Dental Benefits from MetLife

Dental coverage designed for the real world.

MetLife

To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Coverage Type	In-Network[1]	Out-of-Network[1]
Type A - Preventive	**100%** of PDP Fee[2]	**100%** of R&C Fee[3]
Type B - Basic Restorative	**80%** of PDP Fee[2]	**80%** of R&C Fee[3]
Type C - Major Restorative	**50%** of PDP Fee[2]	**50%** of R&C Fee[3]
Deductible[4]		
Individual	$**50**	**Same as In-Network**
Family	$**150**	**Same as In-Network**
Annual Maximum Benefit		
Per Person	**$1000**	**Same as In-Network**

1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP dentist. "Out-of-Network Benefits" means benefits provided 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.
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 charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
4. Applies to Type B, & C services only.

An Example of Savings* When You Visit a MetLife PDP Dentist

Take a look at an example that shows how receiving services from a MetLife PDP dentist can save you money.

Your Dentist says you need a Crown, **a Type C Service****

Dentist's Usual Fee: $600.00 - R&C Fee: $500.00 - PDP Fee: $375.00

IN-NETWORK When you receive care from a MetLife PDP dentist…		**OUT-OF-NETWORK** When you receive care from a Non-Participating dentist…	
The PDP Fee is:	$375.00	Dentist's Usual Fee is:	$600.00
Your Plan Pays: (50% x $375.00 PDP Fee)	- $187.50	Your Plan Pays: (50% x $500.00 R&C Fee)	-$250.00
Your Out-of-Pocket Cost:	$187.00	Your Out-of-Pocket Cost:	$350.00

In this example, YOU SAVE $162.50 ($350.00 minus $187.50)… by using a MetLife PDP dentist!

Please note, this is only an example and may not match your plan design.

*Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

**Please note: this example assumes that your annual deductible has been met.

List of Primary Covered Services & Limitations*

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	• Cleaning of teeth (oral prophylaxis) once every 6 months.
Oral Examinations	• Oral exams once every 6 months.
Topical Fluoride Treatment	• Topical fluoride treatment for a dependent child under age 14, but not more than once every 12 months.
Bitewing X-rays	• Not more than one set every 12 months.
Type B - Basic Restorative	**How Many/How Often**
X-rays	• Intraoral-periapical x-rays. • Full mouth or panoramic X-rays once every 60 months.
Fillings	• Amalgam and Resin-based Fillings 1 in 24 months.
Space Maintainers	• Space Maintainers limited to one per lifetime per area for dependent children under 14 years of age.
Sealants	• Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for a dependent child up to 14 years of age, no more than once every 60 months.
Endodontics	• Pulpal therapy, pulp capping; excludes final restoration.
Periodontal Maintenance	• Periodontal maintenance where periodontal treatment has been previously performed; the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed two treatments in a calendar year.
Emergency palliative treatment	
Injections of antibiotic drugs	
Type C - Major Restorative	**How Many/How Often**
Endodontics	• Therapeutic pulpotomy (excluding final restoration), apexification/recalcification. • Root canal treatment not more often than once per lifetime for the same tooth.
Periodontics	• Periodontal scaling and root planing; not more than once per quadrant (or area) every 24 months. • Periodontal surgery, including gingivectomy or gingivoplasty, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant or area every 36 months.
Relining and Rebasing	• Relining and rebasing 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.
Bridges and Dentures	• Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 years prior to its replacement.
Crowns/Inlays/Onlays	• Replacement of any crowns, inlays, or onlays; not more than once for the same tooth within a period of 10 years.
Repairs of Dentures, Crowns, Inlays, and Onlays	• Repairs of Dentures, Crowns, Inlays, and Onlays, but not more than once in a 12 month period.
Prefabricated Stainless Steel Crowns	• 1 replacement per 10 years.
Oral Surgery	• When dentally necessary in connection with oral surgery, extractions, or other covered dental services.
Extractions	• When dentally necessary in connection with oral surgery, extractions, or other covered dental services.
Anesthesia	
Consultations	• 1 per 12 months.

*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 for complete details.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, exceptions, limitations, reductions and waiting periods and terms for keeping them in force. Please contact MetLife for details.

We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section of your certificate).
5. 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 and polishing of teeth; or
   - fluoride treatments.

   For NY Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. Services
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.
15. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Policyholder**,** labor union, mutual benefit association, or VA hospital.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.

    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
    - Medicaid
24. 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.
25. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.

    For NY Sitused Groups, this exclusion does not apply.
26. Caries susceptibility tests.
27. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

    For NY Sitused Groups, this exclusion does not apply.

28. Other fixed Denture prosthetic services not described elsewhere in this certificate.
29. Precision attachments, except when the precision attachment is related to implant prosthetics.
30. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
    For NY Sitused Groups, this exclusion does not apply.
31. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
    For NY Sitused Groups, this exclusion does not apply.
32. Addition of teeth to a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
    For NY Sitused Groups, this exclusion does not apply.
33. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
34. Implantology.
35. Repair of implants.
36. Cone Beam Imaging
37. Fixed and removable appliances for correction of harmful habits.
38. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
39. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.
40. Orthodontic services or appliances.
41. Repair or replacement of an orthodontic device.
42. Duplicate prosthetic devices or appliances.
43. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
44. Intra and extraoral photographic images.
45. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
    This exclusion only applies for Maryland Sitused Groups

Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 15-45%* below the average fees charged in a dentist's community for the same or substantially similar services.

*Based on internal analysis by MetLife. Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

How do I find a participating PDP dentist? There are more than 150,000 participating PDP dentist locations nationwide, including over 37,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/dental or call 1-800-GET-MET8 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any negotiated fees on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/dental or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? With the Dental Procedure Fee Tool provided by go2dental.com, you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fee* for dental services in your area.

*Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, pre-treatment estimates through your dentist will provide the most accurate fee and payment information.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart form the benefits provided by MetLife.
** Refer to your dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

Do I need an ID card? No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select? No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date? Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)