



National Association for the Self Employed Dental Plan Benefits

For the savings you need, the flexibility you want and service you can trust.

Benefit Summary – All States except AL, GA, TX, MS, LA

Coverage Type	Basic Option		High Option	
	In-Network Negotiated Fee*	Out-of-Network R&C Fee**	In-Network Negotiated Fee*	Out-of-Network R&C Fee**
Type A – cleanings, oral examinations	100%	60%	100%	90%
Type B – fillings, extractions	55%	40%	70%	60%
Type C – crowns, root canals, bridges	35%	20%	50%	40%
Type D – orthodontia (24 month waiting)	50%	50%	50%	50%
Deductible [†]	In-Network Negotiated Fee*	Out-of-Network R&C Fee**	In-Network Negotiated Fee*	Out-of-Network R&C Fee
Individual	N/A	\$100.00	N/A	\$50.00
Family	N/A	N/A	N/A	N/A
Annual Maximum Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Per Person	\$1,200	\$600	\$3,000	\$3,000
Orthodontia Lifetime Maximum	In-Network	Out-of-Network	In-Network	Out-of-Network
Per Person	\$1,500	\$1,000	\$3,000	\$3,000

* Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, 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 charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

[†] Applies to type B and C Services.

Savings* Example

This hypothetical example** shows how receiving services from an in-network dentist can save you money.

Your Dentist says you need a Crown, a Type C service —

- Negotiated Fee: \$375.00
- R&C Fee: \$500.00
- Dentist's Usual Fee: \$600.00

IN-NETWORK When you receive care from a participating dentist:		OUT-OF-NETWORK When you receive care from a non-participating dentist:	
Dentist's Usual Fee is:	\$600.00	Dentist's Usual Fee is:	\$600.00
The Negotiated Fee is/Schedule Pays:	\$375.00	R&C Fee is:	\$500.00
Your Plan Pays:		Your Plan Pays:	
50% X \$375 Negotiated Fee	- \$187.50	50% X \$500 R&C or Negotiated 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 dentist.

*Savings from enrolling in the MetLife dental program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

**Please note: These examples assume that your annual deductible has been met.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Oral Examinations	• One oral exam in 6 consecutive months.
Cleanings	• One cleaning in 6 consecutive months.
Fluorides	• One fluoride treatment in 12 consecutive months. • Age limit: 14 years old.
Bitewing X-rays	• Adults: one time in 12 consecutive months. • Child: one time in 12 consecutive months.
Sealants	• One sealant per permanent 1st & 2nd Non-Restored Occlusal Surface Molar in 60 consecutive months. • Age limit: 14 years old.
Space Maintainers	• Once per lifetime per area. • Age limit: 14 years old.
Type B - Basic Restorative	How Many/How Often
Fillings	• Amalgam & Resin – Composite fillings: One per tooth surface per 24 consecutive months.
Scaling & Root Planning	• One per quadrant, or area, in any 24 month consecutive month period.
Periodontal Maintenance Visit	• Two periodontal treatments in 1 year; Includes two cleanings.
Rebases/Relining of Dentures	• One per 36 consecutive months.
Type C - Major Restorative	How Many/How Often
Crowns/ Inlays/Onlays	• One replacement per 10 years.
Root Canals	• Once per tooth per lifetime.
Dentures (Complete/Partial/Overdenture)	• Denture replacement: one per 10 years. • Denture Adjustments: one per 12 consecutive months.
Fixed Bridgework	• Bridgework replacement: one per 10 years.
Type D - Orthodontia	How Many/How Often:
	• Your Children, up to age 19, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.

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.

Common Questions... Important Answers

Who is a participating Preferred Dentist Program 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. Negotiated 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 dentist? There are more than 193,000 participating dentist locations nationwide, including thousands of specialist locations. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 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 Program offer any discounts on non-covered services? Negotiated fees with 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 network 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 negotiated, 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, 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 dentist, you are only responsible for the difference between the 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 network participation? Yes. If your current dentist does not participate in the network 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 1-800-942-0854.

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 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 the services they provide are separate and apart from the benefits provided by MetLife.

^{**} 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 requires 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.

Exclusions

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

- 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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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 not required to pay; or
 - ⌘ Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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 or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- 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;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extra oral photographic images.

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 fee or, if non-participating, the actual charge, for the service actually rendered and the negotiated fee or R&C fee (if non-participating) 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 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. 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.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

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

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