

# Dental Benefits from MetLife

Dental coverage designed for the real world.



**MetLife**<sup>®</sup>

## Plan Design for: Professional Insurance Agents Association - Zone 1

Effective Date: **April 1, 2010**

**Choice, Service, Savings.**

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

### Value Plan Benefit Highlights:

### Premier Plan Benefit Highlights:

Coverage Type	In-Network <sup>1</sup>	Out-of-Network <sup>1</sup>	Coverage Type	In-Network <sup>1</sup>	Out-of-Network <sup>1</sup>
Type A - Preventive	100% of PDP Fee <sup>2</sup>	100% of PDP Fee <sup>2</sup>	Type A - Preventive	100% of PDP Fee <sup>2</sup>	100% of R&C Fee <sup>5</sup>
Type B - Basic Restorative	50% of PDP Fee	50% of PDP Fee	Type B - Basic Restorative	80% of PDP Fee	80% of R&C Fee
Type C - Major Restorative	50% of PDP Fee	50% of PDP Fee	Type C - Major Restorative	50% of PDP Fee	50% of R&C Fee

Deductible	In-Network <sup>3a</sup>	Out-of-Network <sup>3b</sup>	Deductible	In-Network <sup>3c</sup>	Out-of-Network <sup>3d</sup>
Individual	\$75	\$75	Individual	\$50	\$50
Family	\$225	\$225	Family	\$150	\$150

Annual Maximum	In-Network	Out-of-Network	Annual Maximum	In-Network	Out-of-Network
Per Person	\$1,000	\$1,000	Per Person	\$2,000	\$2,000

<b>Benefit Waiting Period</b>			
<b>Value Plan:</b>	Benefit Waiting periods may apply without proof of prior dental coverage. Please contact (800) 336-4759 for additional details.	<b>Premier Plan:</b>	Benefit Waiting periods may apply without proof of prior dental coverage. Please contact (800) 336-4759 for additional details.

<sup>1</sup> "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.

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

<sup>3a</sup> Applies to Type B and C services only. <sup>3b</sup> Applies to Type B and C services only. <sup>3c</sup> Applies to Type B and C services only. <sup>3d</sup> Applies to Type B and C services only.

<sup>5</sup> 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 lowest of:

- The dentist's actual charge (the 'Actual Charge'),
- The dentist's usual charge for the same or similar services (the 'Usual Charge') or
- The usual 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 80th percentile. Services must be necessary in terms of generally accepted dental standards.

### **IMPORTANT RATE INFORMATION**

*To obtain pricing for your area please call  
1 (800) 336-4759*

**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 full-time employment ceases, 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.

<b>IMPORTANT ENROLLMENT INFORMATION</b>
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**Benefits Plan Effective Date:** Please see the enclosed cover sheet for specifics on your Plan's effective date.

**Important Enrollment Provision:****Qualifying Event:**

Request to be covered, or to change your coverage, upon a Qualifying Event. If there is a Qualifying Event you may request to be covered, or to change your coverage, for Personal Dental Expense Benefits only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under This Plan because of a loss of the prior dental coverage. If you make a request to be covered for Personal Dental Expense Benefits or a request for change(s) in Personal Dental Expense Benefits within thirty-one days of a Qualifying Event, your Personal Dental Expense Benefits or the change(s) in Personal Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

**MetLife Dual Option Dental - List of Covered Services & Limitations**

**Value Plan: Standard Offering**

**Type A – Preventive**

**How Many/How Often**

Topical Fluoride Applications	• 1 fluoride treatment in 12 months for dependent children up to 14th birthday.
Space Maintainers	• Space Maintainers for dependent children up to 14th 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 60 months.
Bitewing X-rays	• Adult - 1 time in 12 months / Child - 1 time in 12 months up to 14th birthday.
Emergency Palliative Treatment	

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**Type B - Basic Restorative**

**How Many/How Often**

Sealants	• 1 sealant per permanent 1st & 2nd non-restored non-decayed molar in 60 months of a dependent child up to 14th birthday.
Periodontics	• Periodontal maintenance: 4 periodontal treatments in 1 year, includes 2 cleanings.
Periodontics	• Periodontal scaling & root planing: 1 per quadrant in any 24 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	
Crown, Denture and Bridge Repairs	• 1 per 12 Months.
Consultations	• 1 per 12 months

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**Type C - Major Restorative**

**How Many/How Often**

Implants	• Services: 1 per tooth position in 60 months. Repairs: 1 per 12 Months.
Crowns/Inlays/Onlays	• 1 replacement per 60 months.
Bridges	• 1 in 10 years.
Periodontics	• Periodontal surgery: 1 per quadrant in any 36 month period.
Endodontics	• Root Canal treatment limited to 1 in 24 Months.
Dentures	• 1 in 10 years.
Prefabricated Stainless Steel & Resin Crowns	• 1 replacement per 60 months
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

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\* 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. 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. Please contact MetLife for details.

**MetLife Dual Option Dental - List of Covered Services & Limitations**

**Premier Plan: Standard Offering**

**Type A – Preventive**

**How Many/How Often:**

Oral Examinations	• 1 oral exam in 6 months.
Full Mouth X-rays	• 1 full mouth X-ray in 60 months.
Bitewing X-rays	• Adult - 1 time in 12 months / Child - 1 time in 12 months up to 14th birthday.
Prophylaxis (Cleanings)	• 1 cleaning in 6 months.
Topical Fluoride Applications	• 1 fluoride treatment in 12 months for dependent children up to 14th birthday.
Space Maintainers	• Space Maintainers for dependent children up to 14th birthday.
Emergency Palliative Treatment	

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**Type B - Basic Restorative**

**How Many/How Often:**

Sealants	• 1 sealant per permanent 1st & 2nd non-restored non-decayed molar in 60 months of a dependent child up to 14th birthday.
Crown, Denture and Bridge Repairs	• 1 per 12 Months.
Periodontics	• Periodontal scaling & root planing: 1 per quadrant in any 24 month period.
Periodontics	• Periodontal maintenance: 4 periodontal treatments in 1 year, includes 2 cleanings.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery: Simple Extractions	
Amalgam and Composite Fillings	
Consultations	• 1 per 12 months

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**Type C - Major Restorative**

**How Many/How Often:**

Crowns/Inlays/Onlays	• 1 replacement per 60 months.
Endodontics	• Root Canal treatment limited to 1 in 24 Months.
Periodontics	• Periodontal surgery: 1 per quadrant in any 36 month period.
Bridges	• 1 in 10 years.
Dentures	• 1 in 10 years.
Implants	• Services: 1 per tooth position in 60 months. Repairs: 1 per 12 Months.
Prefabricated Stainless Steel & Resin Crowns	• 1 replacement per 60 months
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

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\* 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. 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. 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 in 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.
- For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**
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.
- This exclusion only applies for North Carolina Sitused Groups.**
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.
- This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
- This exclusion only applies for Virginia Sitused Groups.**
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.
- This exclusion only applies for Virginia Sitused Groups.**
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 (**For Oregon, Maryland or Missouri Sitused Groups, this exclusion does not apply.**)
- Medicaid (**This exclusion only applies for Oregon, Maryland or Missouri Sitused Groups**)

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.
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.
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.
32. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
33. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
35. Fixed and removable appliances for correction of harmful habits.<sup>1</sup>
36. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.<sup>1</sup>
37. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.<sup>1</sup>
38. Orthodontic services or appliances.<sup>1</sup>
39. Repair or replacement of an orthodontic device.<sup>1</sup>
40. Duplicate prosthetic devices or appliances.
41. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
42. Intra and extraoral photographic images.
43. 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**

<sup>1</sup> Some of these exclusions may not apply. Please see your plan design and certificate for details.

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

## ***MetLife Preferred Dentist Program (PDP) Overview Frequently Asked Questions***

### **How does the MetLife PDP work?**

With a dental benefit plan featuring the MetLife PDP, you receive benefits whether or not you and/or each eligible dependent visit a participating dentist. But, when you visit a participating dentist, you have the opportunity to maximize your benefit plan with access to lower out-of-pocket expenses. The MetLife PDP is a Preferred Provider Organization, wherein you choose a provider at the time of treatment. You do not have to pre-select a primary dentist nor do you need an ID card or referrals for specialty care.

### **What is a MetLife PDP dentist?**

A general dentist or specialist who meets MetLife's strict credentialing standards and accepts negotiated fees as payment-in-full for services rendered. There are over 110,000 participating PDP dentist locations, including more than 26,000 specialist locations nationwide. So you should have no problem finding a participating PDP dentist near your home or workplace, while you're away on vacation, or while your covered dependents are away at college.

### **How do I find a MetLife PDP dentist?**

You can call the PDP automated Computer Voice Response line to obtain an up-to-date directory of participating dentists in your area. A list of up to 205 participating dentists in the requested ZIP code is then mailed to your home the next business day. To receive your personalized directory, call 1-800-474-PDP1 (7371) Mon.-Fri. 6:00am to 11:00 pm ET or Saturday 7 am to 4:00 pm ET. You can also conduct online provider searches (with direction and mapping capabilities) via MetLife's Dental Internet site at [www.metlife.com/dental](http://www.metlife.com/dental). Please Note: Be sure to verify provider participation when you make your appointment.

### **What is a negotiated fee?**

A negotiated fee refers to the PDP fee schedule which participating dentists agree to accept as payment in full. The fee is typically 10% to 35% below average fees of dentists in your area. Your plan may reimburse you for all or part of the PDP fee. When you use a MetLife PDP dentist, you are responsible only for the difference between MetLife's benefit payment amount and the PDP fee.

### **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.

### **My dentist does not participate in the PDP. Is there anything I can do to encourage my dentist to participate?**

The MetLife PDP Network is continually expanding, and new providers may be added if they meet MetLife's credentialing standards. Just ask your dentist to complete a MetLife PDP nomination card or visit the dentist directory online at [www.metlife.com/dental](http://www.metlife.com/dental), and MetLife will send him or her information on how to apply for participation. The timing depends on how quickly MetLife receives the necessary information. Please note that there may be instances where a dentist chooses not to participate and others where MetLife does not accept the application under our stringent credentialing requirements.

### **Can I find out how much services will cost and obtain an estimate of what will be covered prior to treatment?**

**Yes**, MetLife recommends that you have your dentist submit a request for a pre-treatment estimate for services in excess of \$300.00. This often applies to services such as: crowns, bridges, inlays, and periodontics. When your dentist suggests treatment, have him or her send an undated claim form, along with the proposed treatment plan, to MetLife. A pre-treatment estimate will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level.

### **How do I file a claim?**

Claim forms are available from your human resources department or can be downloaded and printed out from MetLife's dental website at [www.metlife.com/dental](http://www.metlife.com/dental). Remember to bring one with you to your appointment. Complete the employee portion, and your dentist will assist you with the rest. You can use the same claim form whether or not your dentist is a participating PDP dentist. MetLife will mail you a concise explanation of benefits (EOB) after each claim submission. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1-800-ASK-4-MET after your plan's effective date.  
Dental Claims Address: MetLife Dental Claims, P.O. BOX 981282, El Paso, TX 79998-1282