

Dental Benefits from MetLife

Dental coverage designed for the real world.



MetLife

Dental

Plan Design for: **Region VII Employee Benefits Cooperative**

Effective Date: September 1st, 2008

Choice, Service, Savings.

To help you enroll, this overview includes rate information and a List of Covered Services so you can make the most informed decision possible.

Coverage Type:	Covered Percentage
Type A – Preventive	100%
Type B - Basic Restorative	80%
Type C - Major Restorative	50%
Type D – Orthodontia – Adult & Child	50%
Deductible³	
Individual	\$50
Family	\$150
Annual Maximum Benefit:	
Per Person	\$1,000
Orthodontia Lifetime Max Per Person	\$1,500

Benefit Waiting Period

For employees who elect coverage during the 31-day application period, the following Dental Benefits will become effective after the satisfaction of the waiting period(s) shown below. In the case of the transferred business and employees changing between schools within the Region VII Cooperative, if employees elected coverage under the prior plan for which the employees were eligible, the following waiting period(s) will not apply.

- Preventive Services, Basic Services No waiting period
- Major Services, Orthodontic Services 6 months

Like most life insurance policies, MetLife group insurance policies contain certain exclusions, waiting periods, reductions and terms for keeping them in force. For costs and complete details of coverage, call or write your MetLife representative. In addition, a full description of your dental benefits will be provided in the certificate of insurance.

IMPORTANT RATE INFORMATION

Monthly (12 months)	
Employee	\$22.95
Employee + Spouse	\$53.01
Employee + Child(ren)	\$52.22
Employee + Spouse + Child(ren)	\$79.95

PLEASE NOTE THAT IT IS NOT NECESSARY TO PRESENT AN IDENTIFICATION CARD TO THE PROVIDER. YOUR SOCIAL SECURITY WILL BE USED TO VERIFY ELIGIBILITY WITH METLIFE. If you have a claim inquiry or benefit questions, please call MetLife's Dental Customer Service Department at 1-800-ASK - 4 - MET after your plan's effective date

List of Covered Services & Limitations*

Type A – Preventive

How Many/How Often:

Prophylaxis (cleanings) Oral Examinations Topical Fluoride Applications X-rays Bitewing X-rays Emergency palliative treatment Sealants Space Maintainers	<ul style="list-style-type: none"> • Cleaning of teeth (oral prophylaxis) but not more than once every 6 months. • Oral exams but not more than 2 in any 12 month period. • Topical fluoride treatment for a Dependent child under 14 years of age but not more than every 12 months. • Full mouth X-rays: 1 per 60 months. • Not more than once every 6 months for Dependent children under 19 years of age; every 12 months for all other Covered Persons. • 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 lifetime. • Space Maintainers for dependent children to 14 years of age.
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Type B – Basic Restorative

How Many/How Often:

Fillings Simple Extractions Injections of Antibiotic Drugs Relining and Rebasing Prefabricated Stainless Steel Crown	<ul style="list-style-type: none"> • Amalgam and Resin-based Fillings. • Relining and Rebasing of existing removable dentures but not more than once in 36 months. • Prefabricated stainless steel crowns but not more than once in any 10 year period.
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Type C - Major Restorative

How Many/How Often:

Endodontics Periodontics Implantology Bridges and Dentures Anesthesia Consultations Crowns/Inlays/Onlays Repairs of dentures, crowns, inlays and onlays Oral Surgery	<ul style="list-style-type: none"> • Pulp Capping, pulpal therapy, & therapeutic pulpotomy. • Root canal treatment not more than once every 24 months for the same tooth. • Periodontal scaling and root planing once per quadrant or area, every 24 months. • Periodontal surgery once per quadrant or area, every 36 months. • 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. • When dentally necessary in connection with oral surgery, extractions or other covered dental services. • Consultations, but not more than 2 in any 12 month period. • 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 60 months prior to its replacement. • Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period.
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Type D - Orthodontia

<ul style="list-style-type: none"> • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis. • Benefit for initial placement of the appliance will be made representing 20% of the total benefit. • Orthodontic benefits end at cancellation of coverage.
