Dental Insurance`

Coverage that can help make it easier to visit a dentist and can help lower your dental costs

Enrollment Period: October 17th through October 31st

	Plan Option 1: Choice Plan		Plan Option 2: Choice Plus Plan	
	In-Network[1] % of Negotiated Fee[2]	**Out-of-Network[1]** % of Maximum Allowable Charge* % of R&C Fee**	**In-Network[1]** % of Negotiated Fee[2]	**Out-of-Network[1]** % of Maximum Allowable Charge* % of R&C Fee**
Coverage Type				
Type A: Preventive (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%	50%	50%
Type D: Orthodontia	N/A	N/A	50%	50%
Deductible†				
Individual	$50	$50	$50	$50
Family	$150	$150	$100	$100
Annual Maximum Benefit				
Per Person	$1,500	$1,500	$2,000	$2,000
Orthodontia Lifetime Maximum				
Per Person	N/A	N/A	$1,500	$1,500

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

1 "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

2Negotiated fees refer 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.

*Reimbursement for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.
**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, and Ortho Services.

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List of Primary Covered Services

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

Plan Type	Plan Option 1: Choice Plan How Many/How Often	Plan Option 2: Choice Plus Plan How Many/How Often
Type A — Preventive		
Prophylaxis (cleanings)	Two per calendar year	Two 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 14th birthday	One fluoride treatment per calendar year for dependent children up to his/her 14th birthday
X-rays	• Full mouth X-rays; one per 60 months • Bitewings X-rays; one set per calendar year	• Full mouth X-rays; one per 60 months • Bitewing X-rays; one set per calendar year
Space Maintainers	Space maintainers for dependent children up to his/her 19th birthday	Space maintainers for dependent children up to his/her 19th birthday
Sealants	One application of sealant material every 3 years 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 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 19th birthday
Type B — Basic Restorative		
Fillings		
Simple Extractions		
Crown, Denture and Bridge Repair/ Recementations		
Oral Surgery		
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

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Type C — Major Restorative		
Crown, Denture and Bridge Repair/ Recementations		
Implants		
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 5 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 5 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 5 years	Replacement once every 5 years
Occlusal Guards		
Type D — Orthodontia		
	N/A	• 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 • 25% 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