Benefits Handbook Date January 1, 2011

Dental Plan

MMC

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Dental Plan

The Company's Comprehensive Dental Plan (the "Plan") helps you and your family pay for dental care.

Under this Plan, you may receive treatment from any dentist you wish or from a dentist within MetLife's Preferred Dentist Program. Whether you see an IN-NETWORK or out-of network provider, the Plan will reimburse a specified percentage for covered services, but your costs are generally lower when you use a provider in MetLife's Preferred Dentist Program.

SPD and Plan Document

This section provides a summary of the Comprehensive Dental Plan as of January 1, 2011.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

Contents

The Plan at a Glance

Plan Feature	In-Network	Out-of-Network
Annual Deductible	Individual: None Family: None	Individual: $50 per calendar year Family: $150 per calendar year
Plan Payment	Preventive and diagnostic—100% Basic Restorative—80% Major Restorative—70%	Preventive and diagnostic—100% of REASONABLE AND CUSTOMARY CHARGES (R&C) Basic Restorative—80% of R&C after deductible Major Restorative—50% of R&C after deductible
Implants	60%	50% of R&C
Orthodontia	60%	60% of R&C
Orthodontia lifetime maximum	$2,500 per covered individual (combined IN-NETWORK and OUT-OF-NETWORK)	$2,500 per covered individual (combined in-network and out-of-network)
Annual maximum	$2,500 per covered individual (combined in-network and out-of-network)	$2,500 per covered individual (combined in-network and out-of-network)
Lifetime maximum	None	None
Contact Information	For Dental Services: MetLife Dental Claims (Claims Administrator) P.O. Box 981282 El Paso, TX 79998-1282 Phone: (800) 942-0854 www.metlife.com/mybenefits (enter “MMC” in the form to enter your company name) MMC does not administer this Plan. MetLife’s decisions are final and binding.	

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Enrollment

To participate in this plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment
- within 30 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this plan.

Enrollment procedures for you and your eligible family members are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your eligible family members.

The cost of your coverage depends on the level of coverage you choose.

You can choose from three levels of coverage:

	Semi-monthly Cost	Weekly Cost
Employee Only	$10.70	$4.94
Employee + one	$21.40	$9.88
Family	$32.09	$14.81

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

The table below shows the imputed income amounts.

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

Imputed Income for Domestic Partner Coverage in the Comprehensive Dental Plan

	Semi-monthly	Weekly
Employee + one	$10.70	$4.94
Family (you and two or more eligible family members)	$21.40	$9.88

ID Cards

With MetLife, there are no ID cards for IN-NETWORK or OUT-OF-NETWORK services. When you are ready to receive in-network or out-of-network services, simply:

- find a MetLife network dentist, then
- make an appointment and tell the dentist you are a MetLife Preferred Dentist Program member through Marsh & McLennan Companies, Inc. (MMC).

Your dentist and MetLife will handle the rest.

How the Plan Works

This Plan pays benefits for dental services received by you and your covered family members. Services can be provided by an IN-NETWORK or an OUT-OF-NETWORK provider.

If you use an in-network provider, you are responsible for the coinsurance amount on the provider's negotiated fee. The Plan pays the balance directly to a participating MetLife provider. For example, if the Plan pays an 80% benefit, your coinsurance amount would be 20% of the MetLife provider's negotiated fee.

If you use an out-of-network provider, you are responsible for the coinsurance amount on the reasonable and customary (R&C) charges for your geographic area and, depending on the service, you may have to meet a deductible. You must submit out-of-network expenses to the Claims Administrator for reimbursement. For example, if the Plan pays an 80% benefit, your coinsurance amount would be 20% of the reasonable and customary charge for your geographic area, after you meet your deductible. You are also responsible for any amount above the reasonable and customary charge.

Pretreatment estimates are recommended if the cost of the treatment will be over $300, or if you will be undergoing procedures such as crowns, bridges, implants, periodontal work, inlays or onlays.

Some services have limits or restrictions—see “What’s Covered” on page 8.

Certain services are not covered, see “What’s Covered” on page 8.

The Plan reimburses covered dental services and treatment you receive outside the U.S. at the out-of-network reimbursement level.

About the Network

This plan pays benefits at the IN-NETWORK benefit level up to the Plan’s maximum benefit when you receive care from an in-network dentist. The Plan pays an in-network dentist directly.

Note: If a claim is submitted by a participating dentist without an employee’s signature or signature on file authorizing MetLife to pay the dentist, payment will be issued to the employee.

How does the network operate?

You can choose any dentist you wish. But if you use an in-network dentist, that is, a dentist in MetLife’s Preferred Dentist Program, your costs are generally lower.

If you use an in-network provider, you are responsible for the coinsurance amount on the provider’s negotiated fee. The Plan pays the balance directly to a participating MetLife provider. For example, if the Plan pays an 80% benefit, your coinsurance amount would be 20% of the MetLife provider’s negotiated fee. **Note:** If a claim is submitted by a participating dentist without an employee’s signature or signature on file authorizing MetLife to pay the dentist, payment will be issued to the employee.

If you use an OUT-OF-NETWORK provider, you are responsible for the coinsurance amount on the reasonable and customary (R&C) charges for your geographic area and, depending on the service, you may have to meet a deductible. You must submit out-of-network expenses to the Claims Administrator for reimbursement. For example, if the Plan pays an 80% benefit, your coinsurance amount would be 20% of the reasonable and customary charge for your geographic area, after you meet your deductible, subject to the Plan’s maximum benefit.

Dentists are neither agents nor employees of the Claims Administrator. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change.

How can a dentist join MetLife’s Preferred Dentist Program?

If your dentist is not a member of the program, he or she may call MetLife directly at (877) 638-3379, to receive information on applying for participation.

In order to become a member of the program, the dentist must satisfy MetLife's credentialing criteria and agree to MetLife's fee schedule. Not all dentists who apply are guaranteed admittance to MetLife's network.

What happens if I am referred to an out-of-network dentist?

If you start your treatment with an in-network dentist and then are referred to an out-of-network dentist, services of the out-of network dentist will be reimbursed at the rate for an out-of-network dentist, subject to applicable plan provisions. Be sure to secure a pre-treatment estimate, so that you are aware of the cost of the treatment beforehand.

What are the participating dentist's qualifications?

Dentists participating in the MetLife Preferred Dentist Program undergo an extensive credential-checking process by MetLife Dental that focuses on practice location, specialty, licensing, utilization, malpractice coverage and history, and emergency care arrangements. Participating dentists are re-credentialed by MetLife Dental periodically and are monitored periodically to ensure proper utilization patterns.

Where can I get a list of dentists and specialists in the network?

To view the provider directory online, visit the Claim Administrator's website (www.metlife.com/mybenefits). If you do not have internet access, a customized list of providers can be obtained without charge by contacting MetLife Dental.

Does the Plan cover dental services or treatment outside the United States?

Yes, the Plan reimburses covered dental services and treatment you receive outside the United States at the out-of-network reimbursement level.

Deductible

There is no deductible if you use an IN-NETWORK dentist. A $50 per person deductible applies to dental services from an OUT-OF-NETWORK dentist.

Preventive and diagnostic services, however, are covered at 100% of the reasonable and customary amount with no deductible.

Can I carry over any dental expenses from one year to the next to meet my deductible?

No, expenses that apply toward your deductible in one calendar year can't be applied toward the next calendar year deductible.

What is the individual deductible?

Your Plan has no individual deductible for services provided by an in-network dentist.

The deductible that applies to certain services not provided by an in-network dentist is $50 per person, per calendar year.

Preventive and diagnostic services are covered at 100% in-network or 100% of the reasonable and customary amount out-of-network with no deductible.

Your expenses up to the covered benefit amount count toward your deductible.

What is the family deductible?

Your Plan has no family deductible for services provided by an in-network dentist.

The family deductible that applies to certain services not provided by an in-network dentist is $150 per calendar year.

Your expenses up to the covered benefit amount count toward your deductible.

What expenses are covered without my having to meet the deductible?

The following expenses are covered without your first having to meet the annual deductible:

- Services performed by an in-network provider
- Preventive and diagnostic services (in-network or out-of-network)
- ORTHODONTIA services.

What expenses are not applied to the deductible?

The following services do not apply toward the deductible:

- Services not covered by the Plan
- Expenses in excess of REASONABLE AND CUSTOMARY CHARGES.

Predetermination of Benefits

What is the predetermination of benefits?

This feature of the Plan helps you estimate how much the Plan may pay (subject to your deductible and plan maximum at the time the estimate is provided) before you begin treatment with any dentist (in the Preferred Dentist Program or not). It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

How can I find out in advance what my dental plan will pay for my dental treatment?

Ask your dentist to submit a treatment plan to MetLife Dental.

The treatment plan must include the recommended services and their costs, as well as supporting X-rays and other records. MetLife Dental will estimate how much the Plan will pay (subject to your deductible and plan maximum at the time the estimate is provided), and will notify both you and your dentist in two or three weeks of the amount, if any, the Plan will pay.

Amount for a predetermination of benefits

You should get a predetermination of benefits if the cost of the treatment will be over $300, or if you will be undergoing procedures such as crowns, bridges, implants, periodontal work, inlays or onlays.

Can I obtain a predetermination of benefits for my covered family members?

Your covered eligible family members can also obtain a predetermination of benefits, although it will not reflect the coordination of this Plan's benefit with benefits from any other plan under which your eligible family members may be covered. You should compare the benefits of both plans and ask MetLife Dental for an explanation of the coordination of benefits provision if you have any questions.

Treatment Started Before Coverage Begins

Does the Plan pay for treatment started before my coverage starts?

No. The Plan doesn't pay for any treatment performed before you or your covered family member was covered by the Plan.

Treatment Started Before Coverage Ends

Does the Plan continue to pay for orthodontia treatment in progress after my coverage ends?

No, the Plan won't continue to pay for treatment in progress after your coverage ends. You can elect to continue coverage, however, through COBRA.

Does the Plan continue to pay for any other treatments in progress after my coverage ends?

No, the Plan won't continue to pay for treatment in progress after your coverage ends. You can elect to continue coverage, however, through COBRA.

If you retire, you may elect COBRA for dental coverage.

Exception

Crowns, prosthetics and ROOT CANALs will be covered if the procedure was started prior to the date your coverage ends and is completed within 90 days of your coverage end date.

Coordinating with Other Plans

If you or an eligible family member has coverage under the MMC medical or dental benefits programs and coverage under another healthcare plan, MMC's benefits are coordinated with those provided by the other plan. Coordination of benefits is described in *Participating in Healthcare Benefits* section.

What's Covered

The following table summarizes the benefits the Plan pays for certain services. Participants can either use an IN-NETWORK or an out-of network provider.

For more detailed information on covered services, including information on copayment amounts, please refer to "Covered Service Benefits and ADA Codes" on page 14.

Plan Feature	In-Network	Out-of-Network
Plan Payment	Preventive and diagnostic—100% Basic Restorative—80% Major Restorative—70%	Preventive and diagnostic—100% of REASONABLE AND CUSTOMARY CHARGES (R&C) Basic Restorative—80% of R&C after deductible Major Restorative—50% of R&C after deductible
Implants	60%	50% of R&C
Orthodontia	60%	60% of R&C
Orthodontia lifetime maximum	$2,500 per covered individual (combined in-network and OUT-OF-NETWORK)	$2,500 per covered individual (combined in-network and out-of-network)
Annual maximum	$2,500 per covered individual (combined in-network and out-of-network)	$2,500 per covered individual (combined in-network and out-of-network)
Lifetime maximum	None	None

A more detailed list of covered services with general information is provided below.

Anesthetics

Does the Plan cover anesthetics?

The Plan covers:

- separate charges for medically necessary general anesthetics with oral and periodontal surgery
- charges for local anesthetics included in the allowances for treatments requiring local anesthesia

For information on coverage amounts and copayments, see "Covered Service Benefits and ADA Codes" on page 14.

What are the anesthetics exclusions?

The Plan does not cover:

- separate charges for analgesia
- separate charges for local anesthetics

Cleanings and Oral Examinations

Does the Plan cover oral examinations and cleanings?

The Plan covers oral examinations and cleanings twice per calendar year.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the oral examinations and cleanings exclusions?

Refer to “What’s Not Covered” on page 23 for details.

Crowns

Does the Plan cover crowns?

The Plan covers:

- crowns and gold fillings only if a tooth, broken down by decay or injury, cannot be reconstructed by any other filling material
- replacement crowns and gold fillings

The Plan has a CROWN TIME LIMIT. Replacement crowns will be covered only if the existing crown was installed at least 60 months before its replacement.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the crown exclusions?

The Plan does not cover:

- facing or veneers on molar teeth. Full cast or amalgam restorations are covered
- reimbursement for a temporary and a permanent crown is limited to the permanent crown charge

Refer to “What’s Not Covered” on page 23 for details.

Drugs

Does the Plan cover drugs?

The Plan only covers therapeutic drug injections. Any prescriptions you may receive from your dentist generally would be covered under the rules of your medical plan’s prescription plan.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the Plan's drug exclusions?

The Plan only covers therapeutic drug injections.

Refer to the "What's Not Covered" on page 23 section for details.

Emergency Treatment

Does the Plan cover emergency treatment?

The Plan covers emergency care to relieve pain when no other dental treatment is rendered. If any other treatment, except X-rays, is given, the benefit is based on that treatment.

For information on coverage amounts and copayments, see "Covered Service Benefits and ADA Codes" on page 14.

What are the emergency treatment exclusions?

Refer to "What's Not Covered" on page 23 for details.

Endodontic Treatment (Root Canals)

Does the Plan cover endodontics?

The Plan covers ROOT CANAL therapy and other endodontics treatments.

For information on coverage amounts and copayments, see "Covered Service Benefits and ADA Codes" on page 14.

What are the endodontics exclusions?

There are no exclusions.

Fillings

Does the Plan cover fillings?

The Plan covers silver (amalgam), porcelain, resin/composite and plastic fillings to restore the structure of teeth broken down by decay or injury.

For information on coverage amounts and copayments, see "Covered Service Benefits and ADA Codes" on page 14.

What are the fillings exclusions?

The Plan only covers amalgam fillings for restoration of molar teeth and certain surfaces of posterior teeth. If another material is used for these teeth, the Plan will only provide benefits equal to the cost of an amalgam restoration.

Refer to "What's Not Covered" on page 23 for details.

Fluoride Applications

Does the Plan cover fluoride applications?

The Plan covers FLUORIDE applications once per calendar year for children under age 19.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the fluoride applications exclusions?

The Plan does not cover fluoride treatment for individuals age 19 or above.

Refer to “What’s Not Covered” on page 23 for details.

Oral Surgery and Extractions

Does the Plan cover oral surgery and extractions?

The Plan covers all extractions and other ORAL SURGERY.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the oral surgery and extractions exclusions?

The Plan does not cover:

- oral surgery postoperative care
- oral surgery treatment of fractures and dislocations (may be covered under your Medical Plan)

Refer to “What’s Not Covered” on page 23 for details.

Orthodontia

Does the Plan cover orthodontia?

The Plan covers:

- diagnostic procedures
- appliance therapy
- functional/myofunctional therapy to correct position of teeth

The Plan covers ORTHODONTIA for employees and covered family members.

Before undergoing any specialized technique or personalization (e.g. clear braces), make sure to contact MetLife to obtain a predetermination of benefits to see what, if anything, the Plan will cover.

If you use an in-network dentist, the Plan pays 60% of the provider's negotiated fee, up to a $2,500 lifetime maximum benefit. The Plan pays 20% of the orthodontia lifetime maximum after the first visit, with the remainder paid in equal quarterly installments over the duration of the treatment program, up to a 24 month payment period. For orthodontia services, fees are negotiated periodically.

If you use an out-of-network dentist, the Plan pays 60% of reasonable and customary charges for orthodontia services up to a $2,500 lifetime maximum benefit. The Plan pays 20% of the orthodontia lifetime maximum after the first visit, with the remainder paid in equal quarterly installments over the duration of the treatment program, up to a 24 month payment period. For orthodontia services, fees are negotiated periodically.

Regardless of whether you use an in-network or out-of-network dentist, consultation fees are applied toward the Plan's $2,500 maximum lifetime orthodontia benefit.

Orthodontia services are not subject to a deductible.

What are the orthodontia exclusions?

The Plan doesn't cover:

- charges for continuation of orthodontic treatment that began before the employee or family member was covered by the Plan
- repair or replacement of an orthodontic appliance

Refer to "What's Not Covered" on page 23 for details.

Periodontics and Periodontal Cleanings

Does the Plan cover periodontics?

The Plan covers PERIODONTICS, including periodontal surgery, to treat the gum and supporting tissues.

For information on coverage amounts and copayments, see "Covered Service Benefits and ADA Codes" on page 14.

Are periodontal cleanings covered by the Plan?

Yes, the Plan covers four periodontal cleanings per calendar year (or two periodontal cleanings combined with two regular cleanings) provided one or more of the following periodontal treatments has been performed in two or more quadrants:

- scaling
- root planing
- osseous surgery

What are the periodontics exclusions?

There are no exclusions.

Prosthodontics

Does the Plan cover dentures and bridgework?

The Plan covers:

- DENTURES or bridges to replace existing appliances, even if the teeth were extracted before coverage began
- if the appliances are more than 60 months old and cannot be made serviceable
- full or partial dentures and fixed or partial removable bridgework to replace missing natural teeth
- replacing or repairing damaged dentures and adding teeth to existing dentures

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the denture and bridgework exclusions?

The Plan does not cover:

- adjustments to dentures more than six months after installation
- specialized techniques, precision attachments, personalization or characterization of dentures
- reimbursement for a temporary and a permanent denture is limited to the permanent denture charge

Refer to “What’s Not Covered” on page 23 for details.

Sealants

Does the Plan cover sealants?

The Plan covers sealants once every 60 months for children under age 19, on previously unrestored, decay free permanent molars.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the sealants exclusions?

Refer to “What’s Not Covered” on page 23 for details.

Space Maintainers

Does the Plan cover space maintainers?

The Plan covers fixed, unilateral and removable bilateral SPACE MAINTAINERs required for maintenance of space resulting from the premature loss of deciduous (baby) teeth.

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the space maintainer exclusions?

There are no exclusions.

X-rays and Pathology

Does the Plan cover X-rays?

The Plan covers:

- BITEWING X-rays twice per calendar year
- full-mouth X-rays, including panoramic X-rays, once every 36 months, as part of a general examination

For information on coverage amounts and copayments, see “Covered Service Benefits and ADA Codes” on page 14.

What are the X-ray exclusions?

Frequency limitations apply to these services.

Refer to “What’s Not Covered” on page 23 for details.

Alternative Benefits

There are often several ways to treat a particular dental problem. To determine the benefits the Plan will pay, consideration is given to alternative procedures that will produce a satisfactory result. The Plan will provide benefits based on a less costly procedure if the results meet accepted standards of dental practices. The patient may choose the more costly procedures, but the patient will be responsible for the difference in charge.

Covered Service Benefits and ADA Codes

Diagnostic

ADA Code	Description	In-Network	Out-of-Network
Clinical Oral Examinations			
120	Periodic oral evaluation—two per calendar year	100%	100%
140	Limited oral evaluation—no more than two per calendar year in lieu of standard exams	100%	100%
150	Comprehensive oral evaluation—two per calendar year	100%	100%

ADA Code	Description	In-Network	Out-of-Network
160	Detailed & extensive oral evaluation—no more than two per calendar year in lieu of standard exams	100%	100%
170	Re-evaluation-limited, problem—no more than two per calendar year in lieu of standard exams	100%	100%
180	Comprehensive periodontal evaluation—no more than two per calendar year in lieu of standard exams	100%	100%
Radiographs			
210	Intraoral-complete series (including bitewings)—once per 36 months	100%	100%
220	Intraoral periapical—first film	100%	100%
230	Intraoral periapical—each additional film	100%	100%
272	Bitewings-two films—two per calendar year	100%	100%
274	Bitewings-four films—two per calendar year	100%	100%
330	Panoramic film—once per 36 months	100%	100%

Preventive Services

ADA Code	Description	In-Network	Out-of-Network
Dental Prophylaxis			
1110	Prophylaxis-adult (limited to twice yearly)	100%	100%
1120	Prophylaxis-child (limited to twice yearly)	100%	100%
1201	Topical application of FLUORIDE (including prophylaxis)—one per calendar year through age 18	100%	100%
1203	Topical application of fluoride (excluding prophylaxis)—one per calendar year through age 18	100%	100%
Other Preventive Services			
1351	SEALANT-per tooth, non restored permanent 1st and 2nd molars only—to age 19, one per 60 months	100%	100%
Space Maintenance (Passive Appliances)			
1510	Fixed, unilateral type	100%	100%
1515	Fixed, bilateral type	100%	100%
1520	Removable, unilateral type	100%	100%
1525	Removable, bilateral type	100%	100%
Other Periodontal Services			
4910	Periodontal maintenance procedure following active therapy where treatment including scaling, root planing, and osseous surgery have been performed. No more then 4 four per calendar year when combined with regular cleanings	80%	80%
Unclassified Treatment			
9110	Palliative (emergency) treatment of dental pain—minor procedures	100%	100%

Restorative

ADA Code	Description	In-Network	Out-of-Network
Amalgam Restorations (including polishing)			
2140	Amalgam—one surface, permanent	80%	80%
2150	Amalgam—two surfaces, permanent	80%	80%
2160	Amalgam—three surfaces, permanent	80%	80%
2161	Amalgam—four or more surfaces, permanent	80%	80%
Resin Restorations			
2330	Resin—one surface, anterior	80%	80%
2331	Resin—two surfaces, anterior	80%	80%
2332	Resin—three surfaces, anterior	80%	80%
2335	Resin—four or more surfaces, anterior	80%	80%
2390	Resin-based composite CROWN, anterior	80%	80%
2391	Resin-based composite—one surface, posterior	80%	80%
2392	Resin-based composite—two surfaces, posterior	80%	80%
2393	Resin-based composite—three surfaces, posterior	80%	80%
2394	Resin-based composite—four or more surfaces, posterior	80%	80%
Inlay Restorations			
2650	Inlay, composite/resin—one surface—one per 60 months	70%	50%
2651	Inlay, composite/resin—two surfaces—one per 60 months	70%	50%
2652	Inlay, composite/resin—three or more surfaces—one per 60 months	70%	50%
2662	Onlay, composite/resin two surfaces laboratory processed—one per 60 months	70%	50%

ADA Code	Description	In-Network	Out-of-Network
2663	Onlay, composite/resin three surfaces laboratory processed—one per 60 months	70%	50%
2664	Onlay, composite/resin four or more surfaces laboratory processed—one per 60 months	70%	50%
Crowns-Single Restorations Only			
2740	Porcelain/ceramic substrate—one per 60 months	70%	50%
2750	Porcelain fused to high noble metal—one per 60 months	70%	50%
2751	Porcelain fused to predominantly base metal—one per 60 months	70%	50%
2752	Porcelain fused to noble metal—one per 60 months	70%	50%
2790	Full cast high noble metal—one per 60 months	70%	50%
2810	3/4 cast metallic—one per 60 months	70%	50%
Other Restorative Services			
2930	Prefabricated stainless steel crown, primary tooth—one per 60 months	80%	80%
2940	Sedative filling	80%	80%
2950	Core buildup, including any pins – one per 60 months	70%	50%
2952	Cast post and core in addition to crown – one per 60 months	70%	50%
2954	Prefabricated post and core in addition to crown – one per 60 months	70%	50%

Endodontics

ADA Code	Description	In-Network	Out-of-Network
Pulp Capping			
3110	Pulp cap—direct (excluding final restoration)	80%	80%
3120	Pulp cap—indirect (excluding final restoration)	80%	80%
Pulpotomy			
3220	Therapeutic pulpotomy (excluding final restoration)	80%	80%
Root Canal Therapy (including treatment plan, clinical procedures, and follow-up care)			
3310	Anterior (excluding final restoration)	80%	80%
3320	Bicuspid (excluding final restoration)	80%	80%
3330	Molar (excluding final restoration)	80%	80%
Periapical Services			
3410	Apicoectomy/periradicular surgery—anterior	80%	80%
3421	Apicoectomy/periradicular surgery—bicuspid (1st root)	80%	80%
3425	Apicoectomy/periradicular surgery—molar (1st root)	80%	80%
3426	Apicoectomy/periradicular surgery (each additional root)	80%	80%

Periodontics

ADA Code	Description	In-Network	Out-of-Network
Surgical and Non-Surgical Services			
4210	GINGIVECTOMY or gingivoplasty—per quadrant—one per 36 months	80%	80%
4211	Gingivectomy or gingivoplasty—one to three teeth per quadrant—one per 36 months	80%	80%
4249	Clinical crown lengthening—hard tissue—one per 36 months	80%	80%
4260	Osseous surgery (including flap entry and closure)—four or more contiguous teeth per quadrant—one per 36 months	80%	80%
4261	Osseous surgery (including flap entry and closure)—one to three teeth per quadrant—one per 36 months	80%	80%
4263	Bone replacement graft—1st tooth in quadrant—one per 36 months	80%	80%
4264	Bone replacement graft—each additional tooth in quadrant—one per 36 months	80%	80%
4271	Free soft tissue graft procedure, including donor site surgery—one per 36 months	80%	80%
Adjunctive Periodontal Services			
4341	Periodontal scaling and root planing-four or more contiguous teeth per quadrant—one per 24 months	80%`	80%
4342	Periodontal scaling and root planing-one to three teeth per quadrant—one per 24 months	80%	80%

Prosthodontics

ADA Code	Description	In-Network	Out-of-Network
Complete Dentures (including routine post-delivery care)			
5110	Complete denture, upper—one per 60 months	70%	50%
5120	Complete denture, lower—one per 60 months	70%	50%
Partial Dentures (including routine post-delivery care)			
5211	Upper partial denture-resin base (including any conventional clasps, rests and teeth)—one per 60 months	70%	50%
5212	Lower partial denture-resin base (including any conventional clasps, rests and teeth)—one per 60 months	70%	50%
5213	Upper partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)—one per 60 months	70%	50%
5214	Lower partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)—one per 60 months	70%	50%
5730	Relines – one per 36 months	80%	80%
5710	Rebase – one per 36 months	80%	80%
Repairs to Complete Dentures			
5520	Replace missing or broken teeth, complete denture (each tooth)	80%	80%
Repairs to Partial Dentures			
5640	Replace broken teeth-per tooth	80%	80%

Prosthodontics, Fixed

ADA Code	Description	In-Network	Out-of-Network
Bridge Pontics			
6010	Implant—one per 60 months	60%	50%
6240	Pontic-porcelain fused to high noble metal—one per 60 months	70%	50%
6242	Pontic-porcelain fused to noble metal—one per 60 months	70%	50%
Bridge Retainers-Crowns			
6750	Crown-porcelain fused to high noble metal—one per 60 months	70%	50%
6751	Crown-porcelain fused to predominantly base metal—one per 60 months	70%	50%
6752	Crown-porcelain fused to noble metal—one per 60 months	70%	50%

Oral Surgery

ADA Code	Description	In-Network	Out-of-Network
Extractions (including local anesthesia and routine post-operative care)			
7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	80%	80%
Surgical Extractions (including local anesthesia and routine post-operative care)			
7210	Surgical removal of erupted tooth	80%	80%
7220	Removal of impacted tooth-soft tissue	80%	80%
7230	Removal of impacted tooth-partially bony	80%	80%
7240	Removal of impacted tooth-completely bony	80%	80%
7250	Surgical removal of residual root (cutting procedure)	80%	80%
Surgical Incisions			
7510	Incision and drainage of abscess, intraoral soft tissue	80%	80%

Adjunctive General Services

ADA Code	Description	In-Network	Out-of-Network
Anesthesia			
9220	General anesthesia-first 30 minutes	80%	80%
9221	General anesthesia-each additional 15 minutes	80%	80%
9240	Intravenous sedation	80%	80%
Professional Consultation			
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	80%	80%
Drugs			
9610	Therapeutic drug injection, by report	80%	80%
Miscellaneous Services			
9910	Application of desensitizing medicaments	80%	80%
9940	Occlusal guards, by report	80%	80%
9951	Occlusal adjustment-limited	80%	80%
9952	Occlusal adjustment-complete	80%	80%
8210	Harmful Habits	70%	50%

What's Not Covered

General Exclusions

What are the general exclusions?

The Plan doesn't cover:

- cosmetic treatment
- replacement for accidental injured teeth (contact your medical plan claims administrator to find out whether services are covered under your medical plan)

- treatment covered under any other plan sponsored by MMC (other than through a health care flexible spending account or health savings account)
- treatment furnished in a U.S. government hospital
- treatment performed before the employee or family member was covered by the Plan
- services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist for scaling and polishing of teeth; or FLUORIDE treatments
- treatment required because of teeth grinding (except for occusal guards)
- replacement of a lost, missing or stolen CROWN BRIDGE or denture
- services or supplies which are covered by any workers' compensation laws or occupational disease laws
- services or supplies, which are, covered by any employers' liability laws
- services or supplies which any employer is required by law to furnish in whole or part
- services or supplies for which no charge would have been made in the absence of dental benefits
- services or supplies which are deemed experimental in terms of generally accepted dental standards
- use of materials or home health aids to prevent decay, such as toothpaste or fluoride gels, other than topical application of fluoride
- instruction for oral care such as hygiene or diet
- charges by the dentist for completing dental forms
- sterilization supplies
- charges for broken appointments
- treatment that would otherwise be free to you.

Diagnostic and Preventive Exclusions

What are the diagnostic and preventive exclusions?

The Plan doesn't cover:

- education or training and supplies used for personal oral hygiene or plaque control and dietary or nutritional counseling
- treatment or appliances to increase vertical dimension (the length of the face determined by the distance of the separation of jaws)
- repair or replacement of SEALANT within 60 months of initial placement.

Restorative Exclusions

What are the restorative exclusions?

The Plan doesn't cover:

- fillings, other than amalgam, for restoration of molar teeth and certain surfaces of posterior teeth (the Plan will only consider for benefits the cost of an amalgam restoration)
- reimbursement for a temporary and a permanent CROWN is limited to the permanent crown charge
- adjustments to DENTURES within six months of installation
- specialized techniques, precision attachments, personalization or characterization of dentures
- reimbursement for a temporary and a permanent denture is limited to the permanent denture charge
- ORAL SURGERY postoperative
- oral surgery treatment of fracture and dislocation of a tooth (may be covered under your medical plan)
- orthognathic surgery (covered under your medical plan if medically necessary)
- replacement of wisdom teeth
- restorations to restore occlusion (chewing or grinding the surface of bicuspid and molar teeth), unless given in connection with orthodontic treatment
- surgery for Temporomandibular Joint Syndrome (TMJ/TMD) (covered under your medical plan if medically necessary).

General Services Exclusions

What are the general services exclusions?

The Plan doesn't cover:

- separate charges for general anesthetics
- separate charges for local anesthetics.

Orthodontic Exclusions

What are the orthodontic exclusions?

The Plan doesn't cover:

- charges for continuation of orthodontic treatment that began before the employee or family member was covered by the Plan
- repair or replacement of an orthodontic appliance.

Filing Claims

How do I file a claim?

If you are using an IN-NETWORK dentist, MetLife Dental pays your dentist directly. You don't have to file a claim.

If you are not using an in-network dentist, you or your dentist will have to submit a claim to MetLife Dental for processing. You have to file the claim within 12 months after the date of service; otherwise, you will not receive reimbursement.

Note: If a claim is submitted by a participating dentist without an employee's signature or signature on file authorizing MetLife to pay the dentist, payment will be issued to the employee.

Where do I get a claim form?

You can get a claim form from:

MetLife Dental
P.O. Box 981282
El Paso, TX 79998-1282
1-800-942-0854
www.metlife.com/mybenefits (enter "MMC" in the field where you can enter your company name)

When will I receive the payment after I submit my claim?

Once you submit the claim, it takes MetLife Dental about 10 business days to process the claim and transmit payment, if any, to your dentist.

Who receives the payment?

If you are using an in-network dentist, MetLife Dental pays your dentist directly.

If you are using an OUT-OF-NETWORK dentist, you can have benefits paid to you or directly to your dentist. To have the benefits paid to your dentist, sign the assignment section of the claim form.

Note: If a claim is submitted by a participating dentist without an employee's signature or signature on file authorizing MetLife to pay the dentist, payment will be issued to the employee

Appealing Claims

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

What happens if I have a Flexible Spending Account?

Your dental claim for any copayment or any other amount not covered by the Plan, including ORTHODONTIA, will be sent automatically to the Flexible Spending Account Claims Administrator for processing.

Glossary

ACTIVELY-AT-WORK

You are "actively at work" if you are fulfilling your job responsibilities at a Company-approved location on the day coverage is supposed to begin (e.g., you are not out ill or on a leave of absence).

ACTIVE WORK STATUS

You must be actively-at-work during your approved scheduled work week and not on any type of leave.

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the plans' criteria, or immediately upon satisfying the plans' criteria if you previously did not qualify. To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership via PeopleLink (www.mmcpeoplelink.com), declaring that:

Spouse / Domestic Partner

- You have already received a marriage license from a U.S. state or local authority, or registered your domestic partnership with a U.S. state or local authority.

Spouse Only

- Although not registered with a U.S. state or local authority, your relationship constitutes a marriage under U.S. state or local law (e.g. common law marriage or a marriage outside the U.S. that is honored under U.S. state or local law).

Domestic Partner Only

- Although not registered with a U.S. state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - be at least 18 years old
  - not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - have agreed to share responsibility for each other's common welfare and basic financial obligations
  - not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

MMC reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

Once your Affidavit of Eligible Family Membership is completed and processed, you may cover the dependent child(ren) of your spouse or domestic partner.

Complete your affidavit, via PeopleLink (www.mmcpeoplelink.com). Select the **Health** tab and under **Dental Plan**, click **Dental**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits.**

BITEWING

A bitewing is the dental X-ray showing the crown portions of the upper and lower teeth.

BRIDGE

A bridge is a strong connecting link between two or more teeth, replacing a missing tooth or teeth. It usually has a gold frame and porcelain that has the shape and color of the missing teeth.

CROWN

A crown—also called a cap—is a porcelain or gold tooth cover for a decayed, damaged, brittle or discolored tooth that has a strong base and roots.

DENTURES

Dentures are removable, artificial teeth designed to help you chew, restore your bite and improve your appearance.

ELIGIBLE FAMILY MEMBERS

Child/Dependent Child means:

- your biological child
- a child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- the child of an approved domestic partner
- your stepchild
- your legally adopted child or a child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify dependency (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

Eligible MMA Employees

As used throughout this document, "MMA Employees" are defined as employees classified on payroll as U.S. regular employees of MMA Corporate, Insurance Alliance, the NIA Agency or the MMA Anchorage office.

Eligible MMC Employees (other than MMA)

As used throughout this document, "MMC Employees (other than MMA)" are defined as employees classified on payroll as U.S. regular employees of MMC or any subsidiary or affiliate of MMC (other than MMA and any of its subsidiaries).

Endodontic Treatment

Endodontics refers to the care of the pulp chambers and root canals of your natural teeth; it usually involves sterilization and filling.

Fluoride

Fluoride is a natural substance found in minerals that works with your tooth or bone structure to make it stronger and more resistant to acid decay.

Gingivectomy

Gingivectomy refers to the surgical removal of the flaps of gum tissue that create pockets alongside teeth that have periodontal damage. This operation is designed to stop periodontal disease.

In-network

When you receive care from a dentist who has an agreement with your Plan, it is referred to as in-network care. Your costs are generally lower for in-network care than for out-of-network care.

Inlays and Onlays

An inlay is a cast porcelain, composite or gold filling that is used to help restore the side or top area of a tooth. Onlays are similar to inlays but are used to cover the entire chewing surface of a tooth.

Oral surgery

Oral surgery is surgery of the oral mouth cavity, including teeth and gums. Dental oral surgery typically includes complex extractions and other surgical procedures.

ORTHODONTIA

Orthodontia is the branch of dentistry that specializes in the diagnosis, prevention and treatment of dental and facial irregularities through the use of devices such as removable appliances or fixed braces to remove teeth or adjust underlying bone.

OUT-OF-NETWORK

When you receive care from a dentist who does not have an agreement with your Plan, your services are considered out-of-network. Your costs are generally lower for in-network care than for out-of-network care.

PERIODONTICS

Periodontics is the treatment of the supporting structure of the tooth—the gum and bone tissue

REASONABLE AND CUSTOMARY CHARGES

A reasonable and customary (R&C) charge is the lesser of the fee most dentists in an area normally charge for the same type of dental service (as determined by MetLife) and your provider's actual charges. It is sometimes called usual, reasonable and customary (URC); or usual, customary and reasonable (UCR) charges.

ROOT CANAL

A root canal is a procedure where the nerve of a heavily decayed tooth is removed from the tooth and replaced with a filling material.

SEALANT

A sealant is the protective plastic coating applied over grooves in your teeth to prevent decay.

SPACE MAINTAINER

A space maintainer is an appliance children use in their mouths to keep a space until a permanent tooth comes in to fill the space so their remaining teeth don't drift or crowd new teeth.

SPLINTING

Splinting is connecting teeth with a fixed appliance.

TIME LIMIT

Some covered services are reimbursed based on time limits. In these cases, reimbursement is determined by the exact date of the covered service. For example, the Plan reimburses dentures only after 60 months since the dentures were placed. So, if you received dentures on June 16, 2001, you will next be eligible to receive a new set of dentures on or after June 16, 2006. This is true even if new dentures are lost or stolen.

TMJ (TEMPOROMANDIBULAR JOINT) SYNDROME

TMJ/TMD syndrome is a medical or dental problem related to the temporomandibular joint that links the jaw bone and skull.