

AMHIC Standard Dental Plan Benefits

For the savings you need, the flexibility you want and service you can trust.

Benefit Summary

Coverage Type	PDP In-Network:	Out-of-Network:
Type A – cleanings, oral examinations	100% of PDP Fee*	80% of R&C Fee**
Type B – fillings,	75% of PDP Fee*	50% of R&C Fee**
Type C –bridges and dentures,	50% of PDP Fee*	30% of R&C Fee**
Deductible [†] :	In-Network	Out-of-Network
Individual	\$50.00	\$50.00
Family	\$150.00	\$150.00
Annual Maximum Benefit:	In-Network	Out-of-Network
Per Person	\$1,000	\$1,000

* PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums.

** 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 only to type B & C Services.

PDP Savings Example

This hypothetical example* shows how receiving services from a PDP (in-network) dentist can save you money.

Your Dentist says you need a Crown, a Type C service —

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

IN-NETWORK When you receive care from a participating PDP dentist:		OUT-OF-NETWORK When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$600.00	Dentist's Usual Fee is:	\$600.00
The PDP Fee is:	\$375.00		
Your Plan Pays:		Your Plan Pays:	
50% X \$375 PDP Fee	- \$187.50	30% X \$500 R&C Fee	- \$150.00
Your Out-of-Pocket Cost:	\$187.50	Your Out-of-Pocket Cost:	\$450.00

In this example, you save \$262.50 (\$450.00 minus \$187.50)...
by using a participating PDP dentist.

*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)	• Two per calendar year
Oral Examinations	• Two exams per calendar year
Topical Fluoride Applications	• One fluoride treatment per calendar year for dependent children up to 19 th birthday.
X-rays	• 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, separated by a six-month period calendar year.
Space Maintainers	• Space Maintainers for dependent children up to 19th birthday.
Sealants	• One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2 nd molar of a dependent child up to 19th birthday.

Type B - Basic Restorative

How Many/How Often:

Fillings	
Simple Extractions	
Crown, Denture, and Bridge Repair	
Endodontics	• 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.
Oral Surgery	• Periodontal scaling and root planing once per quadrant, every 24 months.
Periodontics	• Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
Implants	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan.

Type C - Major Restorative

How Many/How Often:

Bridges and Dentures	• Dentures and bridgework replacement: one every 10 years.
Crowns/Inlays/Onlays	• 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. • Replacement: once every 5 years

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 10-35%[‡] below the average fees charged in a dentist's community for the same or substantially similar services.

[‡] Based on internal analysis by MetLife

How do I find a participating PDP dentist?

There are nearly 115,000 participating PDP dentist locations nationwide, including over 27,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 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 discounts on non-covered services?

Yes. MetLife's negotiated fees with PDP (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a PDP dentist that are not covered under your plan, you are only 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, you can find one online at www.metlife.com/mybenefits 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 (This often applies to services such as crowns, bridges, inlays, and periodontics.) To receive a benefit estimate, simply have your dentist submit a request for pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate (online or by fax) for most procedures *while you're still in the office*, so you can discuss treatment and payment options, and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Exclusions

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

- Temporomandibular joint disorders (TMJ)
- Those received before coverage begins
- Those not performed by a dentist, except cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist that is supervised and billed by a dentist
- Cosmetic services, surgery or supplies
- When covered by any workers' compensation laws, occupational disease laws or employer's liability laws, or which an employer is required by law to furnish in whole or in part
- Which are received through a medical department or similar facility maintained by your employer
- Home health aids used to prevent decay, such as toothpaste and fluoride gels
- Appliances or treatment for bruxism (grinding teeth), including, but not limited to, occlusal guards and night guards
- Duplicate appliances or duplicate prosthetic devices
- Received where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
- Materials or services that are experimental under generally accepted dental standards
- Received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while coverage is in effect
- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Benefits otherwise provided under your employer's plan or any other plan that your employer or an affiliate contributes to or sponsors
- Charges for broken appointments or for completing dental forms
- Sterilization supplies
- Furnished by a family member
- For Type C Expenses: 1) Replacement of a lost, missing or stolen crown, bridge or denture; (2) Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started; 3) replacement of an existing crown, removable denture or fixed bridgework unless it is needed because the existing crown, denture or bridgework can no longer be used and was installed at least 10 years prior (5 years for crowns) to its replacement; 4) replacement of existing immediate temporary full denture by a new permanent full denture unless: (a) the existing denture cannot be made permanent; and (b) the permanent denture is installed within 12 months after the existing denture was installed.
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it
- Temporary or provisional restorations and appliances
- Orthodontia

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. 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 plans 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.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by 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.

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

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.

L05083101(exp1209)(All States)(DC, GU, MP, PR, VI)