Dental Benefits

Savings, flexibility and service. For healthier smiles.

MetLife

American Medical Association Group Insurance Trust

Benefit Summary – Traditional Plan

Coverage Type	PDP In-Network	Out-of-Network
Type A – Preventive	100% of PDP Fee*	100% of R & C Fee**
Type B – Basic	50% of PDP Fee*	50% 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	$1,000.00	$1,000.00

*PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any co-payments, 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.

Request to Change Coverage: After you have been enrolled in the Traditional Plan for 24 consecutive months, you may request to change your optional level of dental insurance to the Premier Plan. The change will also apply to any dependent coverage you may have. A request to change the level of Your Personal Dental Insurance may only be made 30 days prior to the Plan Anniversary which is July 1st. If You change the level, the new level of benefits will become effective on the Plan Anniversary.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams are limited to once every 6 months less the number of problem-focused examinations received during such months
2. Problem-focused examinations are limited to once every 6 months less the number of oral exams received during such months
3. Bitewing x-rays but not more than:
   • 1 set every 6 months for a Child under age 14; and
   • 1 set every calendar year for everyone else
4. Full mouth or panoramic x-rays once every 60 months
5. Cleaning of teeth (oral prophylaxis) once every 6 months
6. Topical fluoride treatment for a Child under age 14, but not more than once in 12 months

Type B Covered Services

1. Consultations, but not more than once in a 12 month period
2. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards
3. Simple extractions
4. Root canal treatment, but not more than once in any 24 month period for the same tooth
5. Periodontal, non-surgical treatment such as scaling and root planing, but not more than once per quadrant in any 24 month period
6. Intraoral-periapical x-rays
7. Dental x-rays except as mentioned elsewhere in this certificate
8. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents
9. Genetic test for susceptibility to oral diseases
10. Diagnostic casts
11. Sealants for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 60 months
12. Space maintainers for a Child under age 14, once per lifetime per tooth area
13. Sedative fillings
14. Initial placement of amalgam fillings
15. Replacement of an existing amalgam filling, but only if:
    • at least 24 months have passed since the existing filling was placed; or
    • a new surface of decay is identified on that tooth
16. Initial placement of resin fillings
17. Replacement of an existing resin filling, but only if:
    • at least 24 months have passed since the existing filling was placed; or
    • a new surface of decay is identified on that tooth
18. Emergency palliative treatment to relieve tooth pain
19. Pulp capping (excluding final restoration)
20. Pulp therapy
21. Therapeutic pulpotomy (excluding final restoration)
22. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited two times in any calendar year less the number of teeth cleanings received during such calendar year.
23. Local chemotherapeutic agents

24. Injections of therapeutic drugs
25. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed
26. Apexification/recalcification

The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan. Please refer to the plan certificate or your plan administrator for further information.

DENTAL INSURANCE: EXCLUSIONS

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

1. 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;
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 primarily cosmetic unless such service is:
   - required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part; or
   - required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect

   For residents of Texas, The exclusion of services which are primarily cosmetic will not apply to the treatment or correction of a congenital defect of a newborn child.
5. 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
6. Services or appliances which restore or alter occlusion or vertical dimension
7. Restoration of tooth structure damaged by attrition, abrasion or erosion
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. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work
12. Missed appointments
13. Services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
14. Temporary or provisional restorations
15. Temporary or provisional appliances
16. Prescription drugs
17. Services for which the submitted documentation indicates a poor prognosis
18. 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
19. 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
20. Caries susceptibility tests
21. Precision attachments
22. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it
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. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.
26. Orthodontic services or appliances
27. Repair or replacement of an orthodontic device
28. Duplicate prosthetic devices or appliances
29. Replacement of a lost or stolen appliance or Cast Restoration, or Denture
30. Intra and extraoral photographic images
31. Cone Beam Imaging
32. Surgical extractions
33. Oral surgery except as specified elsewhere as a Covered Expense
34. Periodontal surgery not mentioned elsewhere, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery
35. Periodontal soft & connective tissue grafts
36. Prefabricated stainless steel crown or prefabricated resin crown
37. Cast Restorations
38. Core buildup
39. Cast post and core
40. Labial veneers
41. Initial installation or replacement of a fixed and permanent Denture
42. Other fixed Denture prosthetic services not described elsewhere
43. Initial installation or replacement of full or removable Dentures
44. Addition of teeth to a partial removable Denture
45. Addition of teeth to a fixed and permanent Denture
46. Relining and rebasing of Dentures
47. Re-cementing of Cast Restorations
48. Re-cementing of Dentures
49. Repair of Cast Restorations
50. Repair of Dentures
51. Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal
52. Repair of implants
53. Implant supported prosthetics
54. Replacement of implant supported prosthetics
55. Repair of implant supported prosthetics
56. Occlusal adjustments

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 may be higher. Discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving any high cost services. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's 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 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.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please refer to the certificate for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Please contact AMA Insurance Agency for complete details, **1-800-458-5736**.