Summary of Benefits
Dental Insurance - Total Combined

Voluntary Dental				
Class Description	All Active Full Time Employees-**Low** Plan (30 Hours)		All Active Full Time Employees-**High** Plan (30 Hours)	
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile	Negotiated Fee Schedule	R&C 90th Percentile
Type A – Preventive	100%	80%	100%	100%
Type B – Basic	80%	60%	90%	80%
Type C – Major	50%	40%	60%	50%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $50 $100 Aggregate	B & C $75 $150 Aggregate	B & C $25 $50 Aggregate	B & C $75 $150 Aggregate
Calendar Year Maximum ***(applies to A,B,C services)***	$1,250	$1,250	$2,250	$1,250
Orthodontia	Not Covered	Not Covered	50%	50%
Orthodontia Lifetime Maximum	Not Covered	Not Covered	$1,500	$1,500

* 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 (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the 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.

Frequency & Allocations / Exclusions
For Illustrative Purposes Only – Refer to Current Carrier SPD

(Custom Primary (Flex) - Custom Standard (Flex))

Class Description: All Active Full Time Employees - Low Plan	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Sealants	▪ 1 per molar in 60 months for a child under age 16
▪ Space Maintainers	▪ 1 per lifetime for a child under age 14
▪ Fluoride	▪ 1 time in 1 calendar year for a dependent child under age 18
▪ Full Mouth X-Rays	▪ Once in 3 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 2 times in 1 calendar year ▪ Adult: 2 times in 1 calendar year
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Consultations	▪ 1 in 12 months
▪ Amalgam Fillings	▪ 1 replacement per surface in 12 Months
▪ Root Canal	▪ 1 in 12 months
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 3 year period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 2 year period
▪ Prefabricated Crowns	▪ 1 per tooth in 24 months
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 12 months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Labs & Other Tests	
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	

▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Dentures	▪ 1 in 5 calendar years
▪ Denture Adjustments	▪ 1 in 6 months
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Implant Services	▪ 1 per tooth position in 5 calendar years
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Occlusal Adjustments	▪ 1 in 12 months

Other services may be added or deleted upon review of your current plan design. It is our intent to match your current plan design to the extent our systems and contracts allow.

Exclusions
All Active Full Time Employees - Low Plan
▪ 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 a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless such service is: required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or required for reconstructive surgery because if a congenital disease or anomaly of a Child which has resulted in a functional defect; or (For residents of Texas) required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ 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 piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services paid under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis.

- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- 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 and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- 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.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.
- Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.

Frequency & Allocations / Exclusions
For Illustrative Purposes Only – Refer to Current Carrier SPD

(Custom Primary (Flex) - Custom Standard (Flex))

Class Description: All Active Full Time Employees- High Plan	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 1 calendar year
▪ Sealants	▪ 1 per molar in 60 months for a child under age 16
▪ Space Maintainers	▪ 1 per lifetime for a child under age 14
▪ Fluoride	▪ 1 time in 1 calendar year for a dependent child under age 18
▪ Full Mouth X-Rays	▪ Once in 3 calendar years
▪ Bitewing X-Rays	▪ For a child under 19: 2 times in 1 calendar year ▪ Adult: 2 times in 1 calendar year
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Consultations	▪ 1 in 12 months
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▪ Root Canal	▪ 1 in 12 months
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 3 year period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 2 year period
▪ Prefabricated Crowns	▪ 1 per tooth in 24 months
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 12 months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Labs & Other Tests	
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	

▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Dentures	▪ 1 in 5 calendar years
▪ Denture Adjustments	▪ 1 in 6 months
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Implant Services	▪ 1 per tooth position in 5 calendar years
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Occlusal Adjustments	▪ 1 in 12 months
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

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Exclusions
All Active Full Time Employees- High Plan
▪ 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 a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless such service is: required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or required for reconstructive surgery because if a congenital disease or anomaly of a Child which has resulted in a functional defect; or (For residents of Texas) required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ 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 piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services paid under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder.

- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- 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 and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- 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.
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- Implants supported prosthetics to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.