

Creighton University's Basic 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, periodontics	70% of PDP Fee*	50% of R & C **
Type C –bridges and dentures, TMJ	50% of PDP Fee*	50% of R & C **
Deductible [†] :	In-Network	Out-of-Network
Individual	\$50.00	\$150.00
Family	\$150.00	\$300.00
Annual Maximum Benefit:	In-Network	Out-of-Network
Per Person	\$1500.00	\$1500.00

*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.

PDP Savings Example

This hypothetical example* shows how receiving services from a PDP (in-network) dentist can save you money.

<p><i>Your Dentist says you need a Crown, a Type C service —</i></p> <ul style="list-style-type: none"> • PDP Fee: \$350.00 • R&C Fee \$500.00 • Dentist's Usual Fee: \$600.00 			
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:	\$350.00	The R&C Fee is:	\$500.00
Your Plan Pays:		Your Plan Pays:	
50% X \$350 PDP Fee	- \$175.00	50% X \$500 R&C Fee	- \$250.00
Your Out-of-Pocket Cost:	\$175.00	Your Out-of-Pocket Cost:	\$350.00
<p>In this example, you save \$175.00 (\$350.00 minus \$175.00)... by using a participating PDP dentist.</p>			

*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, three for pregnant women.
 - Oral Examinations • Two exams per calendar year.
 - Topical Fluoride Applications • Two fluoride treatments per calendar year
 - X-rays • Full mouth X-rays: one per 60 months.
Bitewing X-rays: one set per calendar year
 - Space Maintainers • Space Maintainers for dependent children up to 16th birthday.
 - Sealants • One application of sealant material every 4 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 16th birthday.
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Type B – Basic Restorative

How Many/How Often:

- Fillings
 - Simple Extractions
 - 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
 - Periodontics • Periodontal scaling and root planing once per quadrant, every 24 months.
• Periodontal surgery once per quadrant, every 24 months.
• Total number of periodontal maintenance treatments and prophylaxis cannot exceed five treatments in a calendar year.
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Type C - Major Restorative

How Many/How Often:

- Simple Extractions
- 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 5 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 72 months.

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 110,000 participating PDP dentist locations nationwide, including over 25,000 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.

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;
- 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
- 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 (if it is a traditional dental service that is denied by the medical plan, it can then be reconsidered under the dental plan);
- 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;
- 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. This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

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