MetLife

Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps lower your dental costs.

Network: PDP Plus

	Plan 2- High		Plan 1- Low	
	In-Network % of **Negotiated Fee***	**Out-of-Network** % of Scheduled Amount**	**In-Network** % of **Negotiated Fee***	**Out-of-Network** % of Scheduled Amount**
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100% of PDP* fee	100% of R&C** fee	100% of PDP* fee	100% of R&C** fee
Type B: Basic Restorative (fillings, extractions)	90% of PDP* fee	80% of PDP* fee	80% of PDP* fee	80% of PDP* fee
Type C: Major Restorative (bridges, dentures)	60% of PDP* fee	50% of R&C** fee	50% of PDP* fee	50% of R&C** fee
Type D: Orthodontia	50% of PDP* fee	50% of R&C** fee	50% of PDP* fee	50% of R&C** fee
Deductible†				
Individual	$25	$25	$50	$50
Family	$100	$100	$100	$100
Annual Maximum Benefit				
Per Person	$3,000	$3,500	$1,500	$1,500
Orthodontia Lifetime Maximum				
Per Person	$2,500	$2,000	$2,000	$2,000

Child(ren)'s eligibility for dental coverage is from birth up to age 26

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
**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.
†Applies to Type A, B and C Services.Applies only to Type B & C Services.

List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Plan Type	Plan Option 1: Low Plan How Many/How Often	Plan Option 2: High Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Four per calendar year	Four per calendar year
Oral Examinations	Four exams per calendar year	Four exams per calendar year

Topical Fluoride Applications	One fluoride treatment per calendar year for dependent children up to his/her 19th birthday	One fluoride treatment per calendar year for dependent children up to his/her 19th birthday
X-rays	• Full mouth X-rays; one per 60 months • Bitewings X-rays; one set per calendar year for adults; two sets per calendar year for children	• Full mouth X-rays; one per 60 months • Bitewing X-rays; one set per calendar year for adults; two sets per calendar year for children
Sealants	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 19th birthday	One application of sealant material every 36 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 19th birthday
Fluoride	One per year of a dependent child up to his/her 19th birthday	One per year of a dependent child up to his/her 19th birthday
Type B — Basic Restorative		
Fillings		
Simple Extractions		
Endodontics	Root canal treatment limited to once per tooth per 36 months	Root canal treatment limited to once per tooth per 36 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	• Periodontal scaling and root planing once per quadrant in a calendar year • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year	• Periodontal scaling and root planing once per quadrant in a calendar year • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations		
Oral Surgery		
Implants	Replacement once every 5 years	Replacement once every 5 years
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 10 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; one every 10 years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Replacement once every 10 years	Replacement once every 10 years
Endodontics	Root canal treatment limited to once per tooth per 24 months	Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services	When dentally necessary in connection with oral surgery, extractions or other covered dental services

Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year	• Periodontal scaling and root planing once per quadrant, every 24 months • Periodontal surgery once per quadrant, every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Type D — Orthodontia		
	• Your children, up to age 26, are covered while Dental insurance is in effect.You, your spouse and your children, up to age 26, are covered while Dental insurance is in effect • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage	• Your children, up to age 26, are covered while Dental insurance is in effect.You, your spouse and your children, up to age 26, are covered while Dental insurance is in effect • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services Within each category, but is not a complete description of the plan.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which the Plan's dental optional benefit deems experimental in nature; Services for which the member would not be required to pay in the absence of dental benefits;
- Services or supplies received by the member before coverage begins under the Plan's dental optional benefit;
- 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 Services which are primarily cosmetic;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services: Covered under any workers' compensation or occupational disease law; Covered under any employer liability law;
    - For which the Plan is not required to pay; or Received at a facility maintained by Gates, labor union, mutual benefit association, or
- VA hospital;
- Services covered under other coverage provided by Gates;
- Biopsies of hard or soft oral tissue;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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 (except that analgesia/nitrous oxide is covered for children up to the age of 8 years);
- 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;
- Fixed and removable appliances for correction of harmful habits;
- Adjustment of a denture made within six months after installation by the same dentist who installed it;

- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, cast restoration or denture;
- Diagnosis and treatment of temporomandibular joint disorders;
- Intra and extraoral photographic images.

Limitations

Alternate Benefits: 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 pre-treatment 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 plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the certificate of insurance or contact MetLife.

Questions & Answers

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.[†]

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The certificate of insurance/summary plan description sets forth the covered services under the plan. Please review the enclosed plan benefits to learn more.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[††] The website and phone number are for use by dental professionals only.

Q. How are claims processed?

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

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend 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 are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. 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.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions 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, subject to applicable law. 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, subject to applicable law.

Q. Do I need an ID card?

A. No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Dental

	Low Plan		High Plan <$100k		High Plan >$100k	
	Employee cost	Employer cost	Employee cost	Employer cost	Employee cost	Employer cost
Employee Only	$7.24	$5.62	$8.56	$7.67	$9.91	$6.32
Employee + Spouse	$13.96	$11.70	$16.61	$15.79	$19.23	$13.17
Employee + Child(ren)	$15.97	$13.52	$19.01	$18.23	$22.01	$15.22
Employee + Family	$22.70	$19.60	$27.07	$26.35	$31.34	$22.08

†Based on internal analysis by MetLife. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.