MetLife

Summary of Benefits
Dental Insurance - 100/80/50/50 5000cym

Employer Sponsored Dental		
Class Description	All Active Full Time Employees (30 Hours)	
	In-Network	**Out-of-Network***
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile
Type A – Preventive	100%	100%
Type B – Basic	80%	80%
Type C – Major	50%	50%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $50 $150 Aggregate	B & C $50 $150 Aggregate
Calendar Year Maximum ***(applies to A,B,C services)***	$5,000	$5,000
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000

* 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 (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

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Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: All Active Full Time Employees	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 1 time in 6 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 14
▪ Full Mouth X-Rays	▪ Once in 60 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Sealants	▪ 1 per molar in lifetime for a child under age 14
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 in 24 months
▪ Periodontal Maintenance	▪ 4 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 4)
▪ Periodontal Surgery	▪ 1 per quadrant in any 60 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 60 month period
▪ Labs & Other Tests	
▪ Emergency Palliative Treatment	
▪ Periapical X-Rays	
▪ Other X-Rays	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Space Maintainers	▪ 1 per lifetime for a child under age 14
▪ Cone Beam Imaging	▪ 1 in 60 months
▪ Consultations	▪ 1 in 12 months
▪ Prefabricated Stainless Steel & Resin Crowns	▪ 1 per tooth in 10 calendar years
▪ Crown Buildups / Post Core	▪ 1 per tooth in 10 calendar years
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 10 calendar years
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 60 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 10 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 10 calendar years

▪ Implant Services	▪ 1 per tooth position in 10 calendar years
▪ Implant Repairs	▪ 1 per tooth in 10 calendar years
▪ Implant Supported Prosthetic	▪ 1 per tooth in 10 calendar years
▪ Tissue Conditioning	▪ 1 in 60 months
▪ Occlusal Adjustments	▪ 1 in 12 months
▪ General Anesthesia	
▪ Other Oral Surgery	
▪ General Services	
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions
All Active Full Time Employees
▪ 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. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child. ▪ 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 piks, 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. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ 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. ▪ 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. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 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. ▪ Intra and extraoral photographic images.

- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.