% of Plan Allowance for covered orthodontia services

In-Progress Treatment

In-progress treatment for dependents of retiring active-duty service members who were enrolled in the TRICARE Dental Program (TDP) will be covered for the 2027 plan year, regardless of any current plan exclusion for care initiated prior to the enrollee's effective date.

This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2027 plan year such as crowns and implants.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0, if you use an In- Network- provider. There is no family deductible. If you elect to use an Out-of-Network provider, the Standard Option contains a $100 deductible per person, and the High Option has a $50 deductible per person. Neither Option contains a family deductible, each enrolled covered person must satisfy their own deductible. The calendar year deductible may apply to Type A expenses provided by an Out-of-Network provider.
- The Annual Benefit Maximum in the High Option for non-orthodontia services is unlimited, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontia services is $2,000 for In-Network services and $2,000 for Out-of-Network services. In no instance will MetLife allow more than $2,000 in combined benefits under the Standard Option in any plan year.
- Exams, oral evaluations and treatments such as fluorides and some images are combined under one limitation under the plan. D0210 Intraoral – comprehensive series of radiographic images and/or D0330 Panoramic radiographic image are combined and limited to one every 60 months. D0120 Periodic oral evaluation - established patient, D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver, D0150 Comprehensive oral evaluation - new or established patient, and D0180 Comprehensive periodontal evaluation - new or established patient are combined and limited to two exams in a 12-month period from the date services were last rendered. For example, if you have a periodic oral evaluation and a comprehensive oral examination both services are combined, so that, not more than the maximum allowable benefits and limitations are applied. D0140 Limited oral evaluation - problem focused is not combined with other examinations and has a separate frequency of one every 12 months.
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7. Please request a predetermination of benefits or reach out to MetLife directly if you have any questions regarding treatment coverage.

You Pay (subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** Nothing.
- **Out-of-Network:** 10% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network: Preventive and Diagnostic Services -** Nothing.
- **Out-of-Network:** 40% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Diagnostic and Treatment Services
D0120 Periodic oral evaluation - established patient - *Limited to 2 every 12 months*
D0140 Limited oral evaluation - problem focused - *Limited to 1 every 12 months and is not combined with other examination limitations or frequencies*
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver - *Limited to 2 every 12 months*
D0150 Comprehensive oral evaluation - new or established patient - *Limited to 2 every 12 months*
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0180 Comprehensive periodontal evaluation - new or established patient - *Limited to 2 every 12 months*
D0210 Intraoral – comprehensive series of radiographic images - *Limited to 1 every 60 (sixty) months*
D0220 Intraoral - periapical first radiographic image
D0230 Intraoral - periapical each additional radiographic image
D0240 Intraoral - occlusal radiographic image
D0270 Bitewing - single radiographic image - *Adult - 1 set every calendar year/Children - 1 set every 6 months*
D0272 Bitewings - two radiographic images - *Adult - 1 set every calendar year/Children - 1 set every 6 months*
D0273 Bitewings - three radiographic images
D0274 Bitewings - four radiographic images - *Adult - 1 set every calendar year/Children - 1 set every 6 months*
D0277 Vertical bitewings - 7 to 8 radiographic images – *Adult - 1 set every calendar year/Children - 1 set every 6 months*
D0330 Panoramic radiographic image – *Limited to 1 image every 60 (sixty) months*
D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
D0372 Intraoral tomosynthesis – comprehensive series of radiographic images - *Limited to 1 every 60 (sixty) months*
D0373 Intraoral tomosynthesis- bitewing radiographic image - *Limited to 1 set every 6 months*
D0374 Intraoral tomosynthesis – periapical radiographic image
D0396 3D printing of a 3D dental surface scan
D0415 Collection of microorganisms for culture and sensitivity
D0422 Collection and preparation of genetic sample material for laboratory analysis and report - *Limited to 1 per lifetime*
D0423 Analysis of genetic sample material for susceptibility to diseases - laboratory - *Limited to 1 per lifetime.*
D0470 Diagnostic casts
Preventive Services
D1110 Prophylaxis – adult - *Limited to 2 in 12 months; High Option only: a third cleaning is covered when paired with a diagnosis of pregnancy or diabetes at a limitation of 1 in 12 months*
D1120 Prophylaxis – child - *Limited to 2 in 12 months; High Option only: a third cleaning is covered when paired with a diagnosis of pregnancy or diabetes at a limitation of 1 in 12 months.*
D1206 Application of medicament - topical fluoride varnish; full mouth - *Limited to 1 in 12 months for adults, 2 every 12 months for dependent children based on age limits.*
D1208 Application of medicament - topical fluoride - excluding varnish; full mouth - *Limited to 2 every 12 months for dependent children based on age limits.*
D1209 Application of caries preventive medicament - topical non-fluoride; full mouth - *Limited to 1 in 12 months for adults, 2 every 12 months for dependent children based on age limits.*
D1351 Sealant - per tooth - *Limited to unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months*
D1353 Sealant repair –per tooth - *Limited to permanent teeth, 1 every 36 months*
D1354 Application of caries arresting medicament without surgical intervention - per tooth - *Limited to permanent teeth 1 per tooth every 36 months (Molars/Bicuspids excluding Wisdom Teeth).*
D1355 Application of medicament - primary prevention, or remineralization without surgical intervention; per tooth - *Limited to 1 every 36 months*

Preventive Services - continued on next page

Preventive Services (cont.)
D1510 Space maintainer - fixed, unilateral – per quadrant - *Limited to children under age 19*
D1516 Space maintainer - fixed - bilateral, maxillary - *Limited to children under age 19.*
D1517 Space maintainer - fixed - bilateral, mandibular - *Limited to children under age 19.*
D1520 Space maintainer - removable, unilateral - per quadrant - *Limited to children under age 19*
D1526 Space maintainer - removable - bilateral, maxillary - *Limited to children under age 19.*
D1527 Space maintainer - removable - bilateral, mandibular - *Limited to children under age 19.*
D1551 Re-cement or re-bond bilateral space maintainer - maxillary
D1552 Re-cement or re-bond bilateral space maintainer - mandibular
D1553 Re-cement or re-bond unilateral space maintainer - per quadrant
D1575 Distal shoe space maintainer - fixed, unilateral - per quadrant
Additional Procedures covered as Basic Services
D1999 Unspecified preventive procedure, by report
D9110 Palliative treatment of dental pain – per visit
D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311 Consultation with a medical health care professional
D9440 Office visit - after regularly scheduled hours
Services Not Covered: (Please refer to Section 7 for a list of General Exclusions)
D0320 Temporomandibular joint arthrogram, including injection
D0321 Other temporomandibular joint radiographic images, by report
D0322 Tomographic survey
D0387 Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only
D0388 Intraoral tomosynthesis – bitewing radiographic image – image capture only
D0389 Intraoral tomosynthesis – periapical radiographic image – image capture only
D0414 Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report
D0416 Viral culture
D0418 Analysis of saliva sample – laboratory
D0419 Assessment of salivary flow by measurement
D0425 Caries susceptibility tests
D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures
D0475 Decalcification procedure
D0476 Special stains for microorganisms
D0477 Special stains, not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ hybridization, including interpretation
D0481 Electron microscopy
D0482 Direct immunofluorescence
D0483 Indirect immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation, including preparation of slides from biopsy material supplied by referring source
D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report
D0600 Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D0604 Antigen testing for a public health related pathogen, including coronavirus
D0605 Antibody testing for a public health related pathogen, including coronavirus
D0606 Molecular testing for a public health related pathogen, including coronavirus
D0701 Panoramic radiographic image – image capture only
D0702 2-D cephalometric radiographic image – image capture only
D0703 2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only
D0705 Extra-oral posterior dental radiographic image – image capture only
D0706 Intraoral – occlusal radiographic image – image capture only
D0707 Intraoral – periapical radiographic image – image capture only
D0708 Intraoral – bitewing radiographic image – image capture only
D0709 Intraoral – comprehensive series of radiographic images – image capture only
D0801 3D intraoral surface scan – direct
D0802 3D dental surface scan – indirect
D0803 3D facial surface scan – direct
D0804 3D facial surface scan – indirect
D1301 Immunization counseling
D1310 Nutritional counseling for control of dental disease
D1320 Tobacco counseling for the control and prevention of oral disease
D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330 Oral hygiene instructions
D1556 Removal of fixed unilateral space maintainer - per quadrant
D1557 Removal of fixed bilateral space maintainer - maxillary
D1558 Removal of fixed bilateral space maintainer - mandibular
D1701 Pfizer-BioNTech Covid-19 vaccine administration – first dose
D1702 Pfizer-BioNTech Covid-19 vaccine administration – second dose
D1703 Moderna Covid-19 vaccine administration – first dose
D1704 Moderna Covid-19 vaccine administration – second dose
D1708 Pfizer-BioNTech Covid-19 vaccine administration – third dose
D1709 Pfizer-BioNTech Covid-19 vaccine administration – booster dose
D1710 Moderna Covid-19 vaccine administration – third dose
D1711 Moderna Covid-19 vaccine administration – booster dose
D1713 Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose
D1714 Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose
D1781 Vaccine administration – human papillomavirus – Dose 1
D1782 Vaccine administration – human papillomavirus – Dose 2
D1783 Vaccine administration – human papillomavirus – Dose 3

Class B Intermediate

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the minor restorative care or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0, if you use an In-Network provider. Should you elect to use an Out-of-Network provider, the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy their own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontia services is unlimited, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontia services is $2,000 for In-Network services and $2,000 for Out-of-Network services. In no instance will MetLife allow more than $2,000 in combined benefits under the Standard Option in any plan year.
- A number of the services listed in this section may be subject to Dental Review or an Alternate Benefit may be paid. We recommend that your dentist submit a pre-treatment estimate for any charges in excess of $300.
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7. Please request a predetermination of benefits or reach out to MetLife directly if you have any questions regarding treatment coverage.
- Replacement restorations (fillings) are limited to 1 in 24 months.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

You Pay (subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** 30% of the Plan Allowance
- **Out-of-Network:** 40% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network:** 45% of the Plan Allowance
- **Out-of-Network:** 60% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Minor Restorative Services
D0391 Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report
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 (anterior)
D2390 Resin-based composite crown - direct - *Limited to 1 every 60 months*
D2391 Resin-based composite - one surface, posterior
D2392 Resin-based composite - two surfaces, posterior
D2393 Resin-based composite - three surfaces, posterior
D2394 Resin-based composite - four or more surfaces, posterior
D2610 Inlay - porcelain/ceramic - one surface - *Limited to 1 every 60 months*
D2620 Inlay - porcelain/ceramic - two surfaces - *Limited to 1 every 60 months*
D2630 Inlay - porcelain/ceramic - three or more surfaces - *Limited to 1 every 60 months*
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 Re-cement or re-bond crown
D2921 Reattachment of tooth fragment, incisal edge or cusp
D2929 Prefabricated porcelain/ceramic crown – primary tooth - *Limited to 1 every 60 months*
D2930 Prefabricated stainless steel crown - primary tooth – *Under age 15 -Limited to 1 per tooth in 60 months*
D2931 Prefabricated stainless steel crown - permanent tooth - *Under age 15 - Limited to 1 per tooth in 60 months*
D2940 Placement of interim direct restoration
D2951 Pin retention - per tooth, in addition to restoration
D2976 Band stabilization – per tooth - *Limited to 1 every 60 months*
D2989 Excavation of a tooth resulting in the determination of non-restorability
Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - *If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.*
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - *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) - *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.*
D3355 Pulpal regeneration – initial visit - *Limited to 1 per lifetime.*
D3356 Pulpal regeneration – interim medication replacement - *Limited to 1 per lifetime.*
D3357 Pulpal regeneration – completion of treatment - *Limited to 1 per lifetime*

Periodontal Services
D4341 Periodontal scaling and root planing - four or more teeth per quadrant – *Limited to 1 every 24 months*
D4342 Periodontal scaling and root planing - one to three teeth per quadrant – *Limited to 1 every 24 months.*
D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation - *Limited to 2 in 12 months; High Option only: a third cleaning is covered when paired with a diagnosis of pregnancy or diabetes at a limitation of 1 in 12 months.*
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth
D4910 Periodontal maintenance – *Limited to 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy*
Prosthodontic Services
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture - mandibular
D5511 Repair complete denture base, mandibular
D5512 Repair complete denture base, maxillary
D5520 Replace missing or broken teeth – complete denture – per tooth
D5521 Replace all teeth on complete denture - maxillary - *Limited to 1 every 60 months*
D5522 Replace all teeth on complete denture - mandibular - *Limited to 1 every 60 months*
D5611 Repair resin partial denture base, mandibular
D5612 Repair resin partial denture base, maxillary
D5621 Repair cast partial framework, mandibular
D5622 Repair cast partial framework, maxillary
D5630 Repair or replace broken retentive clasping materials – per tooth
D5640 Replace missing or broken teeth – partial denture – per tooth
D5650 Add tooth to existing partial denture – per tooth
D5660 Add clasp to existing partial denture - per tooth
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*
D5725 Rebase hybrid prosthesis - *Limited to a 1 in a 36-month period 6 months after the initial installation*
D5730 Reline complete maxillary denture (direct) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5731 Reline complete mandibular denture (direct) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5740 Reline maxillary partial denture (direct) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5741 Reline mandibular partial denture (direct) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5750 Reline complete maxillary denture (indirect) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5751 Reline complete mandibular denture (indirect) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5760 Reline maxillary partial denture (indirect) - *Limited to 1 in a 36-month period 6 months after the initial installation*
D5761 Reline mandibular partial denture (indirect) - *Limited to 1 in a 36-month period 6 months after the initial installation.*
D5765 Soft liner for complete or partial removable denture – indirect - *Limited to a 1 in 36-month period 6 months after the initial installation*
D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6930 Re-cement or re-bond fixed partial denture
D6980 Fixed partial denture repair necessitated by restorative material failure
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
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 Removal of residual tooth roots (cutting procedure)
D7251 Coronectomy – intentional partial tooth removal, impacted teeth only
D7252 Partial extraction for immediate implant placement
D7270 Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Exposure of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7471 Removal of lateral exostosis (maxilla or mandible)
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7921 Collection and application of autologous blood concentrate product - *Limited to 1 every 36 months.*
D7953 Bone replacement graft for ridge preservation - per site
D7961 Buccal / labial frenectomy (frenulectomy)
D7962 Lingual frenectomy (frenulectomy)
D7971 Excision of pericoronal gingiva
D7999 Unspecified oral surgery procedure, by report
D9230 Administration of nitrous oxide - *Limited to when medically or dentally necessary*
Services Not Covered: (Please refer to Section 7 for a list of General Exclusions)
D7292 Placement of temporary anchorage device [screw retained plate] requiring flap
D7293 Placement of temporary anchorage device requiring flap
D7294 Placement of temporary anchorage device without flap
D7298 Removal of temporary anchorage device [screw retained plate], requiring flap
D7299 Removal of temporary anchorage device, requiring flap
D7300 Removal of temporary anchorage device without flap
D7880 Occlusal orthotic device, by report
D7881 Occlusal orthotic device adjustment
D7899 Unspecified TMD therapy, by report
D7922 Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952 Sinus augmentation via a vertical approach
D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7998 Intraoral placement of a fixation device not in conjunction with a fracture

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.
- All major prosthodontic services are combined under one replacement limitation under the plan. Benefits for prosthodontic services are combined and limited to one every 60 months. For example, if benefits for a partial denture are paid, this includes benefits to replace all missing teeth in the arch. No additional benefits for the arch would be considered until the 60 month replacement limit was met.
- Interim prosthodontic, if not replaced within 12 months, are then considered permanent and are subject to the replacement limitation under the plan of 1 every 60 months.
- 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-orthodontia services is unlimited, combined for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontia services is $2,000 for In-Network services and $2,000 for Out-of-Network services. In no instance will MetLife allow more than $2,000 of combined benefits under the Standard Option in any plan year.
- A number of the services listed in this section may be subject to Dental Review or an Alternate Benefit may be paid. MetLife recommends receiving a pre-treatment estimate **prior** to receiving services so you and your dental provider are aware of the coverage terms and benefits**.**
- All services requiring more than one visit are payable once all visits are completed.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7. Please request a predetermination of benefits or reach out to MetLife directly if you have any questions regarding treatment coverage.
- In-progress treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This is regardless of any current plan exclusions for care initiated prior to the enrollee's effective date.

You Pay(subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** 50% of the Plan Allowance
- **Out-of-Network:** 60% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network:** 65% of the Plan Allowance
- **Out-of-Network:** 80% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Major Restorative Services

Note: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/ or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc. was not placed while covered under MetLife, or paid by MetLife, the frequency limitations may apply).

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 or more 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 - *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 predominantly 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*

D2753 Crown - porcelain fused to titanium and titanium alloys - *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 predominantly 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 predominantly base metal – *Limited to 1 per tooth every 60 months*

D2792 Crown - full cast noble metal – *Limited to 1 per tooth every 60 months*

D2794 Crown - titanium and titanium alloys – *Limited to 1 per tooth every 60 months*

D2928 Prefabricated porcelain/ceramic crown – permanent tooth - *Limited to 1 per tooth every 60 months*

D2932 Prefabricated resin crown - *Limited to 1 per tooth every 60 months.*

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

D2952 Post and core in addition to crown, indirectly fabricated - *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 necessitated by restorative material failure

D2981 Inlay repair necessitated by restorative material failure

D2982 Onlay repair necessitated by restorative material failure

D2983 Veneer repair necessitated by restorative material failure

D2990 Resin infiltration of incipient smooth surface lesions - *Limited to 1 in 36 months*

D2991 Application of hydroxyapatite regeneration medicament – per tooth – *Limited to 1 in 36 months*

D2999 Unspecified restorative procedure, by report

Endodontic Services

D3310 Endodontic therapy, anterior tooth (excluding final restoration)

D3320 Endodontic therapy, premolar tooth (excluding final restoration)

D3330 Endodontic therapy, molar tooth (excluding final restoration)

D3346 Retreatment of previous root canal therapy - anterior

D3347 Retreatment of previous root canal therapy - premolar

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

Endodontic Services - continued on next page

Endodontic Services (cont.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)
D3410 Apicoectomy - anterior
D3421 Apicoectomy - premolar (first root)
D3425 Apicoectomy - molar (first root)
D3426 Apicoectomy (each additional root)
D3450 Root amputation - per root
D3471 Surgical repair of root resorption - anterior
D3472 Surgical repair of root resorption – premolar
D3473 Surgical repair of root resorption – molar
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption – molar
D3920 Hemisection (including any root removal), not including root canal therapy
D3921 Decoronation or submergence of an erupted tooth
D3999 Unspecified endodontic procedure, by report
Periodontal Services
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant - *Limited to 1 every 36 months*
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant - *Limited to 1 every 36 months*
D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth - *Limited to 1 every 36 months*
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 every 36 months*
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 every 36 months*
D4249 Clinical crown lengthening - hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 every 36 months*
D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant – *Limited to 1 every 36 months*
D4263 Bone replacement graft – retained natural tooth – first site in quadrant - *Limited to 1 every 36 months*
D4270 Pedicle soft tissue graft procedure
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft - *Limited to 1 every 36 months*
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site - *Limited to 1 every 36 months*
D4355 Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit – *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, retentive/clasping materials, rests, and teeth) – *Limited to 1 every 60 months*
D5212 Mandibular partial denture – resin base (including, retentive/clasping materials, rests, and teeth) – *Limited to 1 every 60 months*
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – *Limited to 1 every 60 months*
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) – *Limited to 1 every 60 months*
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) - *Limited to 1 every 60 months.*
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) - *Limited to 1 every 60 months.*
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *Limited to 1 every 60 months.*
D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) - *Limited to 1 every 60 months.*
D5227 Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth) - *Limited to 1 every 60 months*
D5228 Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth) - *Limited to 1 every 60 months*
D5282 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary - *Limited to 1 every 60 months*
D5283 Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular - *Limited to 1 every 60 months*
D5284 Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth) – per quadrant - *Limited to 1 every 60 months.*
D5286 Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth) – per quadrant - *Limited to 1 every 60 months.*
D5859 Placement of semi-precision abutment - natural tooth - *Limited to 1 every 60 months*
D5876 Add metal substructure to acrylic complete denture – per arch - *Limited to 1 every 60 months*
D5877 Duplication of complete denture – maxillary - *Limited to 1 per 60 consecutive months, combined with D5110 Complete denture - maxillary*
D5878 Duplication of complete denture – mandibular - *Limited to 1 per 60 consecutive months, combined with D5120 Complete denture - mandibular*
D5899 Unspecified removable prosthodontic procedure, by report
Note: An **implant** is a covered procedure of the plan only if determined to be a dental necessity. MetLife claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.
D6010 Surgical placement of implant body: endosteal implant - *Limited to 1 every 60 months*
D6012 Surgical placement of interim implant body for transitional prosthesis: endosteal implant - *Limited to 1 every 60 months*
D6040 Surgical placement: eposteal implant – *Limited to 1 every 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6049 Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure - *Limited to 1 in 12 months*
D6050 Surgical placement: transosteal implant – *Limited to 1 every 60 months*
D6055 Connecting bar – implant supported or abutment supported - *Limited to 1 every 60 months*
D6056 Prefabricated abutment – includes modification and placement – *Limited to 1 every 60 months*
D6057 Custom fabricated abutment – includes placement - *Limited to 1 every 60 months*
D6058 Abutment supported porcelain/ceramic crown - *Limited to 1 every 60 months*
D6059 Abutment supported porcelain fused to metal crown (high noble metal) - *Limited to 1 every 60 months*
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal) - *Limited to 1 every 60 months*
D6061 Abutment supported porcelain fused to metal crown (noble metal) - *Limited to 1 every 60 months*
D6062 Abutment supported cast metal crown (high noble metal) - *Limited to 1 every 60 months*
D6063 Abutment supported cast metal crown (predominantly base metal) - *Limited to 1 every 60 months*
D6064 Abutment supported cast metal crown (noble metal) - *Limited to 1 every 60 months*
D6065 Implant supported porcelain/ceramic crown - *Limited to 1 every 60 months*
D6066 Implant supported crown - porcelain fused to high noble alloys - *Limited to 1 every 60 months*
D6067 Implant supported crown - high noble alloys - *Limited to 1 every 60 months*
D6068 Abutment supported retainer for porcelain/ceramic FPD - *Limited to 1 every 60 months*
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal) - *Limited to 1 every 60 months*
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) - *Limited to 1 every 60 months*
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal) - *Limited to 1 every 60 months*
D6072 Abutment supported retainer for cast metal FPD (high noble metal) - *Limited to 1 every 60 months*
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal) - *Limited to 1 every 60 months*
D6074 Abutment supported retainer for cast metal FPD (noble metal) - *Limited to 1 every 60 months*
D6075 Implant supported retainer for ceramic FPD - *Limited to 1 every 60 months*
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys - *Limited to 1 every 60 months*
D6077 Implant supported retainer for metal FPD - high noble alloys - *Limited to 1 every 60 months*
D6080 Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments - *Limited to 1 every 60 months*
D6081 Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure - *Limited to 1 every 60 months*
D6082 Implant supported crown – porcelain fused to predominantly base alloys - *Limited to 1 every 60 months*
D6083 Implant supported crown – porcelain fused to noble alloys - *Limited to 1 every 60 months*
D6084 Implant supported crown – porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6086 Implant supported crown – predominantly base alloys - *Limited to 1 every 60 months*
D6087 Implant supported crown – noble alloys - *Limited to 1 every 60 months*
D6088 Implant supported crown – titanium and titanium alloys - *Limited to 1 every 60 months*
D6089 Accessing and retorquing loose implant screw – per screw
D6090 Repair of implant/abutment supported prosthesis - *Limited to 1 every 60 months*
D6091 Replacement of replaceable part of semi-precision attachment of implant/abutment retained prosthesis, per attachment - *Limited to 1 every 60 months*
D6096 Remove broken implant retaining screw - *Limited to 1 every 12 months*
D6097 Abutment supported crown - porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6098 Implant supported retainer – porcelain fused to predominantly base alloys - *Limited to 1 every 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6099 Implant supported retainer for FPD – porcelain fused to noble alloys - *Limited to 1 every 60 months*
D6100 Surgical removal of implant body - *Limited to 1 every 60 months*
D6101 Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure - *Limited to 1 every 60 months*
D6102 Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure - *Limited to 1 every 60 months*
D6103 Bone graft for repair of peri-implant defect – does not include flap entry and closure
D6104 Bone graft at time of implant placement
D6105 Removal of implant body not requiring bone removal or flap elevation - *Limited to 1 every 60 months*
D6106 Guided tissue regeneration – resorbable barrier, per implant - *Limited to 1 every 36 months*
D6107 Guided tissue regeneration – non-resorbable barrier, per implant - *Limited to 1 every 36 months*
D6110 Implant /abutment retained removable denture for edentulous arch - maxillary -*Limited to 1 every 60 months*
D6111 Implant /abutment retained removable denture for edentulous arch - mandibular - *Limited to 1 every 60 months*
D6112 Implant /abutment retained removable denture for partially edentulous arch - maxillary - *Limited to 1 every 60 months*
D6113 Implant /abutment retained removable denture for partially edentulous arch - mandibular - *Limited to 1 every 60 months*
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary - *Limited to 1 every 60 months*
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular - *Limited to 1 every 60 months*
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary - *Limited to 1 every 60 months*
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular - *Limited to 1 every 60 months*
D6120 Implant supported retainer – porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6121 Implant supported retainer for metal FPD – predominantly base alloys - *Limited to 1 every 60 months*
D6122 Implant supported retainer for metal FPD – noble alloys - *Limited to 1 every 60 months*
D6123 Implant supported retainer for metal FPD – titanium and titanium alloys - *Limited to 1 every 60 months*
D6126 Replace all teeth and acrylic on hybrid prosthesis - per arch - *Limited to 1 every 60 months*
D6180 Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments - *Limited to 1 every 60 months*
D6190 Radiographic/surgical implant index, by report - *Limited to 1 every 60 months*
D6191 Placement of semi-precision abutment - implant body - *Limited to 1 every 60 months*
D6192 Semi-precision attachment – placement - *Limited to 1 every 60 months*
D6193 Replacement of an implant screw - *Limited to 1 every 12 months*
D6195 Abutment supported retainer – porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6197 Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant
D6210 Pontic - cast high noble metal – *Limited to 1 every 60 months*
D6211 Pontic - cast predominantly base metal – *Limited to 1 every 60 months*
D6212 Pontic - cast noble metal – *Limited to 1 every 60 months*
D6214 Pontic - titanium and titanium alloys – *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 predominantly base metal – *Limited to 1 every 60 months*
D6242 Pontic - porcelain fused to noble metal – *Limited to 1 every 60 months*
D6243 Pontic – porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6245 Pontic - porcelain/ceramic – *Limited to 1 every 60 months*

Prosthodontic Services - continued on next page

Prosthodontic Services (cont.)
D6280 Implant maintenance procedures when a full arch removable implant/abutment retained denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch - *Limited to 1 in 12 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 - *Limited to 1 every 60 months*
D6549 Retainer – resin bonded fixed prosthesis - *Limited to 1 every 60 months*
D6740 Retainer crown - porcelain/ceramic - *Limited to 1 every 60 months*
D6750 Retainer crown - porcelain fused to high noble metal - *Limited to 1 every 60 months*
D6751 Retainer crown - porcelain fused to predominantly base metal - *Limited to 1 every 60 months*
D6752 Retainer crown - porcelain fused to noble metal - *Limited to 1 every 60 months*
D6753 Retainer crown – porcelain fused to titanium and titanium alloys - *Limited to 1 every 60 months*
D6780 Retainer crown - 3/4 cast high noble metal - *Limited to 1 every 60 months*
D6781 Retainer crown - 3/4 cast predominantly base metal - *Limited to 1 every 60 months*
D6782 Retainer crown - 3/4 cast noble metal - *Limited to 1 every 60 months*
D6783 Retainer crown - 3/4 porcelain/ceramic - *Limited to 1 every 60 months*
D6784 Retainer crown - 3/4 - titanium and titanium alloys - *Limited to 1 every 60 months*
D6790 Retainer crown - full cast high noble metal - *Limited to 1 every 60 months*
D6791 Retainer crown - full cast predominantly base metal - *Limited to 1 every 60 months*
D6792 Retainer crown - full cast noble metal - *Limited to 1 every 60 months*
D6794 Retainer crown - titanium and titanium alloys
D6999 Unspecified fixed prosthodontic procedure, by report
D9932 Cleaning and inspection of removable complete denture, maxillary - *Limited to 1 every 6 months*
D9933 Cleaning and inspection of removable complete denture, mandibular - *Limited to 1 every 6 months*
D9934 Cleaning and inspection of removable partial denture, maxillary - *Limited to 1 every 6 months*
D9935 Cleaning and inspection of removable partial denture, mandibular - *Limited to 1 every 6 months*
D9937 Cleaning and inspection of occlusal orthotic device - per appliance - *Limited to 1 every 6 months*
D9942 Repair and/or reline of occlusal guard - *Limited to 1 every 24 months for patients 13 and older.*
D9943 Occlusal guard adjustment - *Limited to 1 every 24 months for patients 13 and older.*
D9944 Occlusal guard - hard appliance, full arch - *Limited to 1 in 24 months for patients 13 and older.*
D9945 Occlusal guard - soft appliance, full arch - *Limited to 1 in 24 months for patients 13 and older.*
D9946 Occlusal guard - hard appliance, partial arch - *Limited to 1 in 24 months for patients 13 and older.*
D9954 Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device – *Limited to 1 in 12 months*
D9955 Oral appliance therapy (OAT) titration visit – *Limited to 1 in 12 months.*
Services Not Covered: (Please refer to Section 7 for a list of General Exclusions)
D0171 Re-evaluation - post-operative office visit
D2410 Gold foil - one surface
D2420 Gold foil - two surfaces
D2430 Gold foil - three surfaces
D2799 Interim crown – further treatment or completion of diagnosis necessary prior to final impression
D2955 Post removal
D2975 Coping
D3460 Endodontic endosseous implant
D3470 Intentional re-implantation (including necessary splinting)
D3910 Surgical procedure for isolation of tooth with rubber dam
D3911 Intraorifice barrier

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D3950 Canal preparation and fitting of preformed dowel or post
D4230 Anatomical crown exposure – four or more contiguous teeth or tooth bounded spaces per quadrant
D4231 Anatomical crown exposure – one to three teeth or tooth bounded spaces per quadrant
D4286 Removal of non-resorbable barrier
D4322 Splint – intra-coronal; natural teeth or prosthetic crowns
D4323 Splint – extra-coronal; natural teeth or prosthetic crowns
D5810 Interim complete denture (maxillary)
D5811 Interim complete denture (mandibular)
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary
D5821 Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular
D5862 Precision attachment, by report
D5867 Replacement of replaceable part of semi-precision attachment of natural tooth borne prosthesis, per attachment
D5986 Fluoride gel carrier
D6051 Placement of interim implant abutment
D6085 Interim implant crown
D6118 Implant/abutment supported interim fixed denture for edentulous arch – mandibular
D6119 Implant/abutment supported interim fixed denture for edentulous arch – maxillary
D6198 Remove interim implant component
D6199 Unspecified implant procedure, by report
D6253 Interim pontic - further treatment or completion of diagnosis necessary prior to final impression
D6793 Interim retainer crown - further treatment or completion of diagnosis necessary prior to final impression
D6920 Connector bar
D6940 Stress breaker
D6950 Precision attachment
D9219 Evaluation for moderate sedation, deep sedation or general anesthesia
D9986 Missed appointment
D9987 Cancelled appointment
D9991 Dental case management - addressing appointment compliance barriers
D9992 Dental case management - care coordination
D9993 Dental case management - motivational interviewing
D9994 Dental case management - patient education to improve oral health literacy
D9997 Dental case management – patients with special health care needs

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.
- Adults (Members and Spouses) are eligible for a $3,000 orthodontia lifetime maximum benefit in the High Option. Adults in the Standard Option will have a lifetime maximum benefit of $1,500.
- The lifetime maximum benefit for a child receiving orthodontia services depends on the option in which you enroll and if services are received from a network provider. If you are covered by the High Option, the lifetime maximum benefit is $3,500. The lifetime maximum benefit is $1,500 under the Standard Option.
- The benefit payable for the initial placement will not exceed 25% of the Lifetime Maximum Benefit Amount for the appliance. All supplemental payments will be made in equal installments pro-rated over the balance of a maximum period of 29 months. Should your coverage terminate or your child reach the coverage age limit, your dependent child's orthodontia benefit payments will end.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7. Please request a predetermination of benefits or reach out to MetLife directly if you have any questions regarding treatment coverage.
- In-progress orthodontia treatment for dependents of retiring TDP enrollees will be covered for the 2027 plan year. This requirement includes assumption of payments for covered orthodontia services up to the FEDVIP policy limits, and full payment where applicable up to the terms of FEDVIP policy for covered services completed (but not initiated) in the 2026 plan year.

You Pay (subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** 50% of the Plan Allowance
- **Out-of-Network:** 50% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network:** 50% of the Plan Allowance.
- **Out-of-Network:** 50% of the Plan Allowance plus any amount over the Plan Allowance billed by the provider.

Orthodontia Services

D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8040 Limited orthodontic treatment of the adult dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8091 Comprehensive orthodontic treatment with orthognathic surgery

Orthodontia Services - continued on next page

Orthodontia Services (cont.)
D8210 Adjunctive orthodontic therapy - removable appliance
D8220 Adjunctive orthodontic therapy - fixed appliance
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit
D8671 Periodic orthodontic treatment visit associated with orthognathic surgery
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8689 Re-cement or re-bond orthodontic fixed appliance

Services Not Covered:

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

- Repair of orthodontic appliance/retainer.
- Removable orthodontic retainer adjustment.
- Replacement of lost or broken appliance/retainer.
- Re-cement or re-bond retainer.
- 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.
- Removal of fixed orthodontic appliances for reasons other than completion of treatment
- Orthodontic care for dependent children age 22 and over for Federal civilian employees.
- Orthodontic care for dependent children age 21 and over OR full-time students age 23 and over for TRICARE eligible enrollees.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, minor restorative care or treatment of a covered condition and meet generally accepted dental protocols.
- The calendar year deductible is $0 if you use an In-Network provider. Should you elect to use an Out-of-Network provider the Standard Option contains a $100 deductible per covered person, and the High Option has a $50 deductible per covered person. Neither Option contains a family deductible; each enrolled covered person must satisfy their own deductible.
- The Annual Benefit Maximum in the High Option for non-orthodontia services is unlimited, combined, for both In-Network and Out-of-Network services. The Standard Option Annual Benefit Maximum for non-orthodontia services is $2,000 for In-Network services and $2,000 for Out-of-Network services. In no instance will MetLife allow more than $2,000 in combined benefits under the Standard Option in any plan year.
- The following list of services includes those services most commonly provided to covered individuals. It is not an all-inclusive list of covered services. MetLife will provide benefits for ADA codes not included in the following list, subject to the exclusions and limitations shown in this section and Section 7. Please request a predetermination of benefits or reach out to MetLife directly if you have any questions regarding treatment coverage.

You Pay (subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** 30% of the Plan Allowance
- **Out-of-Network:** 40% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network:** 45% of the Plan Allowance
- **Out-of-Network:** 60% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

For Anesthesia Services:

You Pay (subject to any deductibles, plan limitations and maximums):

High Option

- **In-Network:** 50% of the Plan Allowance
- **Out-of-Network:** 60% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Standard Option

- **In-Network:** 65% of the Plan Allowance
- **Out-of-Network:** 80% of the Plan Allowance plus any amount above the Plan Allowance billed by the provider.

Anesthesia Services
D9222 Administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof
D9223 Administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof
D9224 Administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof
D9225 Administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof
Intravenous & Non-Intravenous Sedation Services
D9239 Administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof
D9243 Administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof
D9244 In-office administration of minimal sedation – single drug – enteral
D9245 Administration of moderate sedation – enteral
D9246 Administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof
D9247 Administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof
Medications
D9610 Therapeutic parenteral drug, single administration
D9613 Infiltration of sustained release therapeutic drug, per quadrant
Adjunctive General Services
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report
D9936 Cleaning and inspection of occlusal guard – per appliance - *Limited to once every 6 consecutive months*
Services Not Covered: (Please refer to Section 7 for a list of General Exclusions)
D0310 Sialography
D0472 Accession of tissue, gross examination, preparation and transmission of written report
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report
D0480 Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report
D0502 Other oral pathology procedures, by report
D5911 Facial moulage (sectional)
D5912 Facial moulage (complete)
D5913 Nasal prosthesis
D5914 Auricular prosthesis
D5915 Orbital prosthesis
D5916 Ocular prosthesis
D5919 Facial prosthesis
D5922 Nasal septal prosthesis
D5923 Ocular prosthesis, interim
D5924 Cranial prosthesis
D5925 Facial augmentation implant prosthesis
D5926 Nasal prosthesis, replacement
D5927 Auricular prosthesis, replacement
D5928 Orbital prosthesis, replacement
D5929 Facial prosthesis, replacement
D5931 Obturator prosthesis, surgical
D5932 Obturator prosthesis, definitive

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D5933 Obturator prosthesis, modification
D5934 Mandibular guidance prosthesis with guide flange
D5935 Mandibular guidance prosthesis without guide flange
D5936 Obturator prosthesis, interim
D5937 Trismus appliance (not for TMD treatment)
D5951 Feeding aid
D5952 Speech aid prosthesis, pediatric
D5953 Speech aid prosthesis, adult
D5954 Palatal augmentation prosthesis
D5955 Palatal lift prosthesis, definitive
D5958 Palatal lift prosthesis, interim
D5959 Palatal lift prosthesis, modification
D5960 Speech aid prosthesis, modification
D5982 Surgical stent for soft tissue healing
D5983 Radiation carrier
D5984 Radiation shield
D5985 Radiation cone locator
D5987 Commissure splint
D5988 Surgical splint
D5992 Adjust maxillofacial prosthetic appliance, by report
D5993 Cleaning and inspection of a maxillofacial prosthesis (extra or intra-oral), by report
D7284 Excisional biopsy of minor salivary glands
D7285 Incisional biopsy of oral tissue-hard (bone, tooth)
D7286 Incisional biopsy of oral tissue-soft
D7295 Harvest of bone for use in autogenous grafting procedure
D7410 Excision of benign lesion up to 1.25 cm
D7411 Excision of benign lesion greater than 1.25 cm
D7412 Excision of benign lesion, complicated
D7413 Excision of malignant lesion up to 1.25 cm
D7414 Excision of malignant lesion greater than 1.25 cm
D7415 Excision of malignant lesion, complicated
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465 Destruction of lesion(s) by physical or chemical method, by report
D7490 Radical resection of maxilla or mandible
D7509 Marsupialization of odontogenic cyst
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540 Removal of reaction producing foreign bodies, musculoskeletal system
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610 Maxilla - open reduction (teeth immobilized, if present)
D7620 Maxilla - closed reduction (teeth immobilized, if present)

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D7630 Mandible - open reduction (teeth immobilized, if present)
D7640 Mandible - closed reduction (teeth immobilized, if present)
D7650 Malar and/or zygomatic arch - open reduction
D7660 Malar and/or zygomatic arch - closed reduction
D7670 Alveolus - closed reduction, may include stabilization of teeth
D7671 Alveolus - open reduction, may include stabilization of teeth
D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710 Maxilla - open reduction
D7720 Maxilla - closed reduction
D7730 Mandible - open reduction
D7740 Mandible - closed reduction
D7750 Malar and/or zygomatic arch - open reduction
D7760 Malar and/or zygomatic arch - closed reduction
D7770 Alveolus - open reduction stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones - complicated reduction with fixation and multiple approaches
D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7830 Manipulation under anesthesia
D7840 Condylectomy
D7850 Surgical discectomy, with/without implant
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-arthroscopic lysis and lavage
D7872 Arthroscopy - diagnosis, with or without biopsy
D7873 Arthroscopy: lavage and lysis of adhesions
D7874 Arthroscopy: disc repositioning and stabilization
D7875 Arthroscopy: synovectomy
D7876 Arthroscopy: discectomy
D7877 Arthroscopy: debridement
D7911 Complicated suture - up to 5 cm
D7912 Complicated suture - greater than 5 cm
D7920 Skin graft (identify defect covered, location and type of graft)
D7939 Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940 Osteoplasty - for orthognathic deformities
D7941 Osteotomy - mandibular rami
D7943 Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944 Osteotomy - segmented or subapical
D7945 Osteotomy - body of mandible

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D7946 LeFort I (maxilla - total)
D7947 LeFort I (maxilla - segmented)
D7948 LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949 LeFort II or LeFort III - with bone graft
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7955 Repair of maxillofacial soft and/or hard tissue defect
D7956 Guided tissue regeneration, edentulous area – resorbable barrier, per site
D7957 Guided tissue regeneration, edentulous area – non-resorbable barrier, per site
D7979 Non-surgical sialolithotomy
D7980 Surgical sialolithotomy
D7981 Excision of salivary gland, by report
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7993 Surgical placement of craniofacial implant – extra oral
D7994 Surgical placement: zygomatic implant
D7995 Synthetic graft - mandible or facial bones, by report
D7996 Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D9130 Temporomandibular joint dysfunction - non-invasive physical therapies - each 15 minute increment, or portion thereof
D9210 Local anesthesia not in conjunction with operative or surgical procedures
D9211 Regional block anesthesia
D9212 Trigeminal division block anesthesia
D9215 Local anesthesia in conjunction with operative or surgical procedures
D9410 House/extended care facility call
D9420 Hospital or ambulatory surgical center call
D9450 Case presentation, subsequent to detailed and extensive treatment planning
D9630 Drugs or medicaments dispensed in the office for home use
D9912 Pre-visit patient screening
D9920 Behavior management, by report
D9938 Fabrication of a custom removable clear plastic temporary aesthetic appliance
D9939 Placement of a custom removable clear plastic temporary aesthetic appliance
D9941 Fabrication of athletic mouthguard
D9947 Custom sleep apnea appliance fabrication and placement
D9948 Adjustment of custom sleep apnea appliance
D9949 Repair of custom sleep apnea appliance
D9950 Occlusion analysis - mounted case
D9951 Occlusal adjustment - limited
D9952 Occlusal adjustment - complete
D9953 Reline custom sleep apnea appliance (indirect)
D9956 Administration of home sleep apnea test
D9957 Screening for sleep related breathing disorders
D9961 Duplicate/copy patient's records

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) - continued on next page

Services Not Covered: (Please refer to Section 7 for a list of General Exclusions) (cont.)
D9970 Enamel microabrasion
D9971 Odontoplasty - per tooth
D9972 External bleaching - per arch - performed in office
D9973 External bleaching - per tooth
D9974 Internal bleaching - per tooth
D9975 External bleaching for home application, per arch; includes materials and fabrication of custom trays
D9990 Certified translation or sign-language services – per visit

Section 6 International Services and Supplies

International Claims Payment	We will pay benefits, subject to plan provisions, in an amount equal to the covered percentage for the charges incurred by you. All payments will be made in U.S. currency.
Finding an International Provider	International employees and their dependents may contact AXA Assistance USA (AXA) for referral to dental providers outside of the continental United States or may use the dentist of their choice. The process involves a plan participant calling AXA at (312) 935-9210 collect or (866) 384-2771 to find a local provider in their country. International participants will receive In-Network benefit when services are performed by an Out-of-Network internationally located provider.
Filing International Claims	The plan participant will be responsible for paying the dentist and submitting the claims to MetLife for reimbursement at the following address. Mail completed claim form to: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
International Rates	There is one international region. Please see the rate table for the actual premium amount.

Section 7 General Exclusions – Things We Do Not Cover

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

We do not cover the following:

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

- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- Charges by the provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
- Cone Beam Imaging and Cone Beam MRI procedures;
- Sealants for teeth other than permanent molars;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Orthodontic care for dependent children age 22 and over for federal civilian employees.
- Orthodontic care for dependent children age 21 and over OR full-time students age 23 and over for TRICARE eligible enrollees.
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Oral sedation;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants;
- When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by MetLife.
- When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by MetLife.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your claims please have your dentist submit your claims directly to MetLife for payment.

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 www.MetLife.com/FederalDental

Mail completed claim form to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

When a claimant files a claim for dental insurance benefits described in this brochure, both the notice of claim and the required Proof should be sent to us within 90 days of the date of a 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

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. **FEDVIP legislation does not provide a role for OPM to review disputed claims.**

Step 1:

Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and mail your additional proof to us within 180 days from the date of receipt of our decision.

Step 2:

Send your request for reconsideration to:

MetLife Dental Claims Appeals

P.O. Box 14589

Lexington, KY 40512

We will review your request and provide you with a written or electronic explanation of benefit determination within 30 days of the receipt of your request.

Step 3:

If you disagree with the decision regarding your request for reconsideration, you may request a second review of the denial. You must submit your request to us in writing to the address shown above 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.

Step 4:

If you do not agree with our final decision, under certain circumstances you may request an independent third party, mutually agreed upon by MetLife and OPM, review the decision. To qualify for this independent third party review the charge for the procedure in question must be in excess of $300 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, for example, a bridge being given an alternate benefit of a partial denture.

The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

If the matter is not eligible for this third level of review, the second level of review is binding and is the final remedy available to you. This decision is not subject to judicial review.

Initial Determination

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

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

Overpayments

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

An overpayment occurs if we determine that:

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

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

Recovery of Dental Insurance Overpayments

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

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

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

If such payment occurs, you have an obligation to reimburse us any monies you have received over and above what your normal out of pocket would have been had the overpayment not occurred.

HIPAA Privacy Practices

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

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

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

We are required to provide notice of our privacy practices for Personal Health Information to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.metlife.com/about-us/privacy-policy/ or www.metlife.com. You may submit questions to us there or you may write to us directly at MetLife, Americas-U.S. HIPAA Privacy Office PO Box 902, New York, NY 10159-0902

We are required by law to:

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

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

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

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

For Payment:	We may use and disclose Personal Health Information to pay benefits under the MetLife Federal Dental Plan. For example, we may review Personal Health Information contained in claims to reimburse providers for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.
For Health Care Operations	We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for dental insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates, and to business associates outside of the MetLife family of companies, if they need to receive Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health information organization, e-prescribing gateways or personal health record vendors that provide services to covered entities. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons. Personal Health Information may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.
Where Required by Law or for Public Health Activities	We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
To Avert a Serious Threat to Health or Safety	We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
For Health-Related Benefits or Services	We may use your Personal Health Information to provide you with information about benefits available to you under your current coverage and, in limited situations, about health-related products or services that may be of interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.
For Law Enforcement or Specific Government Functions	We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
When Requested as Part of a Regulatory or Legal Proceeding	If you or your estate are involved in a lawsuit or a dispute, we may disclose Personal Health Information about you in response to a court or administrative order. We may also disclose Personal Health Information about you in response to a subpoena, discovery request, or other lawful process. But only if efforts have been made to tell you about the request or to obtain an order protecting the Personal Health Information requested. We may disclose Personal Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

Other Uses of Personal Health Information

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

Your Rights Regarding Personal Health Information We Maintain About You

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

Right to Inspect and Copy Your Personal Health Information

In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to MetLife Dental P.O. Box 14587, Lexington, KY 40512-4587. If we maintain the requested Personal Health Information electronically, you may ask us to provide you with the Personal Health Information in electronic format if readily producible or if not, in a readable electronic form and format agreed by you and us. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing, electronic media or other supplies associated with your request. You may also direct us to send the Personal Health Information you have requested to another person designated by you so long as your request is in writing and clearly identifies the designated individual. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Right to Amend Your Personal Health Information

If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to MetLife Dental P.O. Box 14587, Lexington, KY 40512-4587. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
- is not part of the Personal Health Information kept by or for us; or
- is not part of the Personal Health Information, which you would be permitted to inspect and copy.

Right to a List of Disclosures	You have the right to request a list of the disclosures we have made of your Personal Health Information. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement to corrections personnel or to your authorization or directly to you. To request this list, you must submit your request in writing to MetLife Dental P.O. Box 14587, Lexington, KY 40512-4587. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (For example, on paper or electronically). The first list you request within a 12- month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before you incur any cost.
Right to Request Restrictions	You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to MetLife Dental P.O. Box 14587, Lexington, KY 40512-4587. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.
Right to Request Confidential Communications	You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to MetLife Dental P.O. Box 14587, Lexington, KY 40512-4587 and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
Right to File a Complaint	If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, America's-U.S. HIPAA Privacy Office P.O. Box 902, New York, NY 10159-0902 All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as how to file a complaint please contact us at (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com
Changes to Our HIPAA Privacy Practices	We reserve the right to change the terms of our HIPAA privacy practices for Personal Health Information at any time. We reserve the right to make the revised or changed practices effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future. You will receive a copy of any revised notice from MetLife by mail or by e-mail, but only if e-mail delivery is offered by MetLife and you agree to such delivery.
Additional Information	You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at (212) 578-0299, or write to us at MetLife, U.S. HIPAA Privacy Office P.O. Box 902 New York, NY 10159-0902.

Section 9 Definitions of Terms We Use in This Brochure

Alternate Benefit	If we determine a service less costly than the one performed by your dentist could have been performed by your dentist, we will pay benefits based upon the less costly services. See Section 3 How You Obtain Care for a definition of alternate benefit.
Annual Benefit Maximum	The maximum annual benefit that you can receive per person.
Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment 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.
Calendar Year	From January 1, 2027 through December 31, 2027. Also referred to as the Plan Year.
Class A Services	Basic services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
Class B Services	Intermediate services, which include restorative procedures such as fillings, 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	Orthodontia services.
Date of Service	The calendar date on which you visit the dentist's office and services are rendered.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual 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 from multiple sources including but not limited to relevant clinical dental research from various research organizations including dental schools, current recognized dental school standard of care curriculums and organized dental groups including the American Dental Association, which is necessary to treat decay, disease or injury of teeth, or essential for the care of teeth and supporting tissues of the teeth.
Plan	MetLife Federal Dental Plan
Plan Allowance	The plan allowance is the maximum amount we will consider for payment for a specific procedure. The actual benefit will be a specified percentage of the plan allowance. When you use a participating (in-network) provider, your out-of-pocket cost is limited to the difference between the plan allowance and our payment. When you use services provided by a provider that does not participate in our network of providers, they are considered out-of-network services.

	The Plan Allowance for Out-of-Network services will be equal to the In-Network Plan Allowance for the covered service (see page 18 for further details). When you use an Out-of-Network provider, you are responsible for the difference between the Plan Allowance and our payment plus the difference between the amount the provider bills and the Plan Allowance. Out-of-network providers may charge their normal fees which may be greater than the Plan Allowance. The plan allowance may vary by geographic location and/or a participating provider's contracted fee schedule. 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.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on their direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	The MetLife Federal Dental Plan
You/Your	Enrollee or eligible family member.
In-Progress Treatment	Dental services initiated in 2026 that will be completed in 2027.

Non-FEDVIP Benefits

MetLife + Aura Identity and Fraud Protection -<u>at no additional cost</u> to MetLife Federal Dental Members

Enrollees in the MetLife Federal Dental Plan gain access to MetLife + Aura Identity & Fraud Protection at no additional cost. Service begins upon activation by the enrollee. Once dental coverage is effective, service may be activated at any time using instructions included in dental plan welcome communications.

Key Features

- Credit monitoring and alerts related to:
  - Financial accounts and transactions
  - Social Security numbers and personal information
  - Home and vehicle title activity
- People-search site and spam-list removal
- Secure document and information storage and password management and email alias functionality
- Virtual private network (VPN) and Wi-Fi security tools and safe browsing and ad-blocking tools
- Lost wallet assistance, including up to $500 in emergency cash assistance and fraud resolution assistance
- U.S. based customer support available 24 hours a day, 7 days a week
- Mobile app access for iOS and Android devices

The following voluntary benefits are available to federal employees and retirees at discounted rates. Enrollment is open year-round. Visit <u>MetLife.com/FederalBenefits</u> to learn more and enroll.

Auto and Home Insurance from Farmers GroupSelect® - *New in 2026*

Federal employees and retirees have access to discounts on a variety of personal lines of insurance from Farmers GroupSelect. Coverage and rates vary by policy and individual circumstances.

Key Features

- Program-specific discounts
- Flexible coverage options
- 24/7 claim support
- Claim-free driving rewards
- Guaranteed auto repair program
- Roadside assistance
- Home contractor services
- Mobile app. access

Available policies include: auto, home, renter's, condominium, recreational vehicle (RV), boat, motorcycle, landlord's rental dwelling, personal excess liability, and bundled policy packages.

Farmers GroupSelect disclosures are available at <u>https://fedvip.metlife.com/farmersgroupselect/</u>; limitations apply.

MetLife and Farmers GroupSelect operate independently and are not responsible for each other's financial obligations.

MetLife Pet Insurance

Federal employees and retirees have access to discounted rates on MetLife Pet Insurance, which can help offset the cost of covered veterinary care for insured dogs and cats. Premium rates vary based on factors such as the coverage selected, reimbursement level, deductible amount, and pet characteristics.

Key Features

- Discounts of up to 30%*
- Customizable coverage options
- Reimbursement of up to 90%* of covered veterinary expenses
- Freedom to visit any licensed U.S. veterinarian
- No breed exclusions
- Family plans that allow coverage for multiple cats and dogs under one policy*
- Optional preventive care coverage

How the Plan Works:

In case of a covered accident or illness, a member may:

1. Visit any licensed veterinarian in the United States.

2. Submit claims for paid expenses through MetLife's online portal.

3. Receive reimbursement for a portion of covered expense based on the member's policy.

*Restrictions apply. Full coverage details and disclosures are available at https://fedvip.metlife.com/metLife-pet-insurance-for-the-federal-government-family/.

MetLife Legal Plans

Federal employees and retirees have access to MetLife Legal Plans at discounted rates. These plans cover certain legal services for a broad range of personal matters in areas such as estate planning, home and real estate, driving and traffic, civil issues, financial issues, family law, and more. **For covered services provided by a network attorney, members pay no hourly attorney fees or other out-of-pocket costs.**

Plan options: Standard Plan **($14 per month)** and High Plan **($22 per month).** Coverage varies by plan option:

- For all covered matters, both plans include Advice & Consultation, Document Review, and Document Preparation, at a minimum.
- Attorney representation may also be included for many covered matters, depending on the plan option selected.

Key Features

- 18,000+ network attorneys nationwide
- No copays, deductibles or claims submissions for covered in-network services
- Family coverage for spouses and eligible dependent children
- Unlimited initial consultations for covered matters
- Online estate planning tools

How the Plan Works

When a covered legal need arises, a member may:

1. Find a network attorney using an online search tool

2. Schedule a consultation by phone or email

3. Meet with the attorney in person, by phone, or online to receive covered legal services at no out-of-pocket cost

*Full coverage details and disclosures are available at https ://www. metlife.com/federal/legal/?BTID=Header_FedLegal_FedVIPHome_LegalPlanDetails.

Stop Health Care Fraud!

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

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

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

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

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

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes your portion of the expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit www. BENEFEDS.gov or call 1-877-888-FEDS (1-877-888-3337), TTY number 711, International 1-571-730-5942. Hearing and Speech impaired individuals may communicate using a text telephone device and Relay Services by dialing the MetLife Federal Dental number of "888-865-6854". Relay Services is immediate assistance. The Message Relay Service enables customers who are deaf, hard of hearing, or speech impaired, and who use a Teletypewriter (TTY), to communicate with others via the telephone. You simply type your conversation to a Relay Agent who then reads the typed conversation to the other party. The text telephone is used through a callers wireless provider as long as they have a TTY compatible phone.
- Out-of-Network services under Classes A, B and C are subject to a deductible of $50 for the High Option and $100 for the Standard Option per calendar year.
- Percentages shown are a percentage of the Plan Allowance.
- For Out-of-Network services, you are responsible for paying the percentage of the Plan Allowance shown in the table plus any amount above the Plan Allowance billed by the provider (subject to any deductibles, plan limitations and benefits maximums).
- The amount you pay is subject to any deductibles, plan limitations and maximums.

High Option	You Pay	
High Option Benefits	**In-Network**	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic	0%	10%
Class B (Intermediate) Services – includes minor restorative services	30%	40%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	50%	60%
Class A, B, and C Services are subject to an unlimited maximum benefit		
Class D Services – orthodontic $3,500 Child Lifetime Maximum, $3,000 Adult Lifetime Maximum	50%	50%

Standard Option	You Pay	
Standard Option Benefits	**In-Network**	**Out-of-Network**
Class A (Basic) Services – preventive and diagnostic	0%	40%
Class B (Intermediate) Services – includes minor restorative services	45%	60%
Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	65%	80%
Class A, B, and C Services are subject to a $2,000 annual maximum benefit for the In-Network benefits and $2,000 for the Out-of-Network benefits		
Class D Services – orthodontic $1,500 Child Lifetime Maximum, $1,500 Adult Lifetime Maximum.	50%	50%

Notes

Rate Information

How to find your rate

- In the first chart below, look up your zip code (first 3 digits) to determine your rating area.
- In the charts on the next page, match your rating area (same for the high and standard) to your enrollment type to locate your monthly or bi-weekly premium cost.

Premium Rating Areas by State/Zip Code (first three digits)								
State	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**	**State**	**Zip**	**Rating Region**
AK	Entire State	5	MA	Rest of State	5	OR	Rest of State	3
AL	Entire State	1	MD	Rest of State	4	PA	172-174	4
AR	Entire State	1	MD	219	3	PA	180-181,183	5
AZ	856-857	1	ME	039-042	5	PA	189-196	3
AZ	850-853,855,859,86-0,863,865	2	ME	Rest of State	2	PA	Rest of State	1
AZ	864	3	MI	480-485	3	PR	Entire Territory	1
CA	919-921,942,956-959	4	MI	Rest of State	2	RI	Entire State	5
CA	Rest of State	5	MN	550-551,553-555,563	4	SC	Entire State	2
CO	Entire State	4	MN	Rest of State	2	SD	Entire State	1
CT	Entire State	5	MO	Entire State	1	TN	Entire State	1
DC	Entire District	4	MS	Entire State	1	TX	733,739,750-754,76-0-762,770,772-775,-786-787	2
DE	Entire State	3	MT	Entire State	1	TX	Rest of State	1
FL	330-334,349	3	NC	Entire State	2	UT	Entire State	1
FL	320-328,335-339,3-41-342,344,346,347	2	ND	Entire State	1	VA	201,205,220-227	4
FL	329	1	NE	Entire State	1	VA	231,233-237	2
GA	Entire State	2	NH	Entire State	5	VA	Rest of State	1
GU	Entire Territory	1	NJ	080-084	3	VI	Entire Territory	1
HI	Entire State	4	NJ	Rest of State	5	VT	Entire State	2
IA	Entire State	1	NM	874,877-884	2	WA	980-985	5
ID	Entire State	2	NM	Rest of State	1	WA	Rest of State	4
IL	600-609,613	4	NV	889-891	3	WI	540	4
IL	Rest of State	1	NV	897	4	WI	Rest of State	2
IN	463-464	4	NV	Rest of State	2	WV	254	4
IN	Rest of State	1	NY	120-123,127-149	1	WV	Rest of State	1
KS	Entire State	1	NY	Rest of State	5	WY	Entire State	2
KY	Entire State	1	OH	Entire State	1	INT	All	5
LA	Entire State	1	OK	Entire State	2			
MA	012	1	OR	970-973	4			

High & Standard Rates

Rating Area	High - Bi-Weekly			High - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$18.81	$37.62	$56.42	$40.76	$81.51	$122.24
2	$19.92	$39.84	$59.76	$43.16	$86.32	$129.48
3	$21.78	$43.56	$65.35	$47.19	$94.38	$141.59
4	$23.72	$47.43	$71.15	$51.39	$102.77	$154.16
5	$25.90	$51.80	$77.69	$56.12	$112.23	$168.33

Rating Area	Standard - Bi-Weekly			Standard - Monthly		
	Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
1	$11.09	$22.17	$33.26	$24.03	$48.04	$72.06
2	$12.00	$24.00	$35.99	$26.00	$52.00	$77.98
3	$12.80	$25.60	$38.40	$27.73	$55.47	$83.20
4	$13.92	$27.84	$41.76	$30.16	$60.32	$90.48
5	$14.61	$29.22	$43.83	$31.66	$63.31	$94.97