NCD COMPLETE BY MetLife

Product Overview

	In-Network	Out-of-Network
Reimbursement	Negotiated Fee Schedule	Schedule Amount
Type A - Preventive	100%	100%
Type B - Basic	65% - Year 1, 80% - Year 2, 90% - Year 3	65% - Year 1, 80% - Year 2, 90% - Year 3
Type C - Major	10% - Year 1, 50% - Year 2, 60% - Year 3	10% - Year 1, 50% - Year 2, 60% - Year 3
Calendar Year Deductible applies to: Individual	Type B & C: $100 - Year 1, Vanishing Deductible after Year 1	Type B & C: $100 - Year 1, Vanishing Deductible after Year 1
Calendar Year Maximum	$10,000 ($3,000 Calendar year Implant Max within the Plan Max)	$10,000 ($3,000 Calendar year Implant Max within the Plan Max)

Product Details

Type A *Benefits are payable immediately from the start date of an individual's benefits*	
Examinations	3 times in 1 calendar year
Examinations - Problem Focused	Combined with Examinations Limit
Prophylaxis: Cleanings	3 times in 1 year
Fluoride	1 time in 12 months for a dependent child under age 14
Bitewing X-Rays	For a child under 14: 1 time in 12 months Adult: 1 time in 12 months
Type B *Benefits are payable immediately from the start date of an individual's benefits*	
Sealants	1 per molar in 60 months for a child under age 14
Space Maintainers	1 per lifetime for a child under age 14
Full Mouth X-Rays	Once in 60 months
Amalgam Fillings	1 replacement per surface in 24 months
Periodontal Maintenance	2 Treatments in 1 calendar year, includes 2 cleanings (total comb: 2)
Labs & Other Tests	
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Rays	
Resin Composite Fillings (Includes coverage composite fillings on molars)	

Pulp Capping	
Pulp Therapy	
General Services	
Type C *Benefits are payable immediately from the start date of an individual's benefits*	
Consultations	1 in 12 months
Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 per quadrant in any 36 month period
Scaling & Root Planing	1 per quadrant in any 24 month period
Prefabricated Crowns	1 per tooth in 10 calendar years
Crown Buildups / Post Core	1 per tooth in 10 calendar years
Repairs	1 in 12 months
Recementations	1 in 12 months
Dentures	1 in 10 calendar years
Dentures - Rebases / Relines	1 in 36 months
Denture Adjustments	1 in 12 months
Fixed Bridges	1 in 10 calendar years
Inlays / Onlays / Crowns	1 replacement per tooth in 10 calendar years
Implant Services ($3,000 Calendar year Max within the $10,000 Plan Max)	1 per tooth position in 10 calendar years
Implant Repairs	1 per tooth in 12 months
Implant Supported Prosthetic	1 per tooth in 10 calendar years
Tissue Conditioning	1 in 36 months
Occlusal Adjustments	1 in 12 months
General Anesthesia	
Pulpotomy	
Apexification & Recalcification	
Periodontal Surgery - Soft & Connective Tissue Grafts	
Periodontics - Non-Surgical	
Oral Surgery: Simple Extractions	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	

Limitations and Exclusions

§ 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. (For residents of Texas: Services which are primarily cosmetic unless 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 covered under any employer liability law.

§ Services for which the association 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.

§ Implant 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.

Dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166. Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact (800) 485-3855 for costs and complete details. Coverage may not be available in all states.

This brochure provides a brief summary of benefits. For a complete listing of benefits, exclusions, and limitations, please refer to the certificate of coverage. In the event of discrepancies contained in this brochure, the benefits, terms, and conditions contained in the certificate documents shall govern.