



# GROUP DENTAL INSURANCE



Maintaining a healthy smile is important to your overall health, but regular trips to the dentist can be costly. AFSA Group Dental Insurance through MetLife can help keep your budget in check. Our two plan options cover preventive, basic, and major services, helping to ensure your smile stays bright year after year.

## PLAN DETAILS

Exclusively negotiated for members, AFSA Group Dental Insurance features competitive, straightforward coverage to help manage dental expenses, including routine dental visits, cleanings, and fillings for you and your entire family.

### SCHEDULED DENTAL PLAN

The Scheduled Dental Plan provides a fixed price list for dental procedures. The plan pays a flat dollar amount per covered dental procedure, as outlined in the policy. You can visit any provider, and MetLife will pay the lesser of the provider's actual charge or the amount listed on the price list.

### ANNUAL MAXIMUMS

You and your covered spouse and dependents are entitled to receive up to \$1,000 each in dental benefits in any calendar year after the cash deductible is satisfied. The orthodontia lifetime maximum is \$850.

### DEDUCTIBLES

The deductible is the amount the insured must pay out of pocket before benefits will be paid. For the individual plan, an annual deductible of \$50 must be met before benefits can begin. For the family plan, an annual deductible of \$150 aggregate must be met before benefits can begin.

### REIMBURSEMENT

The following table lists the maximum benefits MetLife will consider for covered Type A, B, and C services under the Scheduled Dental Plan. Covered services not listed will be considered by MetLife in accordance with MetLife's standard practices. Orthodontia services will be covered at 50% up to a maximum of \$850.

## GROUP DENTAL INSURANCE

SCHEDULED PLAN – REIMBURSEMENT SCHEDULE	
Description of Service	Maximum Paid
Periodic oral examination	\$15
Limited oral evaluation – problem focus	\$25
Comprehensive oral evaluation	\$25
Comprehensive periodontal evaluation	\$23
Complete set x-ray images	\$45
Panoramic X-Ray	\$35
Periapical (whole tooth) x-ray image	\$10
Additional x-ray images	\$5
Occlusal x-ray image	\$10
Bitewing x-ray – single image	\$15
Bitewing x-ray – two images	\$15
Bitewing x-ray – four images	\$20
Prophylaxis (cleaning) – adult	\$40
Prophylaxis (cleaning) – child	\$25
Topical fluoride varnish	\$11
Topical application of fluoride	\$22
Sealant – per tooth	\$10
Amalgam – (filling) 1 surface primary/permanent	\$30
Amalgam – (filling) 2 surfaces primary/permanent	\$35
Amalgam – (filling) 3 surfaces primary/permanent	\$35
Resin composite – 1 surface anterior	\$30
Resin composite – 2 surfaces anterior	\$35
Resin composite – 3 surfaces anterior	\$45
Resin composite – 4+ surface or incisal angle	\$50
Resin composite – 1 surface posterior	\$33
Resin composite – 2 surfaces posterior	\$44
Resin composite – 3 surfaces posterior	\$53
Crown – porcelain/ceramic substrate	\$215
Crown – porcelain fused to high noble metal	\$230
Crown – porcelain fused to base metal	\$220
Crown – porcelain fused to noble metal	\$220
Crown – full cast high noble metal	\$225
Crown – full cast noble metal	\$215

SCHEDULED PLAN – REIMBURSEMENT SCHEDULE	
Description of Service	Maximum Paid
Recement crown	\$15
Stainless steel crown – child	\$50
Protective restoration	\$21
Core buildup (including any pins)	\$45
Prefabricated post & core addition crown	\$63
Pulp cap – indirect	\$14
Endodontic (root canal) anterior tooth	\$125
Endodontic (root canal) bicuspid tooth	\$135
Endodontic (root canal) molar	\$140
Periodontal scaling & root planing 4+ teeth/quadrant	\$30
Periodontal scaling & root planing 1-3 teeth	\$33
Full-mouth debridement	\$33
Localized delivery antimicrobial agents	\$18
Periodontal maintenance	\$35
Complete upper denture	\$250
Complete lower denture	\$250
Surgical placement endosteal implant	\$418
Pontic – porcelain fused to high noble metal	\$200
Crown – porcelain fused to high noble metal	\$180
Extract erupted tooth or exposed root	\$20
Surgical removal erupted tooth	\$30
Surgical removal impacted tooth	\$45
Removal impacted tooth – partly bony	\$70
Removal impacted tooth – completely bony	\$85
Palliative (emergency) treatment pain – minor procedure	\$15
Deep sedation/general anesthesia – additional 15 min increment	\$50
Consultation	\$20

# GROUP DENTAL INSURANCE

## COVERED SERVICES

The Scheduled Plan covers preventive, basic, and major services. This brochure presents the majority of services within each category but is not a complete description of the plan.

SCHEDULED PLAN – COVERED SERVICES	
<p><b>Type A (Preventive)</b> Benefits are payable immediately from the start date of an individual's benefits.</p>	
Service	Frequency
Examinations	2 times in 1 calendar year
Problem-focused examinations	Combined with examinations limit
Prophylaxis – cleanings	2 times in 1 calendar year
Fluoride	1 time in 1 calendar year for a dependent child under age 14
Bitewing x-rays	1 time in 12 months
Labs and other tests	
<p><b>Type B (Basic)</b> Benefits for fillings are payable after a 6-month waiting period from the start date of an individual's benefits. All other Type B services are payable immediately.</p>	
Service	Frequency
Sealants	1 per molar in 60 months for a child under age 16
Space maintainers	1 per lifetime for a child under age 14
Full mouth x-rays	Once in 60 months
Amalgam fillings	1 replacement per surface in 24 months
Periodontal maintenance	2 periodontal treatments in 1 calendar year; includes 2 cleanings (total combined: 2)
Scaling and root planning	1 per quadrant in any 24-month period
Emergency palliative treatment	
Periapical x-rays	
Other x-rays	
Resin composite fillings	Excludes coverage for composite fillings on molars
Pulpotomy	
Pulp capping	
Pulp therapy	
Periodontics: Non-surgical	
Oral surgery: Simple extractions	
General services	
<p><b>Type C (Major)</b> Benefits are payable after a 12-month waiting period from the start date of an individual's benefits.</p>	
Service	Frequency
Consultations	2 in 12 months
Root canal	1 per tooth per lifetime
Periodontal surgery	1 per quadrant in any 36-month period
Prefabricated crowns	1 per tooth in 84 months
Crown buildups/post core	1 per tooth in 84 months
Repairs	1 in 12 months
Recementations	1 in 12 months
Dentures	1 in 84 months
Dentures – rebases/relines	1 in 36 months
Denture adjustments	1 in 12 months
Fixed bridges	1 in 84 months
Inlays/onlays/crowns	1 replacement per tooth in 84 months
Implant services	1 per tooth position in 60 months
Implant repairs	1 per tooth in 12 months
Implant-supported prosthetic	1 per tooth in 60 months
Tissue conditioning	1 in 36 months
Occlusal adjustments	1 in 12 months
Apexification & recalcification	
Periodontal surgery – soft & connective tissue grafts	
Oral surgery – surgical extractions	
Other oral surgery	
General anesthesia	
Consultations	
Root canal	
Periodontal surgery	
<p><b>Orthodontics</b> For children under age 19: Benefits are payable after a 12-month waiting period from the start date of an individual's benefits.</p>	
Service	Frequency
Orthodontia	

# GROUP DENTAL INSURANCE

## RATES

Your rate depends on whether your spouse and dependents are covered under the plan. Refer to the rate table to determine your rate.

SCHEDULED PLAN – RATE TABLE	
Member Only	\$29.33
Member + 1 Dependent	\$45.33
Member + Family	\$61.66

## PPO DENTAL PLAN

The PPO Dental Plan takes advantage of MetLife's extensive dental network. When you choose an in-network dentist (who has agreed to MetLife's negotiated fees), you are only responsible for any applicable coinsurance and deductible.

## ANNUAL MAXIMUMS

You and your covered spouse and dependents are entitled to receive up to \$1,500 each in dental benefits in any calendar year after the cash deductible is satisfied.

## DEDUCTIBLES

The deductible is the amount the insured must pay out of pocket before benefits will be paid. For the individual plan, an annual deductible of \$50 must be met before benefits can begin. For the family plan, an annual deductible of \$150 aggregate must be met before benefits can begin.

## REIMBURSEMENT

You and your covered dependents will receive reimbursement for dental services according to the following guidelines:

- Type A (preventive): 100%
- Type B (basic): 80%
- Type C (major): 50%

The reimbursement schedule for dental services is the same, regardless of whether you choose an in-network or out-of-network dentist. However, your out-of-pocket costs may be higher with an out-of-network dentist. Out-of-network dentists have not agreed to accept negotiated fees, which are typically 30-45% less than the average fees\* charged in a dentist's community for the same or similar services.

\* Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

## COVERED SERVICES

The PPO Dental Plan covers preventive, basic, and major services. This brochure presents the majority of services within each category but is not a complete description of the plan.\*

### PPO PLAN – COVERED SERVICES

#### Type A (Preventive)

*Benefits are payable immediately from the start date of an individual's benefits.*

Service	Frequency	Service	Frequency
Examinations	2 times in 1 calendar year	Fluoride	1 time in 1 calendar year for a dependent child under age 18
Problem-focused examinations	Combined with examinations limit	Bitewing x-rays	2 sets every 12 months
Prophylaxis – cleanings	2 times in 1 calendar year	Labs and other tests	

#### Type B (Basic)

*Benefits are payable immediately from the start date of an individual's benefits.*

Service	Frequency	Service	Frequency
Sealants	1 per molar in 60 months for a child under age 16	Other x-rays	
Space maintainers	1 per lifetime for a child under age 14	Resin composite fillings	Excludes coverage for composite fillings on molars
Full mouth x-rays	Once in 60 months	Pulpotomy	
Amalgam fillings	1 replacement per surface in 24 months	Pulp capping	
Periodontal maintenance	2 periodontal treatments in 1 calendar year; includes 2 cleanings (total combined: 2)	Pulp therapy	
Scaling and root planning	1 per quadrant in any 24-month period	Periodontics: Non-surgical	
Emergency palliative treatment		Oral surgery: Simple extractions	
Periapical x-rays		General services	

\*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

# GROUP DENTAL INSURANCE

## PPO PLAN – COVERED SERVICES

### Type C (Major)

Benefits are payable after a 12-month waiting period from the start date of an individual's benefits.

Service	Frequency	Service	Frequency
Consultations	2 in 12 months	Implant services	1 per tooth position in 60 months
Root canal	1 per tooth per lifetime	Implant repairs	1 per tooth in 12 months
Periodontal surgery	1 per quadrant in any 36-month period	Implant-supported prosthetic	1 per tooth in 60 months
Prefabricated crowns	1 per tooth in 84 months	Tissue conditioning	1 in 36 months
Crown buildups/post core	1 per tooth in 84 months	Occlusal adjustments	1 in 12 months
Repairs	1 in 12 months	Apexification & recalcification	
Recementations	1 in 12 months	Periodontal surgery – soft & connective tissue grafts	
Dentures	1 in 84 months	Oral surgery – surgical extractions	
Dentures – rebases/relines	1 in 36 months	Other oral surgery	
Denture adjustments	1 in 12 months	Pulpotomy	
Fixed bridges	1 in 84 months	Pulp capping	
Inlays/onlays/crowns	1 replacement per tooth in 84 months	Pulp therapy	

## RATES

Your rate depends on where you live and whether your spouse and dependents are covered under the plan. Refer to the area table and determine which ZIP Code applies to you. Then, refer to the rate table to determine your rate.

## PPO PLAN – RATE TABLE

Area	Member Only	Member + 1	Member + Family
Area 1	\$41.91	\$82.77	\$134.82
Area 2	\$45.33	\$90.46	\$150.88
Area 3	\$50.89	\$107.20	\$164.99
Area 4	\$54.31	\$115.34	\$179.60
Area 5	\$56.02	\$118.95	\$192.25
Area 6	\$59.44	\$127.10	\$206.36

# GROUP DENTAL INSURANCE

PPO PLAN – AREA TABLE		
State	Area	First 3 Digits of Zip Code
<b>Alabama</b>	1	350-354, 362-364, 367-369
	2	355-361, 365-366
<b>Alaska</b>	6	
<b>Arizona</b>	2	850-857
	3	859-865
<b>Arkansas</b>	2	
<b>California</b>	2	923-925
	3	900, 905-922, 926-938, 952-953, 955-961
	4	901-904, 939, 945-946, 948, 950-951
	5	940-944, 947, 949, 954
<b>Colorado</b>	3	
<b>Connecticut</b>	4	
<b>Delaware</b>	4	197, 199
	5	198
<b>D.C.</b>	3	
<b>Florida</b>	2	320-322, 325-329, 334-338, 342-349
	3	323-324, 333, 339-341
	4	330-332
	4	330-332
<b>Georgia</b>	2	306-310, 312, 319
	3	300-305, 311, 313-318, 398
<b>Hawaii</b>	3	
<b>Idaho</b>	2	
<b>Illinois</b>	1	624, 628-629
	2	609-623, 625-627
	3	600-608
<b>Indiana</b>	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	3	463-464
<b>Iowa</b>	1	508-510, 512-516
	2	500-507, 520-528
	3	511
<b>Kansas</b>	2	
<b>Kentucky</b>	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
<b>Louisiana</b>	2	
<b>Maine</b>	3	042-044, 046-047, 049
	4	039-041, 045, 048
<b>Maryland</b>	1	215
	2	206, 210-214, 216-219
	3	207-209
<b>Massachusetts</b>	3	010, 012-013
	4	011, 014-027
<b>Michigan</b>	2	486
	3	480-485, 487-499
<b>Minnesota</b>	3	
<b>Mississippi</b>	2	
<b>Missouri</b>	1	645
	2	630-644, 646-651, 653-659
	3	652

PPO PLAN – AREA TABLE		
State	Area	First 3 Digits of Zip Code
<b>Montana</b>	3	
<b>Nebraska</b>	1	680-684, 689-690
	2	685-688, 691-693
<b>Nevada</b>	2	889-891
	4	893-898
<b>New Hampshire</b>	4	030, 032, 034-038
	5	031, 033
<b>New Jersey</b>	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
<b>New Mexico</b>	3	
<b>New York</b>	2	104, 124-129, 133-136, 142
	3	103, 109-110, 115, 117-123, 130-132, 137-141,
		143-149
	4	063, 105-108, 111-114, 116
	6	100-102
<b>North Carolina</b>	3	270-281, 283-289
	4	282
<b>North Dakota</b>	3	
<b>Ohio</b>	2	430-435, 437-459
	3	436
<b>Oklahoma</b>	2	731, 735-749
	3	730, 734
<b>Oregon</b>	3	
<b>Pennsylvania</b>	1	150-156, 159-161, 163-164, 171-172, 185, 187
	2	157-158, 162, 165-168, 170, 173-176, 180-184, 186,
		188, 190-192
	3	169, 177-179, 189, 193-196
<b>Puerto Rico</b>	1	
<b>Rhode Island</b>	3	
<b>South Carolina</b>	3	
<b>South Dakota</b>	2	570, 572-577
	3	571
<b>Tennessee</b>	2	
<b>Texas</b>	1	782
	2	754-759, 764-769, 773-774, 776-781, 783-785,
		788-789, 794-799
	3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
<b>Utah</b>	1	
<b>Vermont</b>	4	
<b>Virginia</b>	2	230-246
	3	201, 220-229
<b>Virgin Islands</b>	3	
<b>Washington</b>	3	990-992, 994
	4	985-989, 993
	5	980-984
<b>West Virginia</b>	2	
<b>Wisconsin</b>	3	
<b>Wyoming</b>	2	

## COMMON QUESTIONS

### WHO IS ELIGIBLE FOR COVERAGE?

As an AFSA member, you, your lawful spouse, and your eligible dependents under age 26 may enroll for coverage. You and your eligible spouse and dependents must reside in the United States.

### IS ORTHODONTIA A COVERED SERVICE?

Orthodontia is a covered service under the Scheduled Dental Plan. Orthodontia diagnostic and treatment services will be covered at 50%<sup>3</sup> up to a maximum of \$850 for covered dependents under age 19. Orthodontia is not a covered service under the PPO Dental Plan.

### WHEN DOES COVERAGE BEGIN?

Your dental coverage will become effective following receipt of your enrollment form and first premium payment.

### WHEN DOES COVERAGE END?

Your dental coverage will remain in effect unless you cease to be in an eligible class, you fail to pay the appropriate premium when due, insurance ends for your class, the group policy is discontinued, or the last day of the calendar month in which you cease to be a member. Coverage for dependents will end at age 26.

### HOW DO I ENROLL?

To apply for AFSA Group Dental Insurance, go to [HQAFSAplans.com/enroll](https://www.hqafsa.com/plans/enroll) and download the enrollment form. Mail your completed and signed enrollment form, along with your payment, to:

**AFSA Member Insurance Program  
1200 E. Glen Ave.  
Peoria Heights, IL 61616**

Questions? We're here to help. Contact an AFSA Group Dental Insurance representative at **(888) 834-9024**.

### 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 email alerts when a claim has been processed. If you need a claim form, visit [metlife.com/mybenefits](https://www.metlife.com/mybenefits) or call **(800) 942-0854**.

### 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 services provided to plan members. Negotiated fees are typically 30-45% less than the average charges in the same community.<sup>1</sup>

### 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 [metlife.com/mybenefits](https://www.metlife.com/mybenefits). You can also call **(800) 942-0854** to have a list mailed to you.

### CAN 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. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

### 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 [metdental.com](https://www.metdental.com) or call **(866) PDP-NTWK** for an application.<sup>2</sup> The website and phone number are for use by dental professionals only.

### CAN I FIND OUT WHAT MY OUT-OF-POCKET EXPENSES WILL BE BEFORE RECEIVING A SERVICE?

Yes. You can ask for a pretreatment estimate. MetLife strongly recommends that you have your dentist submit a pretreatment estimate to MetLife if the cost is expected to exceed \$300. When your dentist suggests treatment, have him or her send a claim form, along with the proposed treatment plans and supporting documentation, to MetLife. An explanation of benefits (EOB) will be sent to you and the dentist detailing an estimate of what services MetLife will cover and at what payment level. Actual payments may vary from the pretreatment estimate depending upon annual maximums, deductibles, plan frequency limits, and other plan provisions 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.<sup>3</sup> You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at [metlife.com/mybenefits](https://www.metlife.com/mybenefits).

## COMMON QUESTIONS

### CAN METLIFE HELP ME FIND A DENTIST OUTSIDE OF THE U.S. IF I AM TRAVELING?

Yes. Through the international dental travel assistance services program,<sup>4</sup> 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.<sup>5</sup> Please remember to hold on to all receipts to submit a dental claim.

<sup>1</sup> Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

<sup>2</sup> Due to contractual requirements, MetLife is prevented from soliciting certain providers.

<sup>3</sup> The dental procedure fee tool application is provided by 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.

<sup>4</sup> AXA Assistance USA, Inc. provides dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.

<sup>5</sup> Refer to your dental benefits plan summary for your out-of-network dental coverage. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit a dentist, and the cost of services rendered.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY.

### CERTIFICATE OF INSURANCE

This brochure is only a brief description of the principal provisions and features of the AFSA Group Dental Insurance plan. The complete terms and conditions are set forth in the group policy issued by MetLife.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the plan. In the event of any conflict or inconsistency between the information in this brochure and the information contained in the underlying plan documents, the plan documents will in all respects control and govern. If any provision is not explained or is only partially explained, your rights will always be determined under the provisions of the underlying plan documents. Insurance coverage and availability may vary by state.

### ALTERNATE BENEFITS

Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly

treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. 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 plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles, and other limits applicable at time of payment.

### CANCELLATION/TERMINATION OF BENEFITS

Coverage is provided under a group insurance policy (Policy Form GPNP99-ASSN) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage will end on the earliest of 1) the date the Group Policy ends; 2) the date insurance ends for your class; 3) the date you cease to be in an eligible class; 4) the end of the period for which the last premium has been paid for you; or 5) the last day of the calendar month in which you cease to be a member. Coverage for dependents will end at age 26.

There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

### EXCLUSIONS

#### Scheduled Plan

No benefits will be paid for the following:

- 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 a covered person would not be required to pay in the absence of dental insurance
- Services or supplies received by a covered person before the insurance starts for that person
- 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 or polishing of teeth or fluoride treatment
- Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child
- Services or appliances which restore or alter occlusion or vertical dimension

## COMMON QUESTIONS

- Restoration of tooth structure damaged by attrition, abrasion, or erosion unless caused by disease
- 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 piks, toothbrushes, or dental floss
- Initial installation of a denture to replace one or more teeth which were missing before such person was insured for dental insurance, except for congenitally missing natural teeth
- Decoration or inscription of any tooth, device, appliance, crown, or other dental work
- Missed appointments
- Services covered under any workers' compensation or occupational disease law
- Services covered under any occupational disease or employer liability law for which the employee or dependent received benefits under that law
- Services for which the employer of the person receiving such services is not required to pay
- Services received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital
- Services covered under other coverage provided by the policyholder
- Temporary or provisional restorations
- Temporary or provisional appliances
- Prescription drugs
- Services for which the submitted documentation indicates a poor prognosis
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that dental insurance under the group policy be paid first.
- 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 and biting of food
- Caries susceptibility tests
- Precision attachments associated with fixed and removable prostheses
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance, cast restoration, or denture
- Intra and extraoral photographic images
- 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
- Treatment of temporomandibular joint disorder (This exclusion does not apply to residents of Minnesota.)

### PPO Plan

No benefits will be paid for the following:

- 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 a covered person would not be required to pay in the absence of dental insurance
- Services or supplies received by a covered person before the insurance starts for that person
- 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 or polishing of teeth or fluoride treatment
- Services which are primarily cosmetic unless such service is: required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection, or other disease of the involved part; or required for reconstructive surgery because if a congenital disease or anomaly of a child which has resulted in a functional defect; or (for residents of Texas) required for the treatment or correction of a congenital defect of a newborn child)
- Services or appliances which restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion, or erosion unless caused by disease
- 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 piks, toothbrushes, or dental floss
- Initial installation of a denture to replace one or more teeth which were missing before such person was insured for dental insurance, except for congenitally missing natural teeth

## GROUP DENTAL INSURANCE

- Decoration or inscription of any tooth, device, appliance, crown, or other dental work
- Missed appointments
- Services covered under any workers' compensation or occupational disease law
- Services covered under any employer liability law
- Services for which the employer of the person receiving such services is not required to pay
- Services received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital
- Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a health care practitioner refers you to a health care entity in which the health care practitioner or health care practitioner's immediate family or both own a beneficial interest or have a compensation agreement. For the purposes of this exclusion, the terms "referral," "health care practitioner," "health care entity," "beneficial interest," and compensation agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
- Services covered under other coverage provided by the policyholder
- Temporary or provisional restorations
- Temporary or provisional appliances
- Prescription drugs
- Services for which the submitted documentation indicates a poor prognosis
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that dental insurance under the group policy be paid first.
- 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 and biting of food
- Caries susceptibility tests
- Precision attachments associated with fixed and removable prostheses
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance, cast restoration, or denture
- Intra and extraoral photographic images
- 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
- Treatment of temporomandibular joint disorder (This exclusion does not apply to residents of Minnesota)
- Orthodontia services or appliances
- Repair or a replacement of an orthodontic appliance
- Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for dental insurance, except for congenitally missing natural teeth

Policy number: 211269-1-G

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.

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