# Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

## Standard Plan

| | In-Network[1] % of Negotiated Fee[2] | Out-of-Network[1] % of R&C Fee** |
|---|---|---|
| **Coverage Type** | | |
| **Type A: Preventive** (cleanings, exams, X-rays) | 100% | 100% |
| **Type B: Basic Restorative** (fillings, extractions) | 80% | 80% |
| **Type C: Major Restorative** (bridges, dentures, TMJ) | 50% | 50% |
| **Type D: Orthodontia** | Not Covered | Not Covered |
| **Deductible†** | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| **Annual Maximum Benefit** | | |
| Per Person | $1,500 | $1,500 |

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, 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.
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.
Applies only to Type B & C Services.

## List of Primary Covered Services & Limitations

The service categories and plan limitations shown 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.

| Plan Type | How Many/How Often |
|---|---|
| **Type A — Preventive** | |
| Prophylaxis (cleanings) | Two per calendar year |
| Oral Examinations | Two exams per calendar year |
| Topical Fluoride Applications | One fluoride treatment per calendar year for dependent children up to his/her 19th birthday |
| X-rays | • Full mouth X-rays; one per 60 months<br>• Bitewings X-rays; two sets per calendar year |
| Space Maintainers | Space maintainers for dependent children up to his/her 19th birthday |
| Sealants | One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to his/her 19th birthday |
| **Type B — Basic Restorative** | |
| Fillings | |
| Simple Extractions | |

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| | |
|---|---|
| Crown, Denture and Bridge Repair/ Recementations | |
| Oral Surgery | |
| Endodontics | Root canal treatment limited to once per tooth per lifetime |
| Periodontics | • Periodontal scaling and root planing once per quadrant, every 24 months<br>• Periodontal surgery once per quadrant, every 36 months<br>• Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year |
| **Type C — Major Restorative** | |
| Oral Surgery | |
| Implants | Replacement once every 7 calendar years |
| Bridges and Dentures | • Initial placement to replace one or more natural teeth, which are lost while covered by the plan<br>• Dentures and bridgework replacement; one every 7 years<br>• 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 |
| Crowns, Inlays and Onlays | Replacement once every 7 years |
| General Anesthesia | When dentally necessary in connection with oral surgery, extractions or other covered dental services |