# Dental

Metropolitan Life Insurance Company

## Plan Design for: New Wave People

## Date Prepared: February 22, 2023

***Choice, Service, Savings.***

To help you enroll, this overview includes rate information and a Q&A so you can make the most informed decision possible.

| **Coverage Type:** | **In-Network[1]** % of PDP Fee[2] | **Out-of-Network[1]** % of R&C Fee[4] |
|---|---|---|
| Type A - Preventive | 100% | 100% |
| Type B - Basic Restorative | 80% | 80% |
| Type C - Major Restorative | 50% | 50% |
| | | |
| **Deductible[3]** | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| | | |
| **Annual Maximum Benefit:** | | |
| Per Person | $1000 | $1000 |

± Changes have been made to your Plan as of the Amendment Effective Date listed above. Please refer to your Certificate of Insurance/Certificate Rider for more details or contact your benefits administrator with any questions.

[1] "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a Participating PDP Provider. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a Participating PDP Provider.

[2] PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full.

[3] Applies to Type B and C services only.

[4] 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'). Services must be necessary in terms of generally accepted dental standards.



200 Park Ave., New York, NY 10166

## *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 Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Eligibility Date.

If Late Request Is Made - If a request is not a timely request, it is a late request. Dental Expense Benefits will become effective for late requests 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
Orthodontia Services (if applicable)..... 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 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 Dental Expense Benefits or a request for change(s) in Dental Expense Benefits within thirty-one days of a Qualifying Event, your Dental Expense Benefits or the change(s) in 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.

## List of Covered Services & Limitations*

| Type A - Preventive | How Many/How Often: |
|---|---|
| Oral Examinations | • Oral exams but not more than once every 6 months. |
| X-rays | • Full mouth X-rays: once every 60 months. |
| Bitewing X-rays | • Not more than 1 set every 6 months for Dependent Children under 19 years of age, no more than 1 set every 12 months for all other Covered Persons. |
| Prophylaxis (cleanings) | • Cleaning of teeth (oral prophylaxis) but not more than once every 6 months. |
| Topical Fluoride Applications | • Topical fluoride treatment for a Dependent child under 14 years of age but not more than once in 12 months. |
| Oral Surgery | |

| Type B - Basic Restorative | How Many/How Often: |
|---|---|
| Sealants | • Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 14, but not more than once per tooth every 60 months. |
| Space Maintainers | • Space Maintainers for dependent children to 14 years of age. |
| Fillings | • Amalgam and Resin-based Fillings. |
| Periodontal Maintenance | • Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed two treatments in a calendar year. |
| Emergency Palliative Treatment | |
| Injections of Antibiotic Drugs | |

| Type C - Major Restorative | How Many/How Often: |
|---|---|
| Crowns/Inlays/Onlays | • Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period. |
| Prefabricated Crown | • Prefabricated stainless steel crowns but not more than once in any 60 month period. |
| Repairs of Dentures, Crowns, Inlays, and Onlays | • Simple Repairs of Cast Restorations. |
| Endodontics | • Root canal treatment, but not more than once in any 24 month period for the same tooth. |
| Periodontal Surgery | • Periodontal surgery but no more than one surgical procedure per quadrant in any 36 month period. |
| Periodontics | • Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period. |
| Relining and Rebasing | • Relining and Rebasing of existing removable dentures but not more than once in 36 months. |
| Simple Extractions | |
| Oral Surgery | |
| Bridges and Dentures | • Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 Years prior to its replacement. |
| General Anesthesia | • When dentally necessary in connection with oral surgery, extractions or other covered dental services. |
| Consultations | • Consultations but not more than once in a 12 month period. |

Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

* The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, exceptions, limitations, reductions 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..

# *The MetLife® Preferred Dentist Program (PDP) Exclusions*

**The following expenses are not Covered Dental Expenses**

**x Services or Supplies…**

— related to teeth lost before dental benefits began or for congenitally missing natural teeth;
— received by a covered person before the dental expense benefits start for that person;
— which are covered by any worker's compensation laws or occupational disease laws;
— which are covered by any employer's liability laws;
— which an employer is required by law to furnish in whole or in part;
— received through the medical department or similar facility which is maintained by the covered person's employer;
— received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;[2]
— for which a covered person is not required to pay;[1]
— which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
— which do not meet generally accepted dental standards, including experimental treatment;
— received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
— which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.[2]

**x** Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.

**x** Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.

**x** Replacement of a lost, missing or stolen crown, bridge or denture.

**x** Repair or replacement of an orthodontic appliance.

**x** Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.

**x** Any duplicate appliance or prosthetic device.

**x** Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.

**x** Instruction for oral care such as hygiene or diet.

**x** Periodontal splinting.

**x** Charges by a dentist for completing dental forms.[2]

**x** Charges for broken appointments.[3]

**x** Temporary or provisional restorations.

**x** Temporary or provisional appliances.

**x** Sterilization supplies.[3]

**x** Services or supplies furnished by a family member.[3]

**x** Treatment of temporomandibular joint disorders.

**x** Implant Services.

**x** Orthodontia.

**x** Myofunctional therapy or correction of harmful habits.

**x** Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

**In Maryland:**

x 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:

a. refers a covered person to; or
b. directs an employee or a person under contract with the Health Care Practitioner to refer a covered person to a Health Care Entity in which:
   a. the Health Care Practitioner; or
   b. the Health Care Practitioner's immediate family; or
   c. both own a Beneficial Interest or have a Compensation Agreement.

For the purposes of this provision, 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

[1] In policies sitused in **MD,** these exclusions do not apply to Medicaid.
[2] Not applicable in **MD**.
[3] Not applicable in **FL, MD, NJ** and **TN**.

## 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 150,000 participating PDP dentist locations nationwide, including over 37,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-275-4638 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 discounts 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/mybenefits or request one by calling 1-800-275-4638.

**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?** If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where 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 fees* 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 form 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.

**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
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

## CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
## NOTICE TO INSUREDS

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Por favor, indique a quién y a dónde debe enviarse el documento traducido.
NOMBRE_____

DIRECCIÓN_____

☐ **免費語言服務。**您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。
爲收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____

地址_____

**Անվճար թարգմանչական ծառայություններ:** Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

**សេវាបកប្រែភាសាឥតគិតថ្លៃ ។** អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

**Kev pab txhais lus tsis kom them nqi.** Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus lv-saws-las ntawm 1-800-927-4357.

**無料の通訳サービス。**通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

**무료 통역 서비스.** 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

**Бесплатные услуги устного перевода.** Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

**Libreng serbisyo sa pagsasalin.** Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

**Dịch vụ thông dịch miễn phí.** Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

**لا تتوفر خدمات ترجمة بتكلفة.** يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

**سرویس های ترجمه رایگان.** شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) با شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

**بلا معاوضہ مترجم دی خدمات مل سکدی اے۔** تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گرہوتو دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔

## NEW JERSEY HEALTH BENEFITS (EHB) PLAN

This schedule shows the benefits that are available under the Group Policy. Your Dependents will only be insured for the benefits:

- for which Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

**BENEFIT** **BENEFIT AMOUNT AND HIGHLIGHTS**

This certificate only applies to a Covered Person until the end of the Year in which the Covered Person reaches age 19. This certificate describes the benefit available under the Pediatric Dental Essential Health Benefit. However if a Covered Person receives a covered service, and is also covered for that covered service under another certificate under the same policy between the Group Policyholder and MetLife, We will pay the higher of the two benefits for that covered service.

| **Covered Percentage for:** | **In-Network based on the Maximum Allowed Charge** | **Out-of-Network based on the Maximum Allowed Charge** |
|---|---|---|
| Diagnostic and Preventive Services | 90% | 80% |
| Restorative, Endodontic, and Periodontal Services | 50% | 40% |
| Prosthodontic and Oral and Maxillofacial Surgical Services | 40% | 40% |
| Orthodontic Services (medically necessary Orthodontics) | 50% | 50% |
| Adjunctive General Services | | |
| Type A | 90% | 80% |
| Type B | 50% | 40% |
| Type C | 40% | 40% |

| | | |
|---|---|---|
| Yearly Individual Deductible (applies to Diagnostic and Preventive Services; Restorative, Endodontic, and Periodontal Services; Prosthodontic and Oral and Maxillofacial Surgical Services; and Adjunctive General Services) | $100 | $100 |
| Yearly Individual Maximum (applies to Diagnostic and Preventive Services; Restorative, Endodontic, and Periodontal Services; Prosthodontic and Oral and Maxillofacial Surgical Services; and Adjunctive General Services) | None | $400 |
| Lifetime Individual Maximum for medically necessary Orthodontics | None | $1,000 |
| **Out-of-Pocket Annual Maximum:** | | |
| Individual Out-of-Pocket Maximum (for 1 Covered Person under age 19) | $375 | None |
| Individual Out-of-Pocket Maximum (for 2 or more Covered Persons under age 19) | $750 | None |

## DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

### PEDIATRIC DENTAL BENEFITS

This section of the Description of Covered Services describes services available only to a Covered Person under the age of 19 (Pediatric Dental Benefits).

Subject to the applicable Deductible, Coinsurance or Copayments, coverage is provided for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision.

- Dental services are available from birth with an age one dental visit encouraged.
- A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the Dentist, thus allowing a Covered Person to transfer to a different Dentist and receive these services. The new Dentist is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the Dentist shall include an explanation and identify the reviewer including their contact information.
- Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Policy will not cover any charges for broken appointments.

## DESCRIPTION OF COVERED SERVICES

### DIAGNOSTIC SERVICES

* Indicated diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a. Clinical oral evaluations once every 6 months *

   1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   2. Periodic oral evaluation – subsequent thorough evaluation of an established patient*
   3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*
   4. Limited oral evaluations that are problem focused
   5. Detailed oral evaluations that are problem focused

b. Diagnostic Imaging with interpretation

   1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   3. Additional films/views needed for diagnosing can be provided as needed.
   4. Bitewings, periapicals, panoramic and cephlometric radiographic images
   5. Intraoral and extraoral radiographic images
   6. Oral/facial photographic images
   7. Maxillofacial MRI, ultrasound
   8. Cone beam image capture

c. Tests and Examinations

d. Viral culture

e. Collection and preparation of saliva sample for laboratory diagnostic testing

f. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services

g. Oral pathology laboratory

   1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   3. Other oral pathology procedures, by report

### PREVENTIVE SERVICES

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

a. Dental prophylaxis once every 6 months*

b. Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*

c. Fluoride varnish once every 3 months for children under the age of 6

d. Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars.

e. Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal

1. fixed – unilateral and bilateral
2. removable – bilateral only
3. recementation of fixed space maintainer
4. removal of fixed space maintainer – considered for provider that did not place appliance

**RESTORATIVE SERVICES**

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing of restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for an occlusal restoration includes any extensions onto the occlusal one third of the buccal, facial or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

**Restorative service to include:**

a. Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.

b. Gold foil - Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program

c. Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program

d. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.

1. Service will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.

3. Provisional crowns are not covered.

e. Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,

f. Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.

g. Core buildup including pins

h. Pin retention

i. Indirectly fabricated (custom fabricated/cast) and prefabricated post and core

j. Additional fabricated ( custom fabricated/cast) and prefabricated post

k. Post removal

l. Temporary crown (fractured tooth)

m. Additional procedures to construct new crown under existing partial denture

n. Coping

o. Crown repair

p. Protective restoration/sedative filling

**ENDODONTIC SERVICES**

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
- Emergency services for pain do not require prior authorization.
- Service will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

**Endodontic service to include:**

a. Therapeutic pulpotomy for primary and permanent teeth

b. Pulpal debridement for primary and permanent teeth

c. Partial pulpotomy for apexogensis

d. Pulpal therapy for anterior and posterior primary teeth

e. Endodontic therapy and retreatment

f. Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation

g. Apexification: initial, interim and final visits

h. Pulpal regeneration

i. Apicoectomy/Periradicular Surgery

j. Retrograde filling

k. Root amputation

l. Surgical procedure for isolation of tooth with rubber dam

m. Hemisection

n. Canal preparation and fitting of preformed dowel or post

o. Post removal

**PERIODONTAL SERVICES**

a. Surgical services

1. Gingivectomy and gingivoplasty
2. Gingival flap including root planning
3. Apically positioned flap
4. Clinical crown lengthening
5. Osseous surgery
6. Bone replacement graft – first site and additional sites
7. Biologic materials to aid soft and osseous tissue regeneration
8. Guided tissue regeneration
9. Surgical revision
10. Pedicle and free soft tissue graft
11. Subepithelial connective tissue graft
12. Distal or proximal wedge
13. Soft tissue allograft
14. Combined connective tissue and double pedicle graft

b. Non-Surgical Periodontal Service

1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
2. Periodontal root planing and scaling – can be considered every 6 months for individuals with special healthcare needs
3. Full mouth debridement to enable comprehensive evaluation
4. Localized delivery of antimicrobial agents

c. Periodontal maintenance

**PROSTHODONTIC SERVICES**

- New dentures or replacement dentures may be considered every 5 years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

**Prosthodontic services to include:**

a. Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature

b. Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.

1. Resin base and cast frame dentures including any conventional clasps, rests and teeth
2. Flexible base denture including any clasps, rests and teeth
3. Removable unilateral partial dentures or dentures without clasps are not considered

c. Overdenture – complete and partial

d. Denture adjustments –6 months after insertion

e. Denture repairs – includes adjustments for first 6 months following the treatment

f. Denture rebase – following 12 months post denture insertion denture rebase is covered and includes adjustments for first 6 months following service

g. Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service

h. Precision attachment, by report

i. Maxillofacial prosthetics - includes adjustments for first 6 months following service

1. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
2. Obturator prosthesis: surgical, definitive and modifications
3. Mandibular resection prosthesis with and without guide flange
4. Feeding aid
5. Surgical stents
6. Radiation carrier
7. Fluoride gel carrier
8. Commissure splint
9. Surgical splint
10. Topical medicament carrier
11. Adjustments, modification and repair to a maxillofacial prosthesis
12. Maintenance and cleaning of maxillofacial prosthesis

j. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years. Covered services include: implant body, abutment and crown.

k. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.

1. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
2. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
3. Considerations and requirements noted for single crowns apply
4. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
5. Abutment teeth must be periodontally sound and have a good long term prognosis
6. Repair and recementation

l. Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth.

**ORAL AND MAXILLOFACIAL SURGICAL SERVICES**

- Local anesthesia, suturing and routine post op visit for suture removal are included with service.

a. Extraction of teeth:

1. Extraction of coronal remnants – deciduous tooth,
2. Extraction, erupted tooth or exposed root
3. Surgical removal of erupted tooth or residual root
4. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications

b. Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

c. Other surgical Procedures

1. Oroantral fistula
2. Primary closure of sinus perforation and sinus repairs
3. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
4. Surgical access of an unerupted tooth
5. Mobilization of erupted or malpositioned tooth to aid eruption
6. Placement of device to aid eruption
7. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
8. Surgical repositioning of tooth/teeth
9. Transseptal fiberotomy/supra crestal fiberotomy
10. Surgical placement of anchorage device with or without flap
11. Harvesting bone for use in graft(s)

d. Alveoloplasty in conjunction or not in conjunction with extractions

e. Vestibuloplasty

f. Excision of benign and malignant tumors/lesions

g. Removal of cysts (odontogenic and nonodontogenic) and foreign bodies

h. Destruction of lesions by electrosurgery

i. Removal of lateral exostosis, torus palatinus or torus madibularis

j. Surgical reduction of osseous tuberosity

k. Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.

l. Surgical Incision

1. Incision and drainage of abcess - intraoral and extraoral
2. Removal of foreign body
3. Partial ostectomy/sequestrectomy
4. Maxillary sinusotomy

m. Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.

n. Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.

    1. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
    2. Manipulation under anesthesia
    3. Condylectomy, discectomy, synovectomy
    4. Joint reconstruction

o. Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage

p. Arthroscopy

q. Occlusal orthotic device – includes placement and removal to same provider

r. Surgical and other repairs

    1. Repair of traumatic wounds – small and complicated
    2. Skin and bone graft and synthetic graft
    3. Collection and application of autologous blood concentrate
    4. Osteoplasty and osteotomy
    5. LeFort I, II, III with or without bone graft
    6. Graft of the mandible or maxilla – autogenous or nonautogenous
    7. Sinus augmentations
    8. Repair of maxillofacial soft and hard tissue defects
    9. Frenectomy and frenoplasty
    10. Excision of hyperplastic tissue and pericoronal gingiva
    11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
    12. Emergency tracheotomy
    13. Coronoidectomy
    14. Implant – mandibular augmentation purposes
    15. Appliance removal – "by report" for provider that did not place appliance, splint or hardware

**ORTHODONTIC SERVICES**

**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.**

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 25% of the amount charged by the Dentist when the course of treatment begins. The balance of the treatment fee will be paid proportionately during the remaining course of treatment.

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. Please see the Pretreatment Estimate of Benefits section of the certificate for more details.

- Orthodontia services must be medically necessary. Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.
- Orthodontic treatment is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.
- Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.
- Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

**Orthodontic service to include:**

a. Limited treatment for the primary, transitional and adult dentition

b. Interceptive treatment for the primary and transitional dentition

c. Minor treatment to control harmful habits

d. Continuation of transfer cases or cases started outside of the program

e. Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.

f. Orthognathic Surgical Cases with comprehensive orthodontic treatment

g. Repairs to orthodontic appliances

h. Replacement of lost or broken retainer

i. Rebonding or recementing of brackets and/or bands

**ADJUNCTIVE GENERAL SERVICES**

**Type A - ADJUNCTIVE GENERAL SERVICES**

a. Palliative treatment for emergency treatment – per visit

b. Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service.

- Request must indicate specific medical diagnosis and clinical appearance.
- One unit equals 15 minutes of additional time
- Utilization thresholds are based on place of service as follows.
  - Office or Clinic maximum – 2 units
  - Inpatient/Outpatient hospital – 4 units
  - Skilled Nursing/Long Term Care – 2 units

c. Consultation by specialist or non-primary care provider

**Type B - ADJUNCTIVE GENERAL SERVICES**

a. Anesthesia

1. Local anesthesia NOT in conjunction with operative or surgical procedures.
2. Regional block
3. Trigeminal division block.
4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
5. Intravenous conscious sedation/analgesia – 2 hour maximum time
6. Nitrous oxide/analgesia
7. Non-intravenous conscious sedation – to include oral medications

b. Drugs

- Therapeutic parenteral drug
- Single administration
- Two or more administrations - not to be combined with single administration
- Other drugs and/or medicaments – by report

c. Application of desensitizing medicament – per visit

**Type C - ADJUNCTIVE GENERAL SERVICES**

a. Occlusal guard including adjustments – for treatment of bruxism, clenching or grinding

b. Athletic mouthguard covered once per year

c. Occlusal adjustment

- Limited - (per visit)
- Complete (regardless of the number of visits), once in a lifetime

d. Professional visits

- House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
- Hospital or ambulatory surgical center call
- For cases that are treated in a facility.
- For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient.
- General anesthesia and outpatient facility charges for dental services are covered
- Dental services rendered in these settings by a dentist not on staff are considered separately
- Office visit for observation – (during regular hours) no other service performed

e. Odontoplasty

f. Internal bleaching

## DENTAL INSURANCE: EXCLUSIONS

### PEDIATRIC DENTAL EXCLUSIONS

This section of the Exclusions applies only to a covered person under the age of 19.

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

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 and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem 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, unless required for the treatment of correction of a congenital defect or birth anomaly.

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. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.

12. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.

13. Decoration or inscription of any tooth, device, appliance, crown or other dental work.

14. Charges for missed appointments.

15. 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.

16. Services covered under other coverage provided by your employer.

17. Temporary or provisional restorations.

18. Temporary or provisional appliances.

19. Prescription drugs.

20. Services for which the submitted documentation indicates a poor prognosis.

21. 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.

22. 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.

23. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.

24. Duplicate prosthetic devices or appliances.

25. Replacement of a lost or stolen appliance, Cast Restoration or Denture.

26. Fixed and removable appliances for the correction of harmful habits, unless part of overall treatment plan for medically necessary Orthodontia.

27. Labial veneers.

28. The following service is not a Covered Service: a stress breaker.

**PEDIATRIC DENTAL LIMITATIONS**

This section of the Limitations applies only to a covered Dependent Child under the age of 19.

1. Periapical films are allowed on an emergency or episodic basis.

2. Application of desensitizing medicaments is a covered service where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.

Periodontal maintenance is available, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed.

3. 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 not a Covered Service.
    - 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.

4. Diagnostic casts submitted as part of orthodontic treatment are covered as an Orthodontia service and included in the orthodontic records work up service.

5. If a root canal is completed within 45 days of the pulpotomy, We will only pay benefits for the root canal therapy.

6. Root canal treatment is limited to once per lifetime for the same tooth.

7. General anesthesia or intravenous sedation is only a Covered Service in connection with oral surgery, extractions or other Covered Services, when such anesthesia is determined to be medically necessary or Dentally Necessary.

8. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.

9. Fixed partial dentures will be used only 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.

10. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers are only available if Dentally Necessary.

11. Replacement of an immediate, temporary, full Denture, with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.

12. 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 as determined by MetLife. If the insurance ends during the course of the treatment plan, the monthly benefits will end.

13. Have your 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.

14. 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.

15. 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.

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