

MetLife® Preferred Dentist Program (PDP)

State of Arizona Plan Benefits

Coverage with freedom of choice and savings!

Benefit Summary

Coverage Type	PDP In-Network:	Out-of-Network:
Type A – Preventative	100% of PDP Fee*	100% of R&C Fee**
Type B – Basic Restorative	80% of PDP Fee*	80% of R&C Fee**
Type C – Major Restorative	50% of PDP Fee*	50% of R&C Fee**
Type D – Orthodontia	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	\$2,000 (combined for In- and Out-of-Network)	\$2,000 (combined for In- and Out-of-Network)
Orthodontia Lifetime Maximum:	In-Network	Out-of-Network
Per Person	\$1,500 (combined for In- and Out-of-Network)	\$1,500 (combined for In- and Out-of-Network)

- PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any applicable deductibles, cost sharing and benefits maximums.
- ** 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 usual 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 combined for In- and Out-of-Network.

The service categories shown above represent an overview of your Plan of Benefits but are not a complete description of the Plan. An insurance certificate describing all benefits and limitations will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the certificate of insurance and group insurance policy.



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An example of savings when you visit a participating PDP dentist:

This hypothetical example* shows how receiving services from a PDP dentist can save you money.

Your Dentist says you need a Crown, a Type C service:			
PDP Fee: \$375.00		R&C Fee \$500.00	
Dentist's Usual Fee: \$600.00			
*Please note: This example assumes that your annual deductible has been met.			
IN-NETWORK		OUT-OF-NETWORK	
When you receive care from a participating PDP dentist:		When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$600.00	Dentist's Usual Fee is:	\$600.00
The PDP Fee is:	\$375.00		
Your Plan Pays:		Your Plan Pays:	
50% X \$375 PDP Fee	- \$187.50	50% X \$500 R&C Fee	- \$250.00
Your Out-of-Pocket Cost:	\$187.50	Your Out-of-Pocket Cost:	\$350.00

**In this example, you save \$162.50 (\$350.00 minus \$187.50)...
by using a participating PDP dentist.**

We encourage you to consider using a participating PDP Dentist to get the maximum value from your plan.

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List of Primary Covered Services & Limitations

Type A - Preventive

How Many/How Often:

Prophylaxis (cleanings)	• Two per Plan year.
Oral Examinations	• Any type of exam/oral evaluation is limited to two per Plan year.
Topical Fluoride Applications	• Two fluoride treatments per Plan year for dependent children up to 19 th birthday.
X-rays	• Full mouth X-rays: one in three Plan years. • Bitewing X-rays: two per Plan year.
Space Maintainers	• Space Maintainers for dependent children up to 14 th birthday.
Sealants	• One application of sealant material every 36 months for each permanent molar and bicuspid tooth of a Dependent child up to 19 th birthday.

Type B - Basic Restorative

How Many/How Often:

Fillings	• No Plan Limit.
Simple Extractions	• No Plan Limit.
Crown, Denture, and Bridge Repair	• No Plan Limit.
Endodontics	• Root canal treatment limited to once per tooth per Plan year.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Oral Surgery	• No Plan Limit.
Periodontics	• Periodontal scaling and root planing. • Total number of periodontal maintenance treatments where periodontal therapy (such as osseous surgery, gingivectomy, gingivoplasty, or gingival curettage) has been previously performed and prophylaxis cannot exceed four treatments in a Plan year.

Type C - Major Restorative

How Many/How Often:

Bridges and Dentures	• Relinings and rebasings of existing removable dentures but not more than once in 24 months. • Initial placement to replace one or more natural teeth, which are lost while covered by the Plan. • Dentures and bridgework replacement: one every 5 Plan years. Must be unserviceable and at least 5 years old. • Replacement of an existing immediate temporary full denture by a new permanent full denture when the existing denture can not be made permanent and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	• Not more than one such restoration to the same tooth within 5 years of the prior restoration for permanent teeth or for primary teeth.

Type D – Orthodontia

How Many/How Often:

- Covered Adult.
 - Dependent children are covered until the end of the month of their 19th birthday or the end of the month of their 25th birthday if unmarried, full-time students.
 - All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
 - Benefit for initial placement of the appliance will be made representing 20% of the total benefit. Benefits for orthodontic treatment are payable at 50% of the covered charges with a lifetime maximum of \$1,500. For claim processing purposes we consider 20% of the total charge to be incurred at the time of appliance placement. The balance of the total charge is prorated over the estimated months of treatment not to exceed 24 months. Benefits for these months of treatment will be paid automatically provided the patient is still eligible for coverage and active treatment is still rendered and the \$1,500 lifetime maximum has not been met.
 - Orthodontic benefits end at cancellation of coverage.
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The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan. A group insurance Certificate of coverage will be made available following your Plan's effective date and will govern if any discrepancies exist between this overview and the actual Certificate.

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Common Questions...Important Answers

Q. What is a participating PDP dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in-full for services provided to plan participants. PDP fees typically range from 10-35%[‡] below the average fees charged by dentists in your area for the same or substantially similar services.

Q. How do I find a participating PDP dentist?

A. There are nearly 100,000 participating PDP dentist locations nationwide, including over 22,000 specialist locations. You can get 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.

Q. What services are covered by the Preferred Dentist Program (PDP)?

A. The services covered by the MetLife PDP are those defined under your group dental benefits plan. Please review the enclosed plan benefits to learn more.

Q. Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services?

A. Yes. The PDP in-network discounts do extend even to non-covered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these non-covered services as well.

Q. May I choose a non-participating dentist?

A. 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. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee and your plan's payment. Please note: plan designs may vary, so you should always refer to your company's specific plan to help determine actual out-of-network benefits. As always, plan deductibles must be met.

Q. Can my dentist apply for PDP participation?

A. Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply for membership, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. Website and phone number are designed for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which help to reduce your 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, you can find one online at www.metlife.com/mybenefits or request one by calling **1-800-942-0854**. Please remember to use your employee ID# when filing a claim.

[‡] Based on internal analysis by MetLife

Did you know?

- It takes 26 muscles to smile, and 62 muscles to frown.¹
- The first modern toothbrush (bristled) was made in China about 1600 A. D.¹
- Aracchibutyrophobia is the fear of peanut butter sticking to the roof of your mouth.¹
- According to the Academy of General Dentistry, the average person only brushes for 45 to 70 seconds a day; the recommended amount of time is 2-3 minutes.²

¹ Source: http://www.ada.org/public/events/ncdhn/activity_trivia.pdf, accessed February 2006.

² www.dentalgentlecare.com/fun_dental_facts.htm, accessed February 2006.

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Exclusions

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

- Temporomandibular joint disorders (TMJ)
- Those received before coverage begins
- Those not performed by a dentist, except cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist that is supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments
- Cosmetic services, surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn Dependent child
- When covered by any workers' compensation laws, occupational disease laws or employer's liability laws, or which an employer is required by law to furnish in whole or in part
- Which are received through a medical department or similar facility maintained by your employer
- Use of material or home health aids used to prevent decay, such as toothpaste and fluoride gels, other than the topical application of fluoride
- Duplicate appliances or duplicate prosthetic devices
- Received where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
- Materials or services that are experimental under generally accepted dental standards
- Received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while coverage is in effect
- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Benefits otherwise provided under your employer's plan or any other plan that your employer or an affiliate contributes to or sponsors
- Implants
- Charges for broken appointments or for completing dental forms
- Sterilization supplies
- Furnished by a family member
- Replacement of a lost, missing or stolen crown, bridge or denture
- Repair or replacement of an orthodontic appliance
- Services or supplies for which a Covered Person is not required to pay
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it
- Myofunctional therapy or correctional of harmful habits
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as replacement for congenitally missing natural teeth
- Charges by the Dentist for completing dental forms
- Occlusal Guard/Bruxism Appliances

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 (in excess of \$300) such as crowns, bridges or dentures. To do this, the Covered Person should send a claim form to us in which the Dentist tells us: 1) the work to be done; and 2) what the cost will be. 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.

When Benefits End: Coverage is provided under a group insurance policy (Group Policy No. 94639-G) issued by MetLife. All of your benefits will end on the earlier of the 15th or last day of the calendar month in which your employment ends. Your employment ends when you cease active work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. If This Plan ends in whole or in part, your benefits which are affected will end. Your Dependent Benefits will end on the earlier of: the date that the Dependent ceases to be your Dependent; or the date of your death. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefit, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made. The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

