

Montgomery County Dental Plan Benefits

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

Benefit Summary

Core Plan			Enhanced Plan		
Coverage Type	PDP In-Network:	Out-of-Network:	Coverage Type	PDP In-Network:	Out-of-Network:
Type A – cleanings, oral examinations	100% of PDP Fee*	100% of R&C Fee**	Type A – cleanings, oral examinations	100% of PDP Fee*	100% of R&C Fee**
Type B – fillings	50% of PDP Fee*	50% of R&C Fee**	Type B – fillings	80% of PDP Fee*	80% of R&C Fee**
Type C –bridges and dentures	50% of PDP Fee*	50% of R&C Fee**	Type C –bridges and dentures	50% of PDP Fee*	50% of R&C Fee**
Type D – orthodontia	None	None	Type D – orthodontia	50% of PDP Fee*	50% of R&C Fee**
Annual Maximum Benefit:	In-Network	Out-of-Network	Annual Maximum Benefit:	In-Network	Out-of-Network
Per Person	\$1,000 [†]	\$1,000 [†]	Per Person	\$1,250 [†]	\$1,250 [†]
Orthodontia Lifetime Maximum:	In-Network	Out-of-Network	Orthodontia Lifetime Maximum:	In-Network	Out-of-Network
Per Person	Not Applicable	Not Applicable	Per Person	\$1,000	\$1,000
<p>* 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 to type A, B and C</p>			<p>* 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 to type A, B and C</p>		

The service categories shown above represent an overview of your Plan of Benefits but are not a complete description of the Plan. An insurance certificate describing all benefits and limitations will be made available following your plan's effective date, and will govern if any discrepancies exist between the overview and the certificate of insurance and group insurance policy.

Monthly Rates:

The following monthly rates are effective through June 30, 2011.

Eligibility Options	Core Plan	Enhanced Plan
Employee Only	\$18.15	\$26.73
Employee + One	\$36.31	\$53.46
Employee + Family	\$68.50	\$90.75

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 —

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

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	50% X \$500 R&C Fee	- \$250.00
Your Out-of-Pocket Cost:	\$187.50	Your Out-of-Pocket Cost:	\$350.00

In this example, you save \$162.50 (\$350.00 minus \$187.50)...by using a participating PDP dentist

List of Primary Covered Services & Limitations

Core Plan		Enhanced Plan	
Type A - Preventive	How Many/How Often:	Type A - Preventive	How Many/How Often:
Prophylaxis (cleanings)	<ul style="list-style-type: none"> Two per policy period. 	Prophylaxis (cleanings)	<ul style="list-style-type: none"> Two per policy period.
Oral Examinations	<ul style="list-style-type: none"> Two exams per policy period. 	Oral Examinations	<ul style="list-style-type: none"> Two exams per policy period.
Topical Fluoride Applications	<ul style="list-style-type: none"> One fluoride treatment per policy period for dependent children up to 15th birthday. 	Topical Fluoride Applications	<ul style="list-style-type: none"> One fluoride treatment per policy period for dependent children up to 15th birthday.
X-rays	<ul style="list-style-type: none"> Full mouth X-rays: one per 5 years. Bitewing X-rays: one set per policy period. 	X-rays	<ul style="list-style-type: none"> Full mouth X-rays: one per 5 years. Bitewing X-rays: one set per policy period.
Type B - Basic Restorative	How Many/How Often:	Type B - Basic Restorative	How Many/How Often:
Fillings		Fillings	
Simple Extractions		Simple Extractions	
Crown, Denture, and Bridge Repair/Recementations	<ul style="list-style-type: none"> Simple repairs are limited to once per tooth every 2 years. 	Crown, Denture, and Bridge Repair/Recementations	<ul style="list-style-type: none"> Simple repairs are limited to once per tooth every 2 years.
Endodontics	<ul style="list-style-type: none"> Root canal treatment limited to once per tooth per lifetime. 	Endodontics	<ul style="list-style-type: none"> Root canal treatment limited to once per tooth per lifetime.
General Anesthesia	<ul style="list-style-type: none"> When dentally necessary in connection with oral surgery, extractions or other covered dental services. 	General Anesthesia	<ul style="list-style-type: none"> When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Periodontics	<ul style="list-style-type: none"> Periodontal scaling and root planing once per quadrant, every 2 years. Periodontal surgery once per quadrant, every 2 years. Total number of periodontal maintenance treatments and prophylaxis, 2 every 2 years. 	Periodontics	<ul style="list-style-type: none"> Periodontal scaling and root planing once per quadrant, every 2 years. Periodontal surgery once per quadrant, every 2 years. Total number of periodontal maintenance treatments and prophylaxis, 2 every 2 years.
Space Maintainers	<ul style="list-style-type: none"> Space Maintainers for dependent children up to 19th birthday once per lifetime per tooth area. 	Space Maintainers	<ul style="list-style-type: none"> Space Maintainers for dependent children up to 19th birthday once per lifetime per tooth area.
Type C - Major Restorative	How Many/How Often:	Type C - Major Restorative	How Many/How Often:
Surgical Extractions		Surgical Extractions	
Bridges and Dentures	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. Dentures and bridgework replacement: one every 8 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. 	Bridges and Dentures	<ul style="list-style-type: none"> Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. Dentures and bridgework replacement: one every 8 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/Onlays	<ul style="list-style-type: none"> Replacement: once every 8 years. 	Crowns/Onlays	<ul style="list-style-type: none"> Replacement: once every 8 years.
Sealants	<ul style="list-style-type: none"> One application of sealant material per tooth in a lifetime for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 15th birthday. 	Sealants	<ul style="list-style-type: none"> One application of sealant material per tooth in a lifetime for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 15th birthday.
Type D - Orthodontia	How Many/How Often:	Type D - Orthodontia	How Many/How Often:
	<ul style="list-style-type: none"> Not covered. 		<ul style="list-style-type: none"> Your Children up to their 19th birthday, 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. Benefit for initial placement of the appliance will be made representing 20% of the total benefit. Orthodontic benefits end at cancellation of coverage.

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Common Questions... Important Answers

Will I receive a MetLife Dental ID Card?

No. Provide your dentist with your Social Security Number and the MetLife Customer Service Number 1-800-GETMET8 (800-438-6388) or you can obtain a MetLife Dental Claim Form at www.metlife.com/dental or www.mcbenefits.org.

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 130,000 participating PDP dentist locations nationwide, including over 30,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-438-6388 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.

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 www.metlife.com/mybenefits or www.mcbenefits.org or request one by calling 1-800-438-6388.

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. 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, frequency limits and other conditions at time of payment.

How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provision in dental benefits plan is 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.

Exclusions

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

- 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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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 or biting of food;
- Caries susceptibility tests;
- 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;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- 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;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- 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;
- 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;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.
- Sterilization supplies.
- Furnished by a family member.
- Labial Veneers.
- Pulp vitality.

- Diagnostic photographs and bacteriological studies for determination of bacteriological agents.
- Crown lengthening.
- Orthodontia for Core Plan only.

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. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limitations, and other limitations applicable at time of payment. 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 1-800-438-6388 and using the MetLife Dental Automated Information Service.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) 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.

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