

CALIFORNIA ASSOCIATION OF REALTORS®

Summary of Benefits

MetLife Dental Insurance

Plan benefits effective 1/1/26

BENEFITS	VALUE PLAN		SELECT PLAN		CHOICE PLAN	
<i>Plans at a glance</i>						
Reimbursement	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
	Negotiated Fee ² Schedule	Negotiated Fee ² Schedule	Negotiated Fee ² Schedule	R&C ³ 51 st Percentile	Negotiated Fee ² Schedule	R&C ³ 70 th Percentile
Type A – Preventive	70%	70%	100%	80%	100%	90%
Type B – Basic	70%	70%	80%	60%	80%	70%
Type C – Major	70%	70%	50%	40%	50%	50%
Calendar Year Deductible applies to:	Type B & C Services	Type B & C Services	Type B & C Services	Type B & C Services	Type B & C Services	Type B & C Services
	<ul style="list-style-type: none"> ▪ Individual \$100 ▪ Family \$300 Aggregate	<ul style="list-style-type: none"> ▪ Individual \$100 ▪ Family \$300 Aggregate	<ul style="list-style-type: none"> ▪ Individual \$50 ▪ Family \$150 Aggregate	<ul style="list-style-type: none"> ▪ Individual \$100 ▪ Family \$300 Aggregate	<ul style="list-style-type: none"> ▪ Individual \$50 ▪ Family \$150 Aggregate	<ul style="list-style-type: none"> ▪ Individual \$50 ▪ Family \$150 Aggregate
Calendar Year Maximum* <i>(applies to B & C services)</i>	\$1,000	\$750	\$1,750	\$1,000	\$2,000	\$1,500
Orthodontia	Not Covered	Not Covered	50%	50%	50%	50%
Orthodontia Annual Maximum	Not Covered	Not Covered	\$1,000	\$1,000	\$1,000	\$1,000

*MetLife Dental Incentive Provision

Your plan includes a Dental Incentive Provision. For additional information, please click the link below:

[MetLife Dental Incentive Provision Flyer](#)

MetLife Preferred Dentist Program

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

¹ Utilizing an out-of-network dentist for care may cost you more than using an in-network dentist.

² Negotiated Fee refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Non-participating dentists have not agreed to accept negotiated fees. When using a non-participating dentist you will be responsible for any difference in cost between the dentist's fee and your plan's benefit payment. Negotiated fees are subject to change.

³ R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of 1) the dentist's actual charge, 2) the dentist's usual charge for the same or similar services or 3) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

CALIFORNIA ASSOCIATION OF REALTORS®

Summary of Benefits MetLife Vision Insurance

Plan benefits effective 1/1/26

Vision				
PLAN NAME	BASIC VISION		ENHANCED VISION	
Reimbursement For:	In-Network Coverage (Using a Network Provider)	Out-of-Network Reimbursement¹ (Using a Non-Network Provider)	In-Network Coverage (Using a Network Provider)	Out-of-Network Reimbursement¹ (Using a Non-Network Provider)
Eye Examination				
Comprehensive exam of visual functions and prescription of corrective eyewear.	\$20 copay	\$45 allowance	\$0 copay	\$45 allowance
Retinal Imaging <small>This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.</small>	Up to \$39 copay	Applied to the exam allowance	Up to \$39 copay	Applied to the exam allowance
Materials / Eyewear (Either Glasses or Contacts)				
Standard Corrective Lenses <ul style="list-style-type: none"> • Single Vision • Lined bifocal • Lined trifocal • Lenticular 	\$20 Copay \$20 Copay \$20 Copay \$20 Copay	\$30 Allowance \$50 Allowance \$65 Allowance \$100 Allowance	\$20 Copay \$20 Copay \$20 Copay \$20 Copay	\$30 Allowance \$50 Allowance \$64 Allowance \$100 Allowance
Standard Lens Enhancements				
• Ultraviolet coating	Covered in Full	Applied to the allowance for the applicable corrective lens	Covered in Full	Applied to the allowance for the applicable corrective lens
• Polycarbonate (child up to age 18)	Covered in Full	Applied to the allowance for the applicable corrective lens	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements				
• Progressive Standard	Up to \$55 copay	\$50 allowance	Up to \$55 copay	\$50 allowance
• Progressive Premium/Custom	Premium: Up to \$95-\$105 copay Custom: Up to \$150-\$175 copay	\$50 allowance	Premium: Up to \$95-\$105 copay Custom: Up to \$150-\$175 copay	\$50 allowance
• Polycarbonate (adult)	Single Vision: Up to \$31 copay Multifocal: Up to \$35 copay	Applied to the allowance for the applicable corrective lens	Single Vision: Up to \$31 copay Multifocal: Up to \$35 copay	Applied to the allowance for the applicable corrective lens

¹ Utilizing an out-of-network provider may cost you more than using an in-network provider.

PLAN NAME	BASIC VISION		ENHANCED VISION	
	In-Network Coverage (Using a Network Provider)	Out-of-Network Reimbursement ¹ (Using a Non-Network Provider)	In-Network Coverage (Using a Network Provider)	Out-of-Network Reimbursement ¹ (Using a Non-Network Provider)
Reimbursement For:				
• Scratch-resistant coating (variable by type)	Up to \$17 - \$33 copay	Applied to the allowance for the applicable corrective lens	Up to \$17 - \$33 copay	Applied to the allowance for the applicable corrective lens
• Tints (variable by type)	Single Vision: Up to \$17 - \$34 copay Multifocal: Up to \$17 - \$44 copay	Applied to the allowance for the applicable corrective lens	Single Vision: Up to \$17 - \$34 copay Multifocal: Up to \$17 - \$44 copay	Applied to the allowance for the applicable corrective lens
• Anti-reflective coating (variable by type)	Up to \$41 - \$85 copay	Applied to the allowance for the applicable corrective lens	Up to \$41 - \$85 copay	Applied to the allowance for the applicable corrective lens
• Photochromic (variable by type)	Up to \$47 - \$82 copay	Applied to the allowance for the applicable corrective lens	Up to \$47 - \$82 copay	Applied to the allowance for the applicable corrective lens
Frame Allowance (You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco.)				
	\$100 allowance	\$55 allowance	\$150 allowance	\$70 allowance
• Costco	\$55 allowance		\$85 allowance	
Contact Lenses				
• Elective	\$100 allowance	\$80 allowance	\$150 allowance	\$105 allowance
• Necessary	Covered in full after eyewear copay	\$210 allowance	Covered in full after eyewear	\$210 allowance
• Contact Fitting and Evaluation	Standard or Premium fit: Covered in full with a maximum copay of \$60	Applied to the contact lens allowance	Standard or Premium fit: Covered in full with a maximum copay of \$60	Applied to the contact lens allowance

Value Added Features	
Additional Savings on Glasses and Sunglasses²	Get 20% off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.
Laser Vision correction³	Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Offer is only available at MetLife participating locations.

² Member costs for listed lens enhancements will be limited to copays that MetLife has negotiated with participating providers. These copays can be viewed by members after enrollment at www.metlife.com/mybenefits. All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

³ Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Laser vision care discounts are only available from participating locations.

Frequency / Exclusions

Class Description: All Eligible Members		
Frequencies	BASIC VISION	ENHANCED VISION
▪ Examinations	▪ 1 per 12 Months	▪ 1 per 12 Months
▪ Standard Corrective Lenses	▪ 1 per 12 Months	▪ 1 per 12 Months
▪ Frames	▪ 1 per 24 Months	▪ 1 per 12 Months
▪ Contact Lenses	▪ 1 per 12 Months	▪ 1 per 12 Months
Either glasses or contacts allowed per frequency		

Exclusions

- Services and/or materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Summary of Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter)
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Prescription and non-prescription medications.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Any eye examination or any corrective eyewear required as a condition of employment.
- Services and supplies received by you or Your Dependent before the Vision Insurance starts for that person.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- Services, to the extent such services, or benefits for such services, are available under a Government Plan. This exclusion will apply whether or not the person receiving the services is enrolled for the Government Plan. We will not exclude payment of benefits for such services if the Government Plan requires that Vision Insurance under the group policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program or coverage provided by a government as an employer or Medicare.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.



California Association of REALTORS® Monthly Dental & Vision Rates Group Insurance Program



Rating Regions For MetLife Group Dental Coverage

Rating Region 1 Counties
Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Fresno, Glenn, Humboldt, Imperial, Lake, Madera, Marin, Mariposa, Mendocino, Merced, San Luis Obispo, San Mateo, Sierra, Solano, Sonoma, Stanislaus, Tulare and Yolo

Rating Region 2 Counties
Alameda, Contra Costa, Del Norte, Inyo, Kern, Kings, Lassen, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Shasta, Siskiyou, Sutter, Tehama, Trinity, Tuolumne and Yuba

Rating Region 3 Counties
Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura

MetLife Group Dental Rates Effective January 1, 2026 through December 31, 2026

MetLife Group PPO Dental (for All Regions) Note: Rates Subject to Change on 1/1/27

Monthly Rates	Value Plan			Select Plan			Choice Plan		
	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3	Region 1	Region 2	Region 3
Member Only	\$42	\$37	\$40	\$74	\$68	\$72	\$90	\$90	\$96
Member + Spouse	\$89	\$80	\$84	\$151	\$133	\$144	\$180	\$180	\$191
Member + Child(ren)	\$108	\$98	\$104	\$190	\$171	\$178	\$228	\$228	\$241
Family	\$129	\$115	\$123	\$223	\$197	\$212	\$306	\$306	\$323

If a member cancels their C.A.R. Group dental coverage and later wants to enroll, they will not be eligible until the next open enrollment date following 13 months after their termination date. An exception could apply for those members who are coming off another group dental coverage plan.

MetLife Life and AD&D Insurance Rates effective January 1, 2026 through December 31, 2026

MetLife Life & AD&D Insurance (for All Regions) Note: Rates Subject to Change on 1/1/27

Member's Age	Under 30	30-39	40-49	50-54	55-59	60-64	65+
\$25,000 of Coverage	3.53	5.28	8.75	15.68	26.78	36.83	67.35
\$50,000 of Coverage	7.06	10.56	17.50	31.36	53.56	73.66	134.70

Above rates are for life insurance for eligible REALTOR® members; full time employees of REALTORS® or full time employees of C.A.R. boards. Rates are based on subscribers attained age. Life coverage is guaranteed only for new REALTOR® members or employees who enroll during their Initial Eligibility Period and who have not been hospitalized within 90 days of making application. Anyone hospitalized within that time frame will be required to submit evidence of medical insurability and coverage will not be guaranteed. The Initial Eligibility period is the 31 days following one month of membership or full time employment. Existing C.A.R. members may apply but coverage will be subject to underwriting approval. See Plan Summaries for additional information on coverage, including exclusions and limitations.

VSP Vision Plan Rates effective January 1, 2026 through December 31, 2026

VSP Vision Plan (for All Regions) Note: Rates Subject to change on 1/1/27

	Basic Vision	Enhanced Vision
Member Only	\$9	\$14
Member + Spouse	\$18	\$24
Member + Children	\$16	\$24
Member + Family	\$25	\$35

If a member cancels their C.A.R. Group vision coverage and later wants to enroll, they will not be eligible until the next open enrollment date following 13 months after their termination date. An exception could apply for those members who are coming off another group vision coverage plan.

Note: Dental, Vision, and/or Life Insurance Plans may be purchased with or without Medical Coverage. If you enroll on a Dental Plan without Medical Coverage a \$5 administration fee will be added. If you enroll in a Vision or Life Insurance Plan without a Medical or Dental Plan a \$2 administration fee will be added.

Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details. Insurance coverage is issued by Metropolitan Life Insurance Company, New York, NY 10166.

Group dental insurance policies featuring the MetLife Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166. Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP). VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

Frequency & Allocations / Exclusions – CHOICE PLAN

Class Description: Choice plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 19
▪ Full Mouth or panoramic X-Rays	▪ Once in 5 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 1 time in 6 months ▪ Adult: 1 time in 6 months
▪ Periapical X-Rays	▪ No frequency limitation
▪ Other X-Rays	▪ No frequency limitation
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Sealants	▪ 1 per molar in 2 years for a child under age 19
▪ Examinations – Problem Focused	▪ 1 time in 1 calendar year
▪ Space Maintainers	▪ No Limit for a child under age 17
▪ Consultations	▪ 2 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 12 Months
▪ Root Canal	▪ 1 per tooth in 12 months
▪ Periodontal Maintenance	▪ 2 Perio. Treatments in a calendar year, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 in 12 months
▪ Repairs	▪ No frequency limitation
▪ Recementations	▪ No frequency limitation
▪ Labs & Other Tests	▪ No frequency limitation
▪ Emergency Palliative Treatment	▪ No frequency limitation
▪ General Anesthesia	▪ No frequency limitation
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	▪ No frequency limitation
▪ Pulpotomy	▪ No frequency limitation
▪ Pulp Capping	▪ No frequency limitation
▪ Pulp Therapy	▪ No frequency limitation
▪ Apexification & Recalcification	▪ No frequency limitation
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	▪ No frequency limitation
▪ Periodontics – Non-Surgical	▪ No frequency limitation
▪ Oral Surgery: Simple Extractions	▪ No frequency limitation
▪ Oral Surgery: Surgical Extractions	▪ No frequency limitation
▪ Other Oral Surgery	▪ No frequency limitation
▪ General Services	▪ No frequency limitation
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 84 months
▪ Dentures	▪ 1 in 84 months
▪ Dentures – Rebases / Relines	▪ No frequency limitation
▪ Denture Adjustments	▪ No frequency limitation
▪ Fixed Bridges	▪ 1 in 84 months
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 84 months
▪ Implant Services	▪ 1 per tooth position in 60 months

▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 84 Months
▪ Tissue Conditioning	▪ No frequency limitation
▪ Occlusal Adjustments	▪ No frequency limitation
Orthodontics	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Orthodontic Diagnostics	▪ No frequency limitation
▪ Orthodontic Treatment	▪ No frequency limitation

Exclusions
Choice plan
<ul style="list-style-type: none"> ▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it. ▪ Duplicate prosthetic devices or appliances. ▪ Replacement of a lost or stolen appliance, cast restoration or denture. ▪ Intra and extraoral photographic images. ▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

Frequency & Allocations / Exclusions – SELECT PLAN

Class Description: Select plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 19
▪ Full Mouth or panoramic X-Rays	▪ Once in 5 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 1 time in 6 months ▪ Adult: 1 time in 6 months
▪ Periapical X-Rays	▪ No frequency limitation
▪ Other X-Rays	▪ No frequency limitation
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Sealants	▪ 1 per molar in 2 years for a child under age 19
▪ Examinations – Problem Focused	▪ 1 time in 1 calendar year
▪ Space Maintainers	▪ No Limit for a child under age 17
▪ Consultations	▪ 2 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 12 Months
▪ Root Canal	▪ 1 per tooth in 12 months
▪ Periodontal Maintenance	▪ 2 Perio. treatments in a calendar year, includes 2 cleanings
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 in 12 months
▪ Repairs	▪ No frequency limitation
▪ Recementations	▪ No frequency limitation
▪ Labs & Other Tests	▪ No frequency limitation
▪ Emergency Palliative Treatment	▪ No frequency limitation
▪ General Anesthesia	▪ No frequency limitation
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	▪ No frequency limitation
▪ Pulpotomy	▪ No frequency limitation
▪ Pulp Capping	▪ No frequency limitation
▪ Pulp Therapy	▪ No frequency limitation
▪ Apexification & Recalcification	▪ No frequency limitation
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	▪ No frequency limitation
▪ Periodontics – Non-Surgical	▪ No frequency limitation
▪ Oral Surgery: Simple Extractions	▪ No frequency limitation
▪ Oral Surgery: Surgical Extractions	▪ No frequency limitation
▪ Other Oral Surgery	▪ No frequency limitation
▪ General Services	▪ No frequency limitation
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 84 months
▪ Dentures	▪ 1 in 84 months
▪ Dentures – Rebases / Relines	▪ No frequency limitation
▪ Denture Adjustments	▪ No frequency limitation
▪ Fixed Bridges	▪ 1 in 84 months

▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 84 months
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 84 Months
▪ Tissue Conditioning	▪ No frequency limitation
▪ Occlusal Adjustments	▪ No frequency limitation
Orthodontics	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Orthodontic Diagnostics	▪ No frequency limitation
▪ Orthodontic Treatment	▪ No frequency limitation

Exclusions	
Select plan	
<ul style="list-style-type: none"> ▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it. ▪ Duplicate prosthetic devices or appliances. ▪ Replacement of a lost or stolen appliance, cast restoration or denture. ▪ Intra and extraoral photographic images. ▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota. 	

Frequency & Allocations / Exclusions – VALUE PLAN

Class Description: Value plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 19
▪ Full Mouth or panoramic X-Rays	▪ Once in 5 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 1 time in 6 months ▪ Adult: 1 time in 6 months
▪ Emergency Palliative Treatment	▪ No frequency limitation
▪ Periapical X-Rays	▪ No frequency limitation
▪ Other X-Rays	▪ No frequency limitation
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Sealants	▪ 1 per molar in 2 years for a child under age 19
▪ Examinations – Problem Focused	▪ 1 time in 1 calendar year
▪ Space Maintainers	▪ No Limit for a child under age 17
▪ Consultations	▪ 2 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 12 Months
▪ Root Canal	▪ 1 per tooth in 12 months
▪ Periodontal Maintenance	▪ 2 Perio. Treatments in a calendar year, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 in 12 months
▪ Repairs	▪ No frequency limitation
▪ Recementations	▪ No frequency limitation
▪ Labs & Other Tests	▪ No frequency limitation
▪ General Anesthesia	▪ No frequency limitation
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	▪ No frequency limitation
▪ Pulpotomy	▪ No frequency limitation
▪ Pulp Capping	▪ No frequency limitation
▪ Pulp Therapy	▪ No frequency limitation
▪ Apexification & Recalcification	▪ No frequency limitation
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	▪ No frequency limitation
▪ Periodontics – Non-Surgical	▪ No frequency limitation
▪ Oral Surgery: Simple Extractions	▪ No frequency limitation
▪ Oral Surgery: Surgical Extractions	▪ No frequency limitation
▪ Other Oral Surgery	▪ No frequency limitation
▪ General Services	▪ No frequency limitation
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 60 months
▪ Dentures	▪ 1 in 60 months
▪ Dentures – Rebases / Relines	▪ No frequency limitation
▪ Denture Adjustments	▪ No frequency limitation
▪ Fixed Bridges	▪ 1 in 60 months

▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 60 months
▪ Implant Services	▪ 1 per tooth position 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 months
▪ Tissue Conditioning	▪ No frequency limitation
▪ Occlusal Adjustments	▪ No frequency limitation

Exclusions	
Value plan	
<ul style="list-style-type: none"> ▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it. ▪ Duplicate prosthetic devices or appliances. ▪ Replacement of a lost or stolen appliance, cast restoration or denture. ▪ Intra and extraoral photographic images. ▪ Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards. ▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota. ▪ Orthodontia services or appliances. ▪ Repair or a replacement of an orthodontic appliance. 	

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions,

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exceptions, waiting periods, reductions of benefits, limitations and terms for keeping them in force. Please contact MetLife for complete details.