

East Texas Employee Benefits Coop Dental Plan Benefits

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

Benefit Summary

Coverage Type	In-Network	Out-of-Network
Type A – Preventative	100% of PDP Fee*	100% of R&C Fee**
Type B – Basic	80% of PDP Fee*	80% of R&C Fee**
Type C – Major	50% of PDP Fee*	50% of R&C Fee**
Type D – Orthodontia (Child Only)	50% of PDP Fee*	50% of R&C Fee**
Deductible [†]	In-Network	Out-of-Network
Individual	\$50.00	\$50.00
Family	\$150.00	\$150.00
Annual Maximum Benefit**	In-Network	Out-of-Network
Per Person	\$1,500.00	\$1,500.00
Orthodontia Lifetime Maximum	In-Network	Out-of-Network
Per Person	\$1,000.00	\$1,000.00
**Annual maximum applies from January 1, 2010 to December 31, 2011		
Late Enrollment Waiting Period: Type A – immediate coverage		
Type B – immediate coverage		
Type C – 12 months		
Type D – 12 months		

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

** Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:

- The dentist's actual charge (the 'Actual Charge'),
 - The dentist's usual charge for the same or similar services (the 'Usual Charge') or
 - The usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge').
- For your plan, the Customary Charge is based on the 90th Percentile. Services must be necessary in terms of generally accepted dental standards.

[†]Applies only to Type B & C Services.

Monthly Rates

The following monthly rates are effective 9/1/2010 through 8/31/2012.

Eligibility Options

Employee Only	\$23.29
Employee + Spouse	\$47.73
Employee + Child(ren)	\$62.72
Employee + Family	\$87.59

If you have any questions regarding your Plan, the MetLife PDP network, customer service, or for any claims-related questions or forms, please visit us at www.metlife.com/mybenefits or call 1-800-942-0854.

List of Primary Covered Services & Limitations

Type A - Preventive

How Many/How Often:

Prophylaxis (cleanings)	• Two per calendar year, separated by a six-month period.
Oral Examinations	• Two exams per calendar year, separated by a six-month period.
Topical Fluoride Applications	• One fluoride treatment per calendar year for dependent children up to 19 th birthday.
X-rays	• Bitewing X-rays: once every 6 months for adults and children
Palliative Care	

Type B - Basic Restorative

How Many/How Often:

X-rays	• Full mouth or panorex x-rays: once per 36 months.
Sealants	• One application of sealant material for each non-restored, non-decayed 1st and 2 nd molar of a dependent child up to 16th birthday, once every 36 months.
Consultations	• Consultations are limited to twice in 12 consecutive months.
Fillings	
Simple Extractions	

Type C - Major Restorative

How Many/How Often:

Space Maintainers	• Limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children up to age 14.
Crowns/Inlays/Onlays	• Initial installation of crowns, inlays and onlays (cast restorations) once in 84 consecutive months. • All other crown replacement: 7 years replacement should match initial placement once every 7 years.
Crown Build-ups	
Veneers	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
Bridges and Dentures	• Dentures and bridgework replacement: one every 7 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed. • Initial installation of partial or full removable dentures. • Adjustment of dentures (minimum is 6 months after installation). • Initial installation of fixed bridgework.
Implants	
Crown, Denture, and Bridge Repair/Recementations	
Rebases/Relines	• Relines and rebases to dentures are limited to one per 36 months (minimum is 6 months after initial installation)
Endodontics/Root Canal	• Root canal treatment limited to once per tooth per 24 months.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed 2 treatments in a calendar year less the number of teeth cleaning during such 12-month period.
Surgical Extractions	

Type D - Orthodontia

How Many/How Often:

- Your Children, up to age 25, are covered while Dental Insurance is in effect.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Initial payment due upon initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage.

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.

Exclusions

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

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - Scaling and polishing of teeth; or
 - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
 - Covered under any workers' compensation or occupational disease law;
 - Covered under any employer liability law;
 - For which the employer of the person receiving such services is not required to pay; or
 - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
 - Claim form completion;
 - Infection control such as gloves, masks, and sterilization of supplies; or
 - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- 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;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

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

How do I find a participating PDP dentist?

There are more than 125,000 participating PDP dentist locations nationwide, including over 30,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any negotiated fees on non-covered services?

Yes. MetLife's negotiated fees with PDP (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a PDP dentist that are not covered under your plan, you are only responsible for the PDP (in-network) fee.

May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Do I need an ID card?

East Texas Benefits Coop will include MetLife information on your ID card. However, 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.

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/mybenefits or request one by calling - 800-942-0854.

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

Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. 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, pre-treatment estimates through your dentist will provide the most accurate fee and payment information.

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.

* Travel assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by ACE American Insurance Company. AXA Assistance and ACE American are not affiliated with MetLife, and the services provided are separate and apart from the benefits provided by MetLife. Referral services are not available in all locations.

** 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.