WHO IS ELIGIBLE FOR BENEFITS?

This Government dental benefit program helps protect the smiles of Veterans and their families by offering them comprehensive dental coverage. With VADIP there are two plan options (based on needs and budget). Over 8.6 million eligible Veterans have the opportunity to purchase voluntary dental insurance for themselves and their family members. Participation in this program is open to Veterans enrolled in the VA health care program and eligible family members who are beneficiaries of the VA’s Civilian Health and Medical Program (CHAMPVA).

VADIP covers dental services provided in the United States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

ENROLLMENT

Enrollment: MetLife manages the dental enrollment process and enrollment in this program is “evergreen” (throughout the year and not limited to a specific enrollment period). Participants can enroll in a high option or a standard plan option as they become eligible. The dental program effective date for an enrollee cannot be before January 1, 2016.

MetLife will verify an applicant’s eligibility through an eligibility verification process prior to informing the applicant of their eligibility for this dental program. MetLife will enroll eligible applicants within 5 calendar days from the date of receipt of a request to enroll.

If you have any questions or encounter an issue with your enrollment, we ask that you contact our customer service for assistance at 1-888-310-1681.

Lock-in and Lock-out Periods: The initial enrollment period will be at least 12 calendar months.

COVERAGE EFFECTIVE DATE

If you are eligible for coverage in accordance with the VA eligibility guidelines and you enroll, your coverage will be effective on the 1st of the month following your enrollment. (e.g., if you enroll on March 25th, the coverage effective date is April 1st). The effective date shall not be more than 31 calendar days from date of enrollment. MetLife may require 3-5 business days for processing enrollments.

MetLife shall provide each enrolled applicant a written explanation of their effective date of coverage via email or mail as part of their enrollment package.
# PLAN BENEFITS

This dental program has a choice of two plan options – Standard and High. Both options cover a broad range of important dental services. Please review the plan details below to help you decide which option best fits your needs.

## DENTAL PLAN SUMMARY

<table>
<thead>
<tr>
<th>COVERAGE TYPE</th>
<th>STANDARD OPTION</th>
<th>HIGH OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN NETWORK¹</td>
<td>OUT OF NETWORK²</td>
</tr>
<tr>
<td>BASIC – CLASS A</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Cleanings, bitewing x-rays and oral examinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INTERMEDIATE – Class B</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>X-rays (other than bitewing), fillings and periodontal maintenance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAJOR – Class C</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Crowns, bridges, root canal treatment and dentures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORTHODONTIA – Class D*</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>comprehensive orthodontic treatment, fixed appliance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## MAXIMUMS & DEDUCTIBLES

<table>
<thead>
<tr>
<th></th>
<th>STANDARD OPTION</th>
<th>HIGH OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum Per Person</td>
<td>$1,300</td>
<td>$1,000</td>
</tr>
<tr>
<td>Dependent Child Ortho Lifetime Maximum Per Person</td>
<td>NOT COVERED</td>
<td>NOT COVERED</td>
</tr>
<tr>
<td>Annual Deductible Per Person Applies to Basic, Intermediate and Major Services</td>
<td>$50.00</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

*Orthodontia is for dependent children only.* Orthodontia coverage is available for dependents up to age 19 and the dependent must be covered under the High option for 24 consecutive months before orthodontia will be covered.

¹ IN-NETWORK: Negotiated fees with participating dentists are typically 15% to 45% less than average dental charges in the same community. Negotiated fees refer to the fees that participating (in-network) dentists have agreed to accept as payment in full for covered services rendered by them. Negotiated fees are subject to change. For in-network covered services, the percentages shown are the percentage of the negotiated fee that is covered by the plan. Negotiated fees may also apply to services your dental plan does not cover or services received after you’ve reached your annual plan maximum, depending on applicable law.

² OUT-OF-NETWORK: For out-of-network services, fees are set by each individual dentist and are typically higher than in-network negotiated fees. You will be responsible for the difference between your dentist’s charge and the covered percentage of the Reasonable and Customary (R&C) fee for a given service, subject to any deductibles, cost sharing, benefit maximum and terms of the plan. Under your plan, the R&C fee is the lowest of (1) the dentist’s actual charge; or (2) the usual charge of other dentists in the same geographic area equal to the 50th percentile of charges as determined by FAIR Health, a national, independent not-for-profit corporation, based on charge information for the same or similar services.
DESCRIPTION OF COVERED SERVICES

CLASS A Covered Services
- Oral exams and problem-focused exams, but no more than one exam every 6 months
- Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months
- Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months
- Panoramic x-rays once every 60 months
- Bitewing x-rays 1 set every 12 months
- Cleaning of teeth (oral prophylaxis) once every 6 months

CLASS B Covered Services
- Intraoral-periapical x-rays
- X-rays, except as mentioned elsewhere
- Full mouth x-rays once every 60 months
- Emergency palliative treatment to relieve tooth pain
- Initial placement of amalgam fillings
- Replacement of an existing amalgam filling, but only if:
  - at least 24 months have passed since the existing filling was placed; or
  - a new surface of decay is identified on that tooth
- Initial placement of resin-based composite fillings
- Replacement of an existing resin-based composite filling, but only if:
  - at least 24 months have passed since the existing filling was placed; or
  - a new surface of decay is identified on that tooth
- Protective (sedative) fillings
- Periodontal scaling and root planning, but not more than once per quadrant in any 24 month period
- Full mouth debridement, limited to once per lifetime
- Simple extractions
- Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any Year less the number of teeth cleanings received during such Year
- Pulp capping (excluding final restoration)
- Therapeutic pulpotomy (excluding final restoration)
- Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 36 months
- Pulp vitality and bacteriological studies for determination of bacteriologic agents
- Diagnostic casts
CLASS C Covered Services

- Pulp therapy
- Surgical extractions
- Apexification/ recalcification
- Injections of therapeutic drugs
- Initial installation of full or partial Dentures (other than implant supported prosthetics):
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance
- Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 years prior to replacement. 1 in 10 years
- Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 years prior to replacement. 1 in 10 years
- Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture. 1 in 10 years
- Relinings and rebasings of existing removable Dentures:
  - if at least 6 months have passed since the installation of the existing removable Denture; and,
  - not more than once in any 36 month period
- Initial installation of Cast Restorations (except implant supported Cast Restorations)
- Replacement of any Cast Restoration (except an implant supported Cast Restoration) with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth surface within 120 months of a prior replacement
- Prefabricated crown, but no more than one replacement for the same tooth surface within 10 years
- Core buildup, but no more than once per tooth in a period of 10 years
- Posts and cores, but no more than once per tooth in a period of 10 years
- Labial veneers, but no more than once per tooth in a period of 10 years
- Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period
- Other consultations, but not more than twice in a 12 month period
- Root canal treatment, but no more than once in any 24 month period for the same tooth
- Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period
- Implant services (including sinus augmentation and bone replacement and graft for ridge preservation):
  - when needed to replace congenitally missing teeth; or
  - when needed to replace natural teeth that are lost while the person receiving such benefits was insured for Dental Insurance; but no more than once for the same tooth position in a 10 year period
- Repair of implants, but no more than once in a 12 month period
- Implant supported Cast Restorations, but no more than once for the same tooth position in
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- Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 year period
- Implant supported removable Dentures, but no more than once for the same tooth position in a 10 year period
- Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed
- Occlusal adjustments, Complete: 1 in 12 months. Limited: No frequency limitation
- Oral surgery, except as mentioned elsewhere in this certificate
- General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards
- Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period
- Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period
- Addition of teeth to a partial removable Denture to replace natural teeth removed while this Dental Insurance was in effect for the person receiving such services
- Tissue conditioning, but not more than once in a 36 month period
- Simple Repairs of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period
- Modification of removable prosthodontic and other removable prosthetic services

Class D Covered Services
- ONLY COVERED IN THE HIGH PLAN OPTION NOT COVERED IN THE STANDARD PLAN
- Orthodontia, for a Child under the age of 19
- There is a 24 month waiting period for services

DENTAL INSURANCE: EXCLUSIONS

The exclusions in this section apply to all services. Although we may list a specific item as a covered service, we will not cover it unless we determine it is necessary for the prevention, diagnosis, care, or treatment of a covered condition.

We do not cover the following:
- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are experimental or investigational;
- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or
not you claim the benefits or compensation;

- Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, 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 limited by Plan frequency limitations;
- 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 Disorder (TMJ);
- 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;
- Any charge submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;
- Services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- Services for which the member would have no obligation to pay in the absence of this or any similar coverage;
- Services which are for specialized procedures and techniques;
- Services 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;
- 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;
- 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;
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- 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;
- 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 services and appliances for a dependent child enrolled in the standard plan.
- Orthodontic services for members and spouses
- Orthodontic services for dependent children age 19 and over
- Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement.
- Repair or replacement of an orthodontic device;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal and external bleaching;
- Nitrous oxide;
- Oral sedation;
- Topical medicament center;
- Bone grafts when done in connection with extractions, apicoetomies 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;
- All out of network services are subject to the Fair Health R&C maximum allowable fee charges as defined by MetLife. The member is responsible for all remaining charges that exceed the allowable maximum.

PREMIUM COST

There are no Government funds involved in this contract and services provided under this contract are totally funded through premiums paid by enrollees. Premium cost is determined by your residential zip code. Please visit the “Rate” information section of our website (www.metlife.com/vadip) to review your monthly premium cost.

MetLife shall collect premiums directly from enrollees on a monthly basis. MetLife shall employ its standard business practices for the collection of past due premiums and provide proper notification. MetLife shall refund any overpayments within 30 calendar days of identifying the overpayment.
DISENROLLMENT

Disenrollment: Participants may be involuntarily dis-enrolled at any time for failure to make premium payments. Prior to such disenrollment, MetLife shall provide at least 15 days written notice to the participant to allow the participant time to make premium payments. If State law imposes additional restrictions on insurers who wish to involuntarily disenroll participants, then State law would govern. Likewise, State law would also govern any applicable appeals procedures or participant rights relating to involuntary disenrollment.

Participants may ask to be voluntarily dis-enrolled, and will not be required to continue payment of any premiums, under the following circumstances:

a. For any reason, during the first 30 days that the participant is covered by the plan, if no claims for dental services or benefits were filed by the participant or an eligible family member of the participant

b. If the participant relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan

c. If the participant asserts that he or she is prevented by serious medical condition from being able to obtain benefits under the plan, or that he or she would suffer severe financial hardship by continuing in this program

d. For any reason during the month to month coverage period, after the initial 12 month enrollment period

e. At the discretion of MetLife, a 12 month lock-out period from re-enrollment is permitted upon disenrollment

Requests for Disenrollment: All participant requests for disenrollment will be submitted to MetLife for determination of whether the participant qualifies for disenrollment. Requests for disenrollment due to financial hardship or serious medical condition must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to MetLife must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date of coverage, and will prevent the participant from maintaining the insurance benefits.