Dental Benefits

Savings, flexibility and service. For healthier smiles.

MetLife

Overview of Benefits for: Southwestern University

With all of the emphasis on healthy living, it may be refreshing to know you have access to a group dental plan that helps you maintain an oral health regimen with the savings you need, the flexibility you want and service you can count on.

Coverage Type	**In-Network** % of PDP Fee	**Out-of-Network** % of R&C Fee[1]
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible: Per Individual	$50 Applies to Type B & C services only	$50 Applies to Type B & C services only
Deductible: Per Family	$150 Applies to Type B & C services only	$150 Applies to Type B & C services only
Annual Maximum Benefits: Per Individual	$1000	$1000
Orthodontia Lifetime Maximum: Per Individual	$1000	$1000
	Ortho applies to Child Only up to Age 19	
TMJ	Type C - Major Service with a separate Lifetime Maximum	
	None	None

1. The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90th Percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife).

Understanding Your Dental Plans

The MetLife Preferred Dentist Program (PDP) is designed to provide the dental coverage you need with the features you want. Take advantage of what this plan has to offer without compromising what matters most - including the freedom to visit the dentist of your choice – an "in-network" dentist or an "out-of-network" dentist.

If you receive in-network services, you will be responsible for any applicable cost sharing, PDP charges in excess of the benefit maximums, and for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the PDP fee schedule amount, and charges for non-covered services.

Plan benefits are based on the percentage of the PDP fee – MetLife's negotiated fees that PDP dentists have agreed to accept as payment in full.

Plan benefits for in-network services are based on the percentage of the PDP fee – MetLife's negotiated fees that PDP dentists have agreed to accept as payment in full.

Plan benefits for out-of-network services are based on the percentage of the Reasonable and Customary (R&C) charges. 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 for paying any difference between the dentist's fee and your plan's payment for the approved service.

Take advantage of online self-service capabilities with MyBenefits.

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

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

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An Example of Savings

An Example of Savings* When You Visit a MetLife PDP Dentist Take a look at an example that shows how receiving services from a MetLife PDP dentist can save you money:			
Your Dentist says you need a Crown, Type B Service** PDP Fee: $375.00 R&C Fee: $500.00 Dentist's Usual Fee: $550.00			
(**IN-NETWORK**) When you receive care from a MetLife PDP dentist…		(**OUT-OF-NETWORK**) When you receive care from a Non-Participating dentist…	
The PDP Fee is:	$375.00	Dentist's Usual Fee is:	$550.00
Your Plan Pays: (80% x $375.00 PDP Fee)	- $300.00	Your Plan Pays: (80% x $500.00 R&C Fee)	-$400.00
Your Out-of-Pocket Cost:	$75.00	Your Out-of-Pocket Cost:	$150.00

In this example, YOU SAVE $75.00 ($150.00 minus $75.00)…by using a MetLife PDP dentist! Please note, this is only an example and may not match your plan design.

*Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.
**Please note: this example assumes that your annual deductible has been met.

Cancellation/Termination of Benefits:

Coverage is provided under a group insurance policy (Policy form GPN99) 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 terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, a dependent ceases to be a dependent or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. 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.

Important Enrollment Information

Benefits Plan Effective Date: Please see the enclosed cover sheet for specifics on your Plan's effective date.

Important Enrollment Provisions:

If Timely Request Is Made - A timely request for Personal Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Personal Benefits Eligibility Date.

If Late Request Is Made - If a request is not a timely request, it is a late request. If you make a late request for Personal Dental Expense Benefits, your Personal Dental Expense Benefits will become effective after you satisfy the waiting period(s) shown below. The waiting period begins on the date of your request.

Preventive Services.....No waiting period

Basic Restorative Services (Fillings).....6 month waiting period

Basic - All Other Services.....12 month waiting period

Major Services.....24 month waiting period.

Qualifying Event:

Request to be covered, or to change your coverage, upon a Qualifying Event

If there is a Qualifying Event you may request to be covered, or to change your coverage, for Personal Dental Expense Benefits only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under This Plan because of a loss of the prior dental coverage. If you make a request to be covered for Personal Dental Expense Benefits or a request for change(s)in Personal Dental Expense Benefits within thirty-one days of a Qualifying Event, your Personal Dental Expense Benefits or the change(s) in Personal Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

Selected Covered Services and Frequency Limitations

Type A - Preventive	How Many / How Often
• Prophylaxis - Cleanings	1 in 6 months.
• Oral Examinations	1 in 6 months.
• Topical Fluoride Applications	2 in 12 months for children up to 14th birthday.
• Full Mouth X-Rays	1 in 36 months.
• Bitewing X-Rays (Adult/Child)	Adult 1 in 12 months / Child 1 in 12 months up to 14th birthday.
• Sealants	1 per tooth in 36 months (per permanent 1st & 2nd non-restored molar) children up to 16th birthday.
• Emergency Palliative Treatment	
Type B - Basic Restorative	**How Many / How Often**
• Space Maintainers	Children up to 16th birthday. Limited to 1 per lifetime per area.
• Repairs	1 per tooth in 12 months.
• Endodontics - Root Canal	1 per tooth per lifetime.
• General Anesthesia	For oral surgery, extractions or other covered services.
• Oral Surgery (Simple Extractions)	
• Oral Surgery (Surgical Extractions)	
• Other Oral Surgery	
• Periodontal Surgery	1 in 36 months.
• Periodontal Scaling & Root Planing	1 in 24 months.
• Periodontal Maintenance	2 in 1 year, includes 2 cleanings.
• Amalgam & Composite Fillings	1 in 24 months.
• Consultations	1 in 12 months.
• Harmful Habits Appliances	
• Prefabricated Stainless Steel & Resin Crowns	1 per tooth in 24 months.
Type C - Major Restorative	**How Many / How Often**
• Implants	Services: 1 per tooth in 10 years Repairs: 1 per tooth in 10 years.
• Bridges	1 per tooth in 10 years.
• Dentures	1 per tooth in 10 years.
• Crowns/Inlays/Onlays	1 per tooth in 10 years.
TMJ	TMJ -- Major Service with a separate Lifetime Maximum (see page 1).
Type D - Orthodontia	
Dependent children are covered up to 19th birthday. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. • All procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.	

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

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

Exclusions

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

1. Services which are not Dentally Necessary, 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 (For residents of Texas, see notice page section in your certificate).
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.

   For NY Sitused Groups, this exclusion does not apply.
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
    - 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.

    For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    This exclusion only applies for North Carolina Sitused Groups.
15. Services:
    - 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.

    This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
    This exclusion only applies for Virginia Sitused Groups.
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.
24. 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.
    For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. 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.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or 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.
30. 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.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
33. 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.
34. Duplicate prosthetic devices or appliances.
35. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
36. Intra and extraoral photographic images.
37. 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.
    This exclusion only applies for Maryland Sitused Groups
38. Fixed and removable appliances for correction of harmful habits.[1]
39. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
40. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
41. Orthodontic services or appliances.[1]
42. Repair or replacement of an orthodontic device.[1]

1 Some of these exclusions may not apply. Please see your plan design and certificate for details.

Like most group dental insurance policies, MetLife group insurance policies contain certain exclusions, waiting periods, reductions and terms for keeping them in force. Please contact MetLife for details.

Common Questions… Important Answers

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 15-45%* below the average fees charged in a dentist's community for the same or substantially similar services.

*Based on internal analysis by MetLife. Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

How do I find a participating PDP dentist? There are more than 158,000 participating PDP dentist access points nationwide, including 37,000 specialist. You can select a participating dentist or specialist by visiting the MetLife website at www.metlife.com/dental or www.metlife.com/mybenefits if you are registered on MyBenefits. You can also call 1-800-ASK-4MET (800-275-4638).

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 negotiated fees on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be 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. Please note: any plan deductibles must be met before benefits are paid.

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, visit www.metlife.com/dental or www.metlife.com/mybenefits if you are registered on MetLife's MyBenefits. You can also request one by calling 1-800-ASK-4MET (800-275-4638).

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. 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're 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? With the Dental Procedure Fee Tool provided by go2dental.com, you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fee* for dental services in your area.

*Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife.

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

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

Do I need an ID card? No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select? No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date? Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 24 months on Orthodontia Services (if applicable)
- 24 months on Major Services
- 12 months on all other Basic Services
- 6 months on Basic Restorative (Fillings)