

Rockwall Independent School District Dental Plan Benefits

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

Benefit Summary

Coverage Type	PDP In-Network:	Out-of-Network:
Type A – cleanings, oral examinations	100% of PDP Fee*	100% of R&C Fee**
Type B – fillings	80% of PDP Fee*	80% of R&C Fee**
Type C –bridges and dentures	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	\$1,000	\$1,000
Orthodontia Lifetime Maximum:	In-Network	Out-of-Network
Per Person	\$1,000	\$1,000

* PDP Fee refers to the fees that participating PDP 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 only to type B & C Services.

Monthly Rates:

The following monthly rates are effective through August 31, 2010. Your premium will be paid through convenient payroll deduction.

Eligibility Options

Employee Only	\$27.03
Employee + One	\$52.62
Employee + Spouse + Child(ren)	\$91.68

PDP Savings Example

This hypothetical example* shows how receiving services from a PDP (in-network) 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

IN-NETWORK When you receive care from a participating PDP 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 PDP Fee is:	\$375.00		
Your Plan Pays:		Your Plan Pays:	
60% X \$375 PDP Fee	- \$225.00	50% X \$500 R&C Fee	- \$250.00
Your Out-of-Pocket Cost:	\$150.00	Your Out-of-Pocket Cost:	\$350.00

In this example, you save \$200.00 (\$350.00 minus \$150.00)...
by using a participating PDP dentist.

*Please note: This example assumes that your annual deductible has been met.

List of Primary Covered Services & Limitations

Type A - Preventive

How Many/How Often:

- Prophylaxis (cleanings) • Two per calendar year, separated by a six-month period.
 - Oral Examinations • Two exams per calendar year, separated by a six-month period.
 - Topical Fluoride Applications • One fluoride treatment per calendar year for dependent children up to 19th birthday.
 - Sealants • One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 14th birthday.
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Type B - Basic Restorative

How Many/How Often:

- Fillings
 - Simple Extractions
 - X-rays • Full Mouth X- rays: One per 60 months.
• Bitewing X- rays: one set per calendar year for adults; two sets per calendar year for children separated by a six-month period.
 - Periodontics • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
 - Space Maintainers • Space Maintainers for dependent children up to 19th birthday.
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Type C - Major Restorative

How Many/How Often:

- Crown, Denture, and Bridge Repair/Recementations
 - Implants
 - Bridges and Dentures • Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
• Dentures and bridgework replacement: one every 10 years.
• Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
 - Crowns/Inlays/Onlays • Replacement: once every 5 years.
 - Endodontics • Root canal treatment limited to once per tooth per 24 months.
 - General Anesthesia • When dentally necessary in connection with oral surgery, extractions or other covered dental services.
 - Oral Surgery • Periodontal scaling and root planing once per quadrant, every 24 months.
 - Periodontics • Periodontal surgery once per quadrant, every 36 months.
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Type D - Orthodontia

How Many/How Often:

- Your Children, up to the end of the month of their 25th birthday.
- 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.

Common Questions... Important Answers

Who is a participating Preferred Dentist Program (PDP) 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. PDP fees typically range from 10-35%[‡] 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 PDP dentist?

There are nearly 115,000 participating PDP dentist locations nationwide, including over 27,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/mybenefits 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 Preferred Dentist Program (PDP) offer any discounts on non-covered services?

Yes. MetLife's negotiated fees with PDP (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a PDP dentist that are not covered under your plan, you are only responsible for the PDP (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 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 for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP 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 PDP participation?

Yes. If your current dentist does not participate in the PDP 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, you can find one online at 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. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of \$300 (This often applies to services such as crowns, bridges, inlays, and periodontics.) To receive a benefit estimate, simply have your dentist submit a request for pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate (online or by fax) for most procedures *while you're still in the office*, so you can discuss treatment and payment options, and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provision in dental benefits plan is 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 require 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
- Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- 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;
- 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 extraoral 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 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 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) 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 health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife for complete details.

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