Dental

Overview of Benefits for: MTA Higher Education Health & Welfare Fund

Date Prepared: 07-05-2018

Network: PDP Plus

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type	In Network % of Negotiated Fee	Out of Network % of Negotiated/R&C[1] Fee
Type A - Preventive	100%	80%
Type B - Basic Restorative	80%	60%
Type C - Major Restorative	50%	50%
Deductible: Per Individual	$50 Applies to Type B&C services only	$50 Applies to Type B&C services only
Deductible: Per Family	$150 Applies to Type B&C services only	$150 Applies to Type B&C services only
Annual Maximum Benefit: Per Individual	$1,200	$1,200
Dependent Age:	Eligible for benefits until the end of the month that he or she turns 26.	

1. The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 80th percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice – in or out of the network.

- Plan benefits for in-network covered services are based on a percentage of the negotiated fee – the fee that participating dentists have agreed to accept as payment in full for covered services, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees are subject to change.

Once you're enrolled you may take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, just go to
www.metlife.com/mybenefits
and follow the easy registration instructions.

An Example of Savings

In-Network Savings Example*
These hypothetical examples show how receiving services from a participating dentist can help save you money**.

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

- Negotiated Fee: $670.00
- R&C Fee***: $1,386.00
- Dentist's Usual Fee: $1,300.00

IN-NETWORK When you receive care from a participating dentist		**OUT-OF-NETWORK** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$1,300.00	Dentist's Usual Fee is:	$1,300.00
The Negotiated Fee is:	$670.00	R&C Fee is:	$1,386.00
Your Plan Pays:		***Your Plan Pays:***	
50% X $670 Negotiated Fee:	- $335.00	30% X $1,300 Dentist's Fee:	- $390.00
Your Out-of-Pocket Cost:	$335.00	Your Out-of-Pocket Cost:	$910.00

In this example, you save $575.00 ($910.00 minus $335.00) by using a participating dentist.

*Savings from enrolling in a MetLife Dental Plan featuring the Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.
**Please note: This is a hypothetical example that reviews a crown – porcelain/ceramic substrate (D2740) in the Boston area, zip 02210. It assumes that the annual deductible has been met.
***Reasonable and Customary (R&C) charge 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. The example shown reflects the 80th percentile R&C fee.
Please note: These examples assume that your annual deductible has been met.

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Selected Covered Services and Frequency Limitations*

Type A – Preventive	
• Prophylaxis Cleaning	1 in 6 months
• Oral Examinations	1 in 6 months
• Full Mouth X-rays	1 in 60 months
• Bitewing X-rays (Adult/Child)	1 in 6 months
• Space Maintainers	Children up to 19th birthday
• Periapical X-rays	
• Emergency Palliative Treatment	
Type B - Basic Restorative	
• Repairs	
• Endodontics Root Canal	1 per tooth in 24 months
• General Anesthesia	For oral surgery, extractions or other covered services.
• Oral Surgery (Simple Extractions)	
• Oral Surgery (Surgical Extractions)	
• Other Oral Surgery	
• Periodontal Scaling & Root Planing	1 in 24 months per quadrant
• Periodontal Maintenance	4 in 1 year less the number of basic cleanings received
• Amalgam & Composite Fillings	Composite fillings covered on anterior teeth only.
• Consultations	2 in 12 months
Type C - Major Restorative	
• Implants	Services: 1 per tooth in 10 years Repairs: 1 per tooth in 12 months
• Bridges	1 per tooth in 10 years
• Dentures	1 per tooth in 10 years
• Crowns / Inlays / Onlays	1 per tooth in 10 years
• Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 10 years

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

Exclusions

We will not pay Dental Insurance benefits for charges incurred for:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
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 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;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
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. initial installation of a Denture or implant to replace one or more teeth which were missing before such person was insured for Dental Insurance;
12. decoration or inscription of any tooth, device, appliance, crown or other dental work;
13. missed appointments;
14. 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 required to pay; or

    ☐ received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
15. services covered under other coverage provided by the Policyholder;
16. biopsies of hard or soft oral tissue;
17. temporary or provisional restorations;
18. temporary or provisional appliances;
19. prescription drugs;
20. services for which the submitted documentation indicates a poor prognosis;
21. 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;
22. 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;
23. fixed and removable appliances for correction of harmful habits;
24. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
25. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
26. duplicate prosthetic devices or appliances;
27. replacement of a lost or stolen appliance, Cast Restoration or Denture;
28. orthodontic services or appliances;
29. repair or replacement of an orthodontic device;
30. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
31. intra and extraoral photographic images.

Please see your plan design and certificate for details.

Common Questions… Important Answers

Who is a participating dentist?
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, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees typically range from 30-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit participating dentists and the cost of services rendered. Negotiated fees are subject to change.

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefitswww.metlife.com/dental or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan?
All services set forth in your group dental benefits plan are covered. Please review the enclosed plan benefits summary to learn more.*

*The information in this document represents an overview of your plan benefits, but is not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs.

May I choose a non-participating dentist?
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.

How can I receive Graduating Dental Benefits? All you have to do is enroll in the MetLife Dental Benefit Plan — there are no additional requirements or limitations. Assuming you have no gap in MetLife dental coverage* under your employer's plan, your annual maximum will graduate (increase) for you and your covered dependents until reaching the maximum annual benefit.** The increase occurs on the anniversary (12 months of coverage) of when your coverage became effective under the plan.

*MetLife dental coverage refers to dental plans underwritten or administered by Metropolitan Life Insurance Company.
**Upon reaching the maximum Graduating Dental Benefit, there will be no further increases in annual maximums.

Can my annual maximum decrease for any reason? As long as you are continuously enrolled from year to year in your employer's plan, you remain eligible for Graduating Dental Benefits. Benefits may decrease if your employer chooses a different plan design.

What happens if I drop the plan and re-enroll in the future? Upon your re-enrollment after a gap in MetLife dental coverage* under your employer's plan, your annual maximum benefit will begin at the first year benefit level as of your new effective date.

*MetLife dental coverage refers to dental plans underwritten or administered by Metropolitan Life Insurance Company.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him or 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.

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

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, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

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

How can I learn about what dentists in my area charge for different procedures?
If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area.* You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by VerifPoint, an independent vendor. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

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

* AXA Assistance USA, Inc. provides dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits it provides 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.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provision 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. 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.

Do I need an ID card? 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 a MetLife Dental Plan. 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.

The information contained herein is a summary of the provisions of a MetLife Dental Plan. For complete terms and provisions of the plan, please see your certificate of insurance, the terms of which shall govern in all instances.

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. Please contact MetLife or your plan administrator for costs and complete details. Metropolitan Life Insurance Company, New York, NY 10166