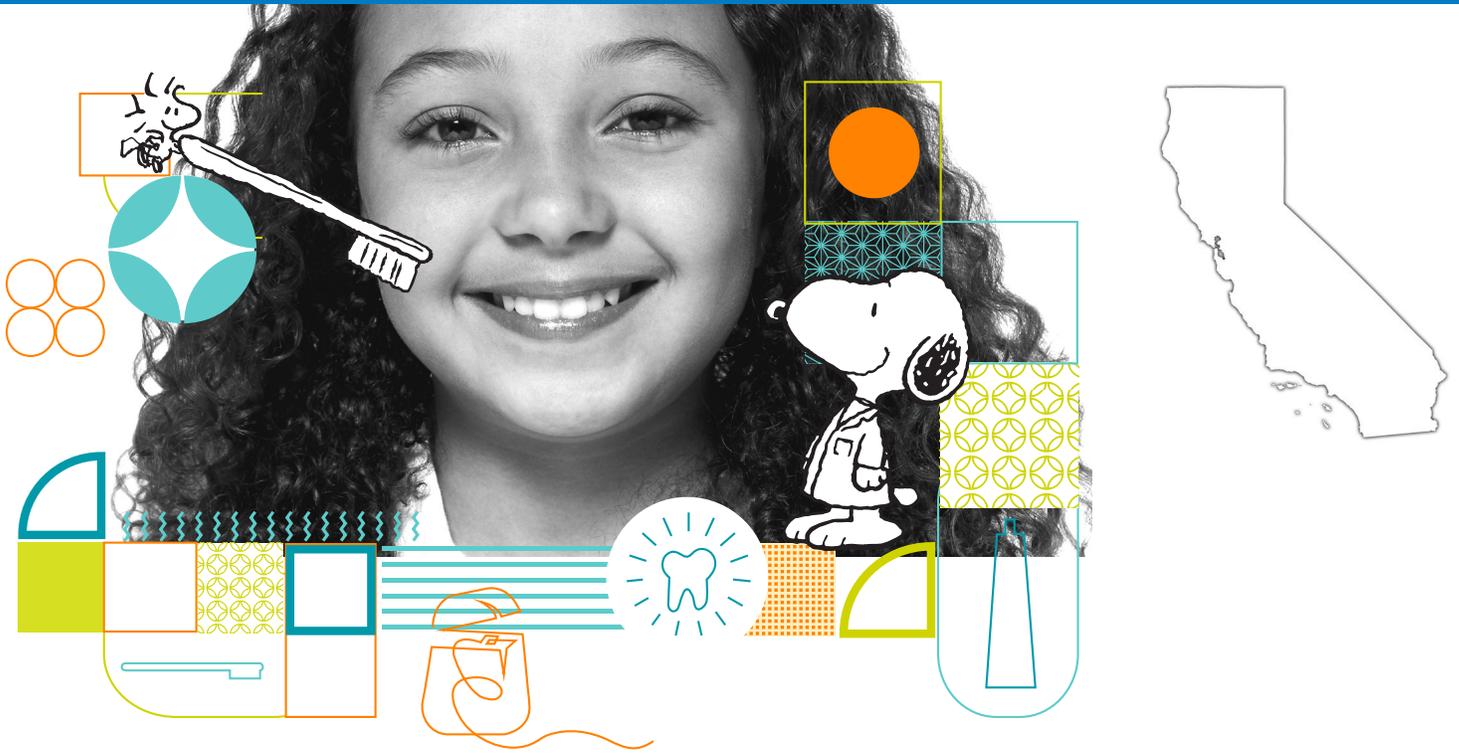


MetLife



Dental Benefits
for a Healthier Family

Regular visits to the dentist may do more than just brighten your smile — they can be important to your family’s overall health. Recent studies link oral infections with diabetes, heart disease, stroke and premature low-weight births.¹

Dental benefits make it more affordable to see a dentist regularly. Choose MetLife dental benefits and you’ll get:

- **Savings** on services that help you keep your mouth healthy,² including medically necessary orthodontia.
- **No annual maximum** for pediatric dental benefits.
- **Freedom of choice** to go to any dentist.
- **Service** where and when you want it.
- **Educational tools and resources** to help promote good oral and overall health.

Your dental benefits will be provided through the Preferred Dentist Program, our dental preferred provider organization³ (PPO) plan.

MetLife Children’s Dental 85 PPO Plan is a Qualified Health Plan in Covered California.

¹ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers: At a Glance 2010.

http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2010/oral_health_aag.pdf. Accessed 06/01/14

² Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit the dentist and the cost of services rendered.

³ Group dental insurance policies featuring the MetLife Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

What you'll find inside

In this booklet, you'll find information to help you make an educated choice about choosing dental benefits:

- An overview of the benefits of choosing MetLife Dental
- How to get the most savings out of your dental benefits
- Highlights of the MetLife Children's Dental 85 PPO Plan
- Important answers to some common questions

We designed our dental benefits 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 competitively priced benefits to help you have a healthier smile and a healthier you. You also get great service and educational support to help you stay on top of your care.

Savings on services that help you keep your mouth healthy.²

This plan provides you with savings on preventive services like cleanings and oral examinations, basic restorative services like fillings, major restorative services like prefabricated crowns, and medically necessary orthodontia (services that help fix problems with the teeth and jaw).

Freedom of choice to go to any dentist.

You have the flexibility to visit any dentist and receive coverage under the plan.

For better savings, visit a participating general dentist or specialist. Participating (or in-network) dentists have agreed to accept negotiated fees as payment in full for covered services. Typically, these fees are 15% to 45% less than the average charges in the same community.⁴

So you can feel confident about choosing a participating dentist, our participating dentists are carefully selected⁵ to support quality and savings. In fact, requirements include ongoing reviews of treatment patterns to ensure they fall within acceptable norms.

For more freedom with less savings, you can visit a non-participating (or out-of-network) general dentist or specialist. Because non-participating dentists have not agreed to accept negotiated fees, your out-of-pocket costs for covered services may be higher than if you were treated by a participating dentist. However, you will save more than if you had no dental coverage.

Plus, whether you choose a participating or non-participating dentist, you don't need any referrals.

Service where and when you want it.

You'll get more service – less paperwork – less worries. Managing your dental benefits is easy with MyBenefits (www.metlife.com/mybenefits), your secure self-service website. It's available 24/7.⁶ You can use the site to get estimates on care or to check coverage and claim status. And you can call us toll-free at 1-855-638-3940.

Educational tools and resources to help promote good oral and overall health.

You and your dentist get a wealth of information and valuable tools to help make informed decisions about your oral health. You'll find a range of helpful topics on our online dental education website, www.oralhealthlibrary.com. Read up on topics like family dental health, the link between dental and overall health, and kid's dental health. Plus, you can take risk assessments to better understand your personal risk for dental disease.

⁴ Based on internal analysis.

⁵ Certain providers may participate with MetLife through an agreement that MetLife has with a vendor. Providers available through a vendor are subject to the vendor's credentialing process and requirements, not MetLife's. If you should have any questions, contact MetLife Customer Service.

⁶ With the exception of scheduled or unscheduled systems maintenance or interruptions, the MyBenefits website is typically available 24 hours a day, 7 days a week.

How to get the most savings out of your dental benefits.

It's easy to get the most out of your dental benefits.

- **Keep a healthy dental regimen** by getting routine preventive services like exams and cleanings. The cost of preventive services is usually less than the cost for fillings, root canals, extractions, etc. Plus, preventive services can help you avoid the need for these higher-cost treatments.
- And, whether you need routine preventive services or more expensive restorative services, **visit a participating general dentist or specialist**. This will help reduce your out-of-pocket costs.

These two hypothetical examples show how receiving services from a participating dentist can help save you money.

Example One

You bring your child to the dentist for a routine cleaning, which is a preventive service.

- Negotiated Fee: \$50.00
- MAC Charge: \$50.00
- Dentist's Usual Fee: \$86.00

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:	\$86.00	Dentist's Usual Fee is:	\$86.00
The Negotiated Fee is:	\$50.00	MAC charge is:	\$50.00
Your Plan Pays:		Your Plan Pays:	
100% X \$50 Negotiated Fee	\$50.00	100% X \$50 MAC	\$50.00
Your Out-of-Pocket Cost		Your Out-of-Pocket Cost	
Negotiated Fee minus Your Plan Pays	\$0.00	Dentist's Usual Fee minus Your Plan Pays	\$36.00

In this example, **you save \$36.00** (\$36.00 minus \$0.00)...
by using a participating dentist.

Without dental insurance, you'd be responsible to pay the dentist's usual fee of \$86.00.

This is a hypothetical example that shows a D1120 Prophylaxis – child in the Los Angeles, CA, area (three-digit ZIP code 900). It assumes that the annual deductible has been met.

MAC (or Maximum Allowed Charge) is the lowest of (1) the amount charged by the dentist or (2) the maximum amount that in-network dentists have agreed to accept as payment in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

Example Two

You visit your dentist for a filling, which is a basic restorative service.

- Negotiated Fee: \$89.00
- MAC Charge: \$89.00
- Dentist's Usual Fee: \$164.00

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:	\$164.00	Dentist's Usual Fee is:	\$164.00
The Negotiated Fee is:	\$89.00	MAC charge is:	\$89.00
Your Plan Pays:		Your Plan Pays:	
80% X \$89 Negotiated Fee	\$71.20	80% X \$89 MAC	\$71.20
Your Out-of-Pocket Cost		Your Out-of-Pocket Cost	
Negotiated Fee minus Your Plan Pays	\$17.80	Dentist's Usual Fee minus Your Plan Pays	\$92.80

In this example, **you save \$75.00** (\$92.80 minus \$17.80)...
by using a participating dentist.

Without dental insurance, you'd be responsible to pay the dentist's usual fee of \$164.00.

This is a hypothetical example that shows a D2330 Resin-based composite – one surface, anterior in the Los Angeles, CA, area (three-digit ZIP code 900). It assumes that the annual deductible has been met. MAC (or Maximum Allowed Charge) is the lowest of (1) the amount charged by the dentist or (2) the maximum amount that in-network dentists have agreed to accept as payment in full for the dental service. When a participant receives dental services from an out-of-network provider, MetLife will reimburse a percentage of the MAC. The participant is then responsible for everything over the percentage of MAC reimbursed up to the charge submitted by the out-of-network dentist.

Highlights of the MetLife Children's Dental 85 PPO Plan

MetLife Children's Dental 85 PPO Plan		
Coverage Type	In-Network	Out-of-Network
Preventive Services (Type A) – cleanings, oral examinations	100% of negotiated fee	100% of MAC
Basic Restorative Services (Type B) – fillings	80% of negotiated fee	80% of MAC
Major Restorative Services (Type C) – prefabricated crowns	50% of negotiated fee	50% of MAC
Orthodontia (Type D)	50% of negotiated fee for medically necessary orthodontia for participants under the age of 19 only	Not Covered
Deductibles		
Individual Deductible	\$65 Applies to B, C & D Services	\$65 Applies to B & C Services
Family Deductible	\$130 (applies to two or more participants under the age of 19 only) Applies to B, C & D Services	\$130 (applies to two or more participants under the age of 19 only) Applies to B & C Services
Annual Maximums		
Annual Maximum	None	None
Out-of-Pocket Annual Maximum	\$350 (applies to participants under the age of 19 only)	None
Family Out-of-Pocket Maximum	\$700 (applies to two or more participants under the age of 19 only)	None

For more detail about this plan, please refer to its dental plan benefits summary document.

Important answers to some common questions

General Plan Questions

Who can enroll?

You can enroll members of your household under the age of 19 in the MetLife Children's Dental 85 PPO Plan.

Will I receive an ID card?

Yes. However, you do not need an ID card to access your benefits. After your enrollment information is processed, we will mail you a letter with important information and an ID card. The ID card will include your assigned unique identifying number. Your dentist must use your personal identification number when he or she submits claims to MetLife on your behalf.

How are claims processed?

Dentists may submit your claims for you, so 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 MyBenefits (www.metlife.com/mybenefits) or request one by calling 1-855-638-3940.

Network and Provider Questions

What 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 typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.⁷

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. Before you enroll, you can review our list of participating dentists on your marketplace.

After you enroll, you can find the names, addresses, languages spoken and telephone numbers of participating dentists in your area by searching our online *Find a Dentist* feature at MyBenefits (www.metlife.com/mybenefits). Or call 1-855-638-3940 to have a list faxed or mailed to you.

Does everyone in my family have to receive care from the same dentist?

No. Each participant may select a different participating dentist.

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. 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 www.metdental.com, or call 1-866-PDP-NTWK for an application.⁸ This website and phone number are for use by dental professionals only.

Benefit Questions

What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please see the dental plan benefits summary for more information.

What is an out-of-pocket annual maximum?

The out-of-pocket annual maximum is the most you pay during a Plan Year in cost-sharing for participants under the age of 19 before we begin to pay 100% of the maximum allowed charge for covered services. This limit does not include your premium, balance billing charges or the cost of health care services we do not cover.

Do I have a waiting period before I can see a dentist?

No. Once you enroll, you will receive a communication from MetLife that gives you the "effective date" of your benefits. As soon as you receive notice of your effective date, you may call your selected participating dentist to make an appointment any time after the effective date. Some plans may have waiting periods for specialty services.

Can I find out 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?

After you enroll, you can use the dental procedure fee tool⁹ on MyBenefits (www.metlife.com/mybenefits) to look up average in- and out-of-network fees for dental services in your community. You'll find fees for services like exams, cleanings, fillings and more. Just log in at www.metlife.com/mybenefits.

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

Yes. Through international dental travel assistance services¹⁰ 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.¹¹ Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans?

The 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.

⁷ Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

⁸ Due to contractual requirements, MetLife is prevented from soliciting certain providers.

⁹ The Dental Procedure Fee tool application is provided by go2dental.com, Inc., an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a third-party. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing claims. Prior to receiving services, pretreatment estimates through the dentist will provide the most accurate fee and payment information.

¹⁰ International dental travel assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services they provide are separate and apart from the benefits provided by MetLife. Referrals are not available in all locations.

¹¹ Refer to your dental plan benefits summary for your out-of-network dental coverage.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Please contact MetLife or your plan administrator for complete details.

MetLife

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CALIFORNIA CHILDREN’S DENTAL 85 PPO PLAN (HIGH)

This Schedule of Benefits lists the services available under the MetLife plan, as well as the co-insurance payments associated with each procedure. There are other factors that impact how the plan works and those are included here and in the Exclusions and Limitations sections below. This Schedule of Benefits describes services available only to a Covered Person under the age of 19.

The Covered Person has access to Dentists through the MetLife Preferred Dentist Program. Dentists participating in the MetLife Preferred Dentist Program have agreed to limit their charges for Covered Services to the Maximum Allowed Charge for such service. The Maximum Allowed Charge is the lesser of (1) the amount charged by the Dentist; or (2) the maximum amount which the In-Network Dentist has agreed with MetLife to accept as payment in full for the dental service. Under the MetLife Preferred Dentist Program, MetLife pays benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, the Covered Person may be able to reduce out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with MetLife to limit their charges.

The Covered Person’s out-of-pocket maximum includes the Covered Person’s costs for Covered Services provided by an In-Network Dentist. The out-of-pocket maximum does not include the Covered Person’s costs for: (1) Covered Services in excess of the Maximum Allowed Charge, or (2) services that are not Covered Services or (3) services delivered by a non-contracted provider.

This summary provides an overview of the plan’s benefits. Claims will be administered using current dental terminology. These benefits are subject to the terms and conditions of the MetLife policy. Specific details regarding these provisions can be found in the certificate. **Like most dental insurance policies, MetLife policies contain exclusions, limitations, terms and conditions for keeping them in force. If there are additional questions regarding the Dental Insurance program underwritten by MetLife, please contact the benefits administrator or MetLife.**

Deductible and Annual/Lifetime Maximums	
In-Network Annual Maximum	None
In-Network Individual Out-of-Pocket Annual Maximum	\$350 for one Covered Person*
In-Network Individual Deductible (applies to Basic Services, Major Services and Orthodontia)	\$65*
In-Network Family Deductible	\$130**
In-Network Family Out-of-Pocket Annual Maximum	\$700 for two or more Covered Persons**
Out-of-Network Annual Maximum	None
Out-of-Network Individual Out-of-Pocket Annual Maximum	None
Out-of-Network Individual Deductible (applies to Basic and Major Services)	\$65*
Out-of-Network Family Deductible	\$130**
Out-of-Network Family Out-of-Pocket Annual Maximum	None

* Each individual insured is only responsible for paying the Individual Deductible and Individual Out-of-Pocket Maximum.

** Deductibles and other cost sharing payments made by each individual in a family contribute to the Family Deductible or Out-of-Pocket Maximum. For these purposes, family is composed of 2 or more Covered Persons under the age of 19. Once the Family Deductible amount is satisfied by 2 Individual Deductibles being satisfied, plan copays or coinsurance apply until the family Out-of-Pocket Maximum is reached, after which the plan pays the Maximum Allowed Charge, or if less, the amount charged, for covered services for all Covered Persons.

Service	Covered Percentage	Limitations
Diagnostic and Preventive Care Services (Subject to applicable Maximums)		
Oral Examinations	100%	
Limited oral evaluation - problem focused	100%	
Preventive dental education and oral hygiene instruction	100%	
Full-mouth and Panoramic X-Rays	100%	Combined Frequency Limitation of once every 24 months.
Periapical X-Rays	100%	
Other X-Rays	100%	
Bitewing X-Rays	100%	1 series of 4 films in any 6 months
Prophylaxis – Cleanings	100%	2 times in any 12 months
Fluoride	100%	
Sealants for Permanent 1 st and 2 nd Molars	100%	
Space Maintainers	100%	
Preventive Resin Restoration in a Moderate to High Caries Risk Patient - Permanent Tooth – for Permanent 1 st and 2 nd Molars	100%	
Palliative (Emergency) Treatment of Dental Pain	100%	
Labs and Other Tests	100%	
Basic Services (Subject to applicable Deductible and Maximums)		
Amalgam Fillings (Includes pins and pin buildup in conjunction with a restoration)	80%	
Resin Composite Fillings (Includes pins and pin buildup in conjunction with a restoration)	80%	
Sedative Base and Sedative Fillings	80%	

Major Services (Subject to applicable Deductible and Maximums)		
Inlays/Onlays/Crowns (Cast Restorations) (Includes related dowel pins and pin build up and cast retention under crowns)	50%	
Prefabricated Crowns	50%	
Crown Buildups/Post & Core	50%	
Simple Repairs of Cast Restorations	50%	
Recementations of Crowns, Fixed Partial Dentures, Inlays and Onlays	50%	
Pulp Capping	50%	
Pulpotomy and Vital Pulpotomy Treatment	50%	
Pulp Therapy	50%	
Endodontics – Root Canal (initial treatment and retreatment) (Includes culture canal)	50%	
Apexification & Recalcification	50%	
Periodontal Surgery	50%	
Periodontal Surgery - Soft and Connective Tissue Grafts (Includes periodontal abscess and acute periodontitis)	50%	
Periodontics – Non-Surgical	50%	
Periodontal Maintenance	50%	
Denture Adjustments	50%	
Dentures – Rebases/Relines	50%	
Repair of Dentures	50%	
Debridement	50%	
Oral Surgery – Simple Extractions	50%	
Oral Surgery – Surgical Extractions	50%	
Other Oral Surgery (including alveolectomies, excision of cysts and neoplasms, treatment of palatal torus, treatment of mandibular torus, frenectomy, incision and drainage of abscesses, post-operative services including exams, suture removal and treatment of complications, root recovery, root amputation, and apicoectomy, vitality tests, local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide)	50%	
General Anesthesia – Intravenous Sedation	50%	
Consultations	50%	
Adjunctive General Services	50%	

Dentures – Complete/Partial/Overdenture (Includes clasps and stress breakers, Denture duplication and stayplates)	50%	
Adding Teeth to Dentures	50%	
Tissue Conditioning	50%	
Biopsies	50%	
Fixed Partial Dentures	50%	
Scaling and Root Planing	50%	
Occlusal Guards/Bruxism Appliances	50%	
Occlusal Adjustments	50%	

Orthodontia (Subject to applicable Deductible and annual out-of-pocket maximum when medically necessary and administered by an In-Network Dentist)

Orthodontia is only covered In-Network and must be medically necessary to be a Covered Service.

Service	Covered Percentage	Limitations
Orthodontia	50%	<p>Orthodontia services must be medically necessary. Orthodontia treatment must begin while this insurance is in force. If the insurance ends during the course of the treatment, the monthly payments will end. Dental procedures performed in connection with Orthodontia treatment are considered under the orthodontia benefit and are Covered Services only if medically necessary.</p> <p>Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits. The benefit payable for the initial placement will not exceed 20% of the amount charged by the Dentist. The balance of the treatment fee will be paid proportionately during the remaining course of treatment.</p>

For orthodontia services, We strongly recommend that you get a pretreatment estimate of proposed orthodontic services and then discuss that estimate with the Dentist before the services are delivered. Even though pretreatment estimates are not guarantees of benefits, obtaining a pretreatment estimate is an important part of making a well-informed decision about orthodontic services, including what your plan may or may not cover under the Essential Health Benefit requirements.

DEFINITIONS

DENTALLY NECESSARY

This means the services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's dental condition due to dental disease, in order to attain or maintain the individual's achievable dental health, provided that such services are:

- Consistent with generally accepted standards of dental practice that are defined standards and are based on:
 - credible scientific evidence published in peer-reviewed dental literature that is generally recognized by the relevant dental community,
 - recommendations of a dental-specialty academy,
 - the views of Dentists practicing in the relevant clinical areas, and
 - any other relevant factors;
- Clinically appropriate in terms type, frequency, timing, site, extent and duration and considered effective for the individual's dental condition;
- Not primarily for the convenience of the patient or Dentist;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's dental condition; and
- Based on an assessment of the individual and his or her dental condition.

Medically Necessary Orthodontia means the services are required to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM

The Individual Deductible is the amount that a Covered Person must pay for Covered Services to which such Deductible applies each Benefit Year before We will pay benefits for such Covered Services.

Each individual insured is only responsible for paying the Individual Deductible and Individual Out-of-Pocket Maximum. Deductibles and other cost sharing payments made by each individual in a family contribute to the Family Deductible or Out-of-Pocket Maximum. Once the Family Deductible amount is satisfied by 2 Individual Deductibles being satisfied, plan copays or coinsurance apply until the Family Out-of-Pocket Maximum is reached, after which the plan pays the Maximum Allowed Charge, or if less, the amount charged, for covered services for all Covered Persons.

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service. The Deductible Amount will be applied based on when Dental Insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is "incurred". When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

TIME PERIODS

The expense periods are based on a Benefit Year.

BENEFITS WE WILL PAY AFTER INSURANCE ENDS

We will pay for benefits for orthodontic covered services for a course of treatment in effect at the time your insurance ends for:

- 60 days after the date insurance ends if the orthodontist has agreed to or is receiving monthly payments; or
- until the later of 60 days after insurance ends or the end of the quarter in progress if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

We will pay benefits for a 60 day period after the Covered Person's Insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before the Covered Person's Insurance ends; and
- the Cast Restoration is installed within 60 days after the date the Insurance ends.

We will pay benefits for a 60 day period after the Covered Person's Insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before the Covered Person's Insurance ends; and
- the treatment is finished within 60 days after the date the Insurance ends.

In addition, for other services, we will pay benefits for Covered Services received within 60 days of the day on which your insurance ends if the treatment:

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a Dentist's office.

DENTAL INSURANCE: EXCLUSIONS

1. Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS are not covered.
2. Services which are not Dentally Necessary; services which are not medically necessary for Orthodontia; services which do not meet generally accepted standards of care for treating the particular dental condition; or services which are experimental in nature.
3. Services for which you would not be required to pay in the absence of Dental Insurance.
4. Services or supplies received by a Covered Person before the Dental Insurance starts for that person.
5. Services which are primarily cosmetic.
6. 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.
7. Services or appliances which restore or alter occlusion or vertical dimension.
8. Restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease.
9. Restorations or appliances used for the purpose of periodontal splinting.
10. The prophylactic removal of third molars is not a Covered Service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.
11. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.
13. Charges for 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 your employer, labor union, mutual benefit association, or VA hospital.
15. Services covered under other coverage provided by your employer.
16. Temporary or provisional restorations.
17. Temporary or provisional appliances.
18. Prescription drugs.
19. Implants including, but not limited to any related surgery, placement, maintenance, and removal.

20. Implant supported prosthetics.
21. Repair of implants.
22. Fixed and removable appliances for correction of harmful habits.
23. Local chemotherapeutic agents.
24. Injections of therapeutic drugs.
25. Application of desensitizing agents.
26. The following, when charged by the Dentist on a separate basis:
 - claim form completion; or
 - infection control, such as gloves, masks, and sterilization of supplies.
27. Precision attachments associated with fixed and removable prostheses.
28. Duplicate prosthetic devices or appliances, except for Dentures.
29. Replacement of an orthodontic device.
30. Intra and extraoral photographic images.
31. Cone beam imaging.
32. Diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders.
33. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal is not a Covered Service, in the absence of pathology.
34. Labial veneers.
35. Other fixed partial Denture services, including a connector bar; and any other fixed partial denture service not listed as a Covered Service.
36. Coping is not a Covered Service.

DENTAL INSURANCE LIMITATIONS

1. Bitewing x-rays are limited to 1 series of 4 films in any 6 months. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
2. Full mouth x-rays and panoramic films have a combined frequency limitation of once every 24 months.
3. Prophylaxis services are limited to 2 times every 12 months.
4. Periodontal maintenance is available, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed.
5. Dental sealant treatments are limited to permanent 1st and 2nd molars.
6. Restorations are limited as follows:
 - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
 - Micro filled resin restorations which are non-cosmetic.
 - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.
 - Preventive resin restorations are limited to first and second permanent molars.
7. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
8. Surgical removal of wisdom teeth is a covered benefit only when evidence of pathology exists.
9. Fixed partial dentures, local anesthetics, oral sedatives, and nitrous oxide are Covered Services.
10. Coverage is provided for general anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when such anesthesia is determined to be Dentally Necessary or in conjunction with Medically Necessary Orthodontia.
11. Crowns and Crown replacements are only available if Dentally Necessary. Crowns will only be a Covered Service if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent they will not hold a filling.
12. Retreatment of root canals is a Covered Service if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms.
13. Fixed partial dentures will only be used when a partial cannot satisfactorily restore the case. If fixed partial dentures are used when a partial could satisfactorily restore the case, the benefit determination will be based upon the partial which is the less costly service. Fixed partial dentures are only available if Dentally Necessary.
14. Fixed partial Dentures are limited to the charges for a cast chrome or acrylic Denture if it would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the Covered Person and the Dentist, and it is not necessary to satisfactorily restore the arch, the Covered Person will be responsible for all additional costs.

16. Fixed partial Dentures are a Covered Service only when necessary to replace a missing permanent anterior tooth for a Covered Person age 16 and over and the Covered Person's oral health and general dental condition permits. For a Covered Person under age 16 it is considered optional treatment and the Covered Person is responsible for the difference in cost between the fixed partial Denture and a space maintainer.
17. The following fixed partial Dentures are considered optional and not a Covered Service:
 - to replace missing posterior teeth are considered optional when the abutment teeth are medically sound and would be crowned only for the purpose of supporting a pontic; or
 - when provided in connection with a partial Denture on the same arch.
18. Removable fixed partial Denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
19. Replacement of a fixed partial Denture is covered only when it cannot be made satisfactory by repair.
20. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers are only available if Dentally Necessary.
21. Complete Denture will be covered for standard procedures. If a more personalized or specialized treatment is chosen by the Covered Person or the Dentists, the Covered Person is responsible for all additional costs.
22. Stayplates are a Covered Service only when used as anterior space maintainers.
23. Replacement of an immediate temporary, full Denture with a permanent full Denture is covered if the immediate, temporary, full Denture cannot be made permanent.
24. Orthodontic services are only covered if the Medically Necessary Orthodontia coverage requirements are met. Services must begin while this insurance is in force. Orthodontic services are covered under the plan if they are medically necessary to treat a handicapping malocclusion. If the insurance ends during the course of the treatment plan, the monthly benefits will end.
25. When multiple dental services of similar types are provided, the frequency limit under the plan will combine all the similar types of services under the stated frequency limit in combination.
26. Have the Dentist submit a complete pretreatment estimate with pretreatment dated x-rays for all third molar extractions to determine if they will be covered. Please see the Pretreatment Estimate of Benefits section of the certificate for more details.
 - Prophylactic removal of third molars is not a Covered Service.
 - Removal because of malocclusion or orthodontic reasons is not covered.
 - Full bony impactions with no evidence of pathology are not covered.
 - The removal of third molars due to active dental disease may be covered with prior approval.
 - Partial bony impactions and soft tissue impactions may be covered with prior approval if the tooth and/or supporting structures are involved with active disease such as an acute periodontal infection.
 - If emergency removal of a third molar is needed, radiographs and/or documentation of the pathological condition causing the emergent situation may be required prior to payment.

27. If it determined according to generally accepted dental standards that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist

28. Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this plan, these separate steps of one service are considered to be part of the more comprehensive service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.