Dental Insurance

Coverage that helps makes it easier to visit a dentist and helps 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 participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

*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 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 • 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	
Crown, Denture and Bridge Repair/ Recementations	
Endodontics	Root canal treatment limited to once per tooth per lifetime

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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 four treatments in a calendar year
Type C — Major Restorative	
Oral Surgery	
Implants	Replacement once every 7 years
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • 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
General Anesthesia	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Crowns, Inlays and Onlays	Replacement once every 7 years