

Benefit Highlights for the Standard and Premier Dental PPO Plans

	Standard Plan		Premier Plan	
Deductible	In-Network^{3a}	Out-of-Network^{3b}	In-Network^{3c}	Out-of-Network^{3d}
Individual	\$50	\$50	\$50	\$50
Family	\$150	\$150	\$150	\$150
Annual Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network
Per Person	\$1,500	\$750	\$1,500	\$1,500
Orthodontia Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual maximum benefit	\$1,000	\$1,000	\$1,000	\$1,000
Coverage Type	In-Network^[1]	Out-of-Network^[1]	In-Network^[1]	Out-of-Network^[1]
Type A - Preventive Care				
<ul style="list-style-type: none"> ▪ Topical Fluoride Applications ▪ Prophylaxis (Cleanings) ▪ Oral Examinations ▪ Full Mouth X-rays ▪ Bitewing X-rays 	100% of PDP Fee ²	80% of PDP Fee ²	100% of PDP Fee ²	90% of R&C Fee ⁵
Type B - Basic Restorative				
<ul style="list-style-type: none"> ▪ Space Maintainers & Sealants ▪ Periodontics ▪ Oral Surgery: Simple Extractions ▪ General Anesthesia ▪ Amalgam and Composite Fillings ▪ Endodontics ▪ Crown, Denture and Bridge Repairs ▪ Consultations ▪ Emergency Palliative Treatment ▪ Prefabricated Stainless Steel & Resin ▪ Oral Surgery: Surgical Extractions ▪ Other Oral Surgery 	80% of PDP Fee	70% of PDP Fee	80% of PDP Fee	70% of R&C Fee
Type C - Major Restorative				
<ul style="list-style-type: none"> ▪ Implants ▪ Crowns/Inlays/Onlays ▪ Bridges ▪ Dentures ▪ Harmful Habits Appliances ▪ Bruxism Appliances 	50% of PDP Fee	50% of PDP Fee	50% of PDP Fee	50% of R&C Fee
Type D - Orthodontia	50% of PDP Fee	50% of PDP Fee	50% of PDP Fee	50% of R&C Fee
TMJ				
Not Covered	N/A	N/A	N/A	N/A

¹ "In-Network Benefits" means benefits under this plan for covered dental services that are provided by a MetLife PDP Dentist. "Out-of-Network Benefits" means benefits under this plan for covered dental services that are not provided by a MetLife PDP Dentist.

² PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.

^{3a} Applies to Type B and C services only. ^{3b} Applies to Type B and C services only. ^{3c} Applies to Type B and C services only. ^{3d} Applies to Type B and C services only.

⁵ Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary Charge is based on the lesser of: • The dentist's actual charge (the 'Actual Charge') or • The charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your membership ends, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, a dependent ceases to be a dependent, or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

The service categories shown above represent an overview of your Plan of Benefits. This document is not a complete description of the Plan. Please see your Plan description and certificate for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping policies in force. A copy of the Plan description is available from RealCare Insurance Marketing, Inc.; (800) 939-8088, Ext. 202.

List of Primary Covered Services & Limitations

Standard and Premier Plans

Type A - Preventive

How Many/How Often:

Topical Fluoride Applications	• 1 fluoride treatment in 12 months for dependent children up to 19th birthday.
Prophylaxis (Cleanings)	• 1 cleaning in 6 months.
Oral Examinations	• 1 oral exam in 6 months.
Full Mouth X-rays	• 1 full mouth X-ray in 24 months.
Bitewing X-rays	• Adult - 1 time in 6 months / Child - 1 time in 6 months up to 14th birthday.

Type B - Basic Restorative

How Many/How Often

Space Maintainers	• Space Maintainers for dependent children up to 17th birthday.
Sealants	• 1 sealant per permanent 1st & 2nd non-restored non-decayed molar in 24 months of a dependent child up to 19th birthday.
Periodontics	• Periodontal maintenance: 2 periodontal treatments in 1 year, includes 2 cleanings. • Periodontal scaling & root planing: 1 per quadrant in any 60 month period. • Periodontal surgery: 1 per quadrant in any 60 month period.
Oral Surgery: Simple Extractions	
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Amalgam and Composite Fillings	• 1 in 24 months. Composite fillings covered on all teeth.
Endodontics	• Root Canal treatment limited to 1 in 24 Months.
Crown, Denture and Bridge Repairs	• 1 per 24 Months. • 1 per 12 months
Consultations	
Emergency Palliative Treatment	• 1 replacement per 5 years
Prefabricated Stainless Steel & Resin Crowns	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

Type C - Major Restorative

How Many/How Often

Implants	• Services: 1 per tooth position in 10 years. Repairs: 1 per 5 years.
Crowns/Inlays/Onlays	• 1 replacement per 5 years.
Bridges	• 1 in 5 years.
Dentures	• 1 in 5 years.
Harmful Habits Appliances	
Bruxism Appliances	

Type D - Orthodontia

- Dependent children are covered until the end of the month of their 19th birthday or until their 23rd birthday if unmarried, full-time students.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Benefit for initial placement of the appliance will be made representing 20% of the total benefit.
- Orthodontic benefits end at cancellation of coverage.

Benefit Waiting Period

For new members who elect coverage between the 60th and 120th day of C.A.R membership, a no waiting period will apply. If you do not enroll during your eligibility period, you will not be able to enroll until the next open enrollment period or until you experience a qualifying event.

In the case of the transferred business, if members elected coverage under the prior plan for which the members were eligible, no waiting waiting period will apply.

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

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description and certificate for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force.

Group Term Life and AD&D Insurance for: California Association of REALTORS®

Effective: June 1st 2009

Build Your Benefit: With MetLife's Term Life insurance, your association gives you the opportunity to buy valuable life insurance coverage at affordable group rates.

	Member/Employee Benefit
Insurance Schedules	<u>Option 1:</u> Flat \$25,000
	<u>Option 2:</u> Flat \$50,000
Non Medical Maximum	\$50,000
Non Medical Maximum – Age 70 or Over	\$50,000
Overall Benefit Maximum	\$50,000
AD&D	Duplicates Life Option

Any purchase or increase in benefits, which does not take place within 31 days of member's/employee's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of MetLife.

Did You Know?

Many people who know they need more life insurance - estimated at 48 million American households, will not take action¹



L12071548(exp1109)(All States)(DC, GU, MP, PR, VI)
Metropolitan Life Insurance Company, 200 Park Ave., New York, NY 10166

¹ *Trillion Dollar Baby. The Sales Potential of the Underinsured Life Market, LIMRA International, 2005*



Benefits:

Comprehensive Vision Examination:	One every 12 months
Lenses	One pair every 12 months
Frame	One frame every 12 months
Contact Lenses	One pair every 12 months

The Policy provides full coverage for Covered Services, when you go to a Participating Provider of The MESVision Network (MES). If Covered Services are provided by a Non-Participating Provider, charges will be paid, but not to exceed the following Schedule of Allowances.

Description of Services	Participating Provider	Non-Participating Provider
Ophthalmologic Examination	Paid-in-Full	Up to \$ 60.00
Optometric Examination	Paid-in-Full	Up to \$ 50.00
Single Vision Lenses	Paid-in-Full	Up to \$ 43.00
Bifocal Lenses	Paid-in-Full	Up to \$ 60.00
Trifocal Lenses	Paid-in-Full	Up to \$ 75.00
Polycarbonate Lenses	Up to \$100.00*	Up to \$ 75.00
Aphakic or Lenticular Monofocal	Paid-in-Full	Up to \$ 120.00
Aphakic or Lenticular Multifocal	Paid-in-Full	Up to \$ 200.00
Frame	Up to \$120.00**	Up to \$ 40.00
Contact Lenses ***		
Medically Necessary Hard	Paid-in-Full	Up to \$ 200.00
Medically Necessary Soft	Paid-in-Full	Up to \$ 250.00
Cosmetic or Convenience	Up to \$120.00	Up to \$ 120.00

* Polycarbonate Lenses for dependent children are covered up to **\$100.00**, after applicable copay, balance is your responsibility.

** Participating Providers allow a selection of frames that retail up to **\$120.00** with lenses that fit an eyesize less than 61 millimeters. If a more expensive frame is selected, you are responsible for the additional cost above **\$120.00**. If the lenses are 61 millimeters or above, the charge for oversize lenses is your responsibility. Retail frame benefits will be converted to wholesale equivalent prices at certain provider locations, see provider directory.

*** This benefit is in addition to the comprehensive vision examination, but in lieu of lenses and frame. If contact lenses are for cosmetic or convenience purposes, the Policy will pay up to **\$120.00** toward the contact lens evaluation, fitting costs and materials. Any balance is your responsibility.

If contact lenses are medically necessary, they are a fully covered benefit. Approval from MES is required. Please refer to your Policy if you require additional information.

A 20% discount is available from selected MES providers for cosmetic extras such as tints, coatings and other add-on charges to standard lenses. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to an additional routine exam or materials when benefits are not otherwise available.

Please visit our website at www.mesvision.com to determine whether your provider offers the 20% discount. Additionally, you may refer to your Participating Provider Directory or call MES at 800/877-6372.

How to Use Your Benefits

Make an appointment with the eyecare specialist of your choice. Participating Provider information and MES Claim Form can be obtained by visiting www.mesvision.com or by contacting your employer or MES.

At the time of your appointment, inform them of your vision coverage and identify yourself as having a MES Vision / AIG Vision plan. Present your Vision Plan ID Card upon arrival at your appointment.

If Covered Services are received from a Non-Participating Provider, you are responsible for paying the provider in full. You or the provider must submit and itemized billing and a copy of your prescription with the Claim Form to MES. Reimbursement will be made to the Insured Person up to the Schedule of Allowances shown for Non-Participating Providers.

Exclusions

Benefits will not be payable under the Policy for expenses incurred for:

1. Professional services and/or materials in connection with:
 - a. Plano (non-prescription) lenses;
 - b. Sub-Normal vision aids;
 - c. Blended bifocals, no-line, or progressive addition lenses;
 - d. Compensated or special multi-focal lenses;
 - e. Anti-reflective, scratch, UV400, or any coating or lamination applied to lenses;
 - f. Tints, except as provided;
 - g. Orthoptics, vision training and developmental vision procedures;
 - h. Contact lens insurance or care kits;
 - i. Services that are experimental or investigational in nature;
2. Broken, lost or stolen lenses, contact lenses or frames;
3. Medical or surgical treatment of the eye, unless such treatment is performed during a vision examination, subject to the applicable Vision Examination Maximum Benefit shown in the Benefit Schedule;
4. Services or materials which are payable under any Workers' Compensation Act or similar law or any other public program other than Medicaid;
5. Services or materials rendered by a provider other than Ophthalmologist, Optometrist or Optician acting within the scope of his or her license; or by an Immediate Family Member;
6. Any additional service required outside basic vision analyses for contact lenses, except fitting fees;
7. Vision examination or vision materials that may be required as a condition of employment, including but not limited to, industrial or safety glasses;
8. Services rendered after the date You or Your Covered Dependent(s) ceases to be covered under the Policy, except when vision materials ordered before coverage ended are delivered and the services are rendered to You or Your Covered Dependent(s) within 31 days from the date of such order, and;
9. Services rendered or materials ordered before the date coverage began for an Insured Person under the Policy.

If you have any questions about the vision benefits, please contact Medical Eye Services:

P.O. Box 25209
Santa Ana, CA 92799-5209
714/619-4660
800/877-6372
www.mesvision.com

This is a brief outline of the vision benefits and is not to be accepted or construed as a substitute for provisions of the Policy.

