

DENTAL INSURANCE



A DESCRIPTION OF BENEFITS FOR EMPLOYER MEMBERS OF THE MICHIGAN MANUFACTURERS ASSOCIATION

FEATURES

PREFERRED DENTIST PROGRAM

MetLife's nationwide network has more than 52,000 participating dentists, including more than 11,000 specialists.

PERSONAL COST SAVINGS

Participating dentists accept fees from MetLife that are typically 15% to 30% below the average charges for the geographic area, so employees' total out-of-pocket costs are generally lower. In addition, participating dentists may extend MetLife's lower, negotiated fees to individuals covered under a MetLife dental plan for services not covered under the plan.

FREEDOM OF CHOICE

MetLife's plans allow employees to select any dentist (in-network or out-of-network) at the time of treatment; it is not necessary to choose a participating dentist at enrollment to obtain network benefits. Plus, MetLife doesn't require referrals from a general dentist to see a specialist.

EASY ACCESS TO PARTICIPATING DENTISTS

Employees have access to customized Preferred Dentist directory information that is mailed the next business day from the day of inquiry. To obtain a list of participating dentists call MetLife toll-free at 1-800-474-7371, or contact MetLife on-line at <http://www.metlife.com/dental>. Dentists interested in joining MetLife's network should call 1-800-METDENT.

NO BENEFIT WAITING PERIODS

There are no benefit waiting periods for employees who enroll when they are first eligible. This is applicable to both transfer groups and non-transfer groups. There is a one year waiting period for all dental services if an employee is enrolling as a late entrant (*see "Limitations" section*).

CONTINUITY OF COVERAGE

To prevent loss or gain of coverage when a group is transferring between insurance carriers, MetLife gives credit for service requirements and deductibles that were fully or partially met under a prior carrier's plan, but plan maximums fully or partially satisfied under a prior carrier's plan will be deducted from the MetLife plan's maximum benefit.

CLAIMS ADMINISTRATION

MetLife's state-of-the-art claims system automatically identifies advanced procedures and claims that require professional review and refers them to MetLife's on-site professional dental consultants. Based on the review of the claim and radiographs, the dental consultant considers whether benefits are payable for the treatment rendered. If it is determined that a treatment alternative was appropriate under generally accepted dental standards, the plan will provide a benefit based upon the alternative treatment.

COMPUTER VOICE RESPONSE SYSTEM

MetLife offers providers and insureds telephone access to dental benefit plan information, to verify eligibility and to obtain claim status.

STUDENT AGE

Each case, as standard, has dependent children covered to age 19, or to age 25 if a full-time student.

DEDUCTIBLE

The deductible is waived on Type A expenses in and out of network. All deductibles are based on a calendar year. A deductible of up to \$50 per covered individual shall apply to reimbursable claims per individual up to an aggregate family deductible of \$150.

(Continued)

PRE-TREATMENT ESTIMATES

If a dental bill is expected to be \$200 or more, before the dentist starts the treatment, a covered person can find out what dental expense benefits will be paid under the plan. To do this, the covered person should send a claim form to MetLife in which the dentist tells us: 1) the work to be done; and 2) what the cost will be.

MetLife will then tell the covered person what dental expense benefits the plan will pay. MetLife recommends the covered person use this method to find out what dental expense benefits the plan will pay because MetLife's decision will be final and binding with regard to what are covered dental expenses and what dental expense benefits the plan will pay.

This method should **not** be used for:

1. emergency treatment;
2. routine oral exams;
3. X-rays, cleaning and scaling, and fluoride treatments; or
4. dental services which cost less than \$200.

WHAT'S COVERED?

DIAGNOSTIC & PREVENTIVE SERVICES – TYPE A EXPENSES

- Oral examinations but not more than one exam every 6 months.
- Cleaning and scaling of teeth — oral prophylaxis — but not more than once every 6 months.
- Bite-wing x-rays but not more than once every 6 months.
- Topical fluoride treatment once per calendar year for dependent children under age 19.
- Space maintainers for dependents under age 19.
- Periodontal maintenance following periodontal surgery, but the number of covered maintenance treatments and scaling and polishing treatments will not exceed four treatments in a calendar year.

BASIC SERVICES – TYPE B EXPENSES

- Full mouth x-rays but not more than once every 5 years.
- Root canal treatment.
- Extractions, except for orthodontics.
- Fillings — amalgam, silicate, acrylic, synthetic porcelain or composite fillings.
- Oral surgery except procedures covered under any medical plan.
- Treatment of periodontal disease (other than by periodontal maintenance) and treatment of other diseases of the gums and tissues of the mouth.
- Emergency palliative treatment.
- Injections of antibiotic drugs.
- Administration of general anesthesia, when medically necessary in connection with oral surgery.

MAJOR SERVICES – TYPE C EXPENSES

- Inlays, onlays, crown laminates, and gold foils but no more than once in a ten year period for the same tooth surface.
- Repair or re-cementing of
 1. crowns;
 2. inlays or onlays;
 3. dentures; or
 4. bridgework.
- Relinings and rebasings of existing removable dentures but not more than once in 36 months.
- Replacement of crowns, but no more than once for the same tooth in a ten year period.
- Replacement of inlays or onlays, but no more than once for the same tooth surface in a ten year period.
- Those services needed to replace one or more natural teeth which are lost while dental expense benefits for the employee are in effect for:
 1. Installation of fixed bridgework done for the first time.
 2. Installation for the first time of:
 - I. a partial removable denture; or
 - II. a full removable denture.
 3. Replacing an existing removable denture or fixed bridgework if:
 - I. it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed; or
 - II. it is needed because the existing denture or bridgework can no longer be used and was installed at least 10 years prior to its replacement.
 4. Replacing an existing immediate temporary full denture by a new permanent full denture when:
 - I. the existing denture cannot be made permanent; and
 - II. the permanent denture is installed within 12 months after the existing denture was installed.
 5. Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

DEFINITIONS

EMPLOYER MEMBER

Employer Member means an employer who is a member of the Michigan Manufacturers Association.

LIST BILLING SERVICES

The employer member receives a monthly premium statement which shows the amount of premium due and provides a list of insured employees and premium by coverage.

PREFERRED DENTIST PROGRAM (PDP)

Dentists who meet MetLife's credentialing criteria may participate in the Preferred Dentist Program. When dental care is given by a dentist who participates in this program, the insured may incur less out-of-pocket cost for the services rendered.

IN-NETWORK BENEFITS

Benefits provided under the plan for covered dental services which are provided by a dentist who participates in the PDP.

OUT-OF-NETWORK BENEFITS

Benefits provided under the plan for covered dental services that are provided by a dentist who does not participate in the PDP. Reimbursements for out-of-network services are based on Reasonable and Customary (R&C) charges.* These services must be necessary in terms of generally accepted dental standards.

RATES

INITIAL RATE GUARANTEE

Initial rates, provided on the quote date, are guaranteed for the period stated on the cost and benefit summary, provided that:

- The plan of benefits and eligibility remains unchanged;
- There are no additions or deletions of subsidiaries or affiliates; and
- The census, volume or geographic distribution does not change by 25% or more.

Final Rates will be based on actual enrollment and contribution levels.

SUPPLEMENTARY OPTION

ORTHODONTIA COINSURANCE

When selected, orthodontia coinsurance is provided at 50% for dependent children under age 19 to a lifetime maximum of \$1,000.

ELIGIBILITY

FULL-TIME EMPLOYEES

Must be an active full-time employee who works at least 20 hours per week to be eligible for coverage.

MINIMUM PARTICIPATION REQUIREMENTS

CONTRIBUTORY PLANS

The employer member's contribution must equal at least 25% of the employees' premium. Dependent coverage may be written with no employer member contributions. At least 75% of all eligible employees must participate.

NON-CONTRIBUTORY PLANS

The employer member pays 100% of the employee and dependent premium. All eligible employees and dependents, regardless of coverage elsewhere, must be covered.

LIMITATIONS

COORDINATION OF BENEFITS

MetLife's plans contain a coordination of benefits clause that may reduce benefits received from other group, employer or government sponsored plans. The benefits paid under a MetLife group dental plan and any other plan providing benefits for covered dental services cannot exceed 100% of the allowable charge.

LATE ENTRANTS

Persons who request coverage more than 31 days after their eligibility date are late entrants. Benefits for dental expenses will become effective one year after the date of the request, subject to the active work requirements.

GENERALLY ACCEPTED DENTAL STANDARDS

MetLife determines benefit payments for dental expenses under a MetLife group dental plan. Benefits will be payable for a recommended dental service only if it is classified as "necessary," under generally accepted dental standards.

* The Reasonable and Customary (R&C) charge is the lowest of (a) the dentist's actual charge for the services, or (b) the dentist's usual charge for the same or similar services, or (c) the usual charge of most other dentists in the same geographic area for the same or similar services as determined by MetLife.

EXCLUSIONS

(THE FOLLOWING EXPENSES ARE NOT COVERED DENTAL EXPENSES)

- **Services or Supplies...**
 - related to teeth lost before dental benefits began;
 - received by a covered person before the dental expense benefits start for that person;
 - which are covered by any worker's compensation laws or occupational disease laws;
 - which are covered by any employer liability laws;
 - which an employer member is required by law to furnish in whole or in part;
 - received through the medical department or similar facility which is maintained by the covered person's employer member;
 - received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;
 - for which a covered person is not required to pay;
 - which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
 - which do not meet generally accepted dental standards, including experimental treatment;
 - received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
 - which are provided by any other plan which the employer member (or an affiliate) contributes to or sponsors;
 - not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.
- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; and it is required for re-constructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Repair or replacement of an orthodontic appliance.
- Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of materials to prevent decay other than fluorides.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Sealants.
- Myofunctional therapy or correction of harmful habits.
- Implantology.
- Charges by a dentist for completing dental forms.
- Charges for broken appointments.
- Treatment of temporomandibular joint disorders.
- Orthodontia, unless the orthodontia option is elected.

CANCELLATION/ TERMINATION

Coverage is provided through employer member participation in the Michigan Manufacturers Association (MMA) Master Group Policy (Form G.2130-S) situated in the State of Michigan, with certificates of insurance (Form G.23000) issued to each insured employee. In any state validly exercising extraterritorial jurisdiction, the plan will be modified to meet applicable laws.

COVERAGE TERMINATES:

- On the first day of the calendar month following the date the employee's full-time employment ceases;
- When the employee's contributions cease (if such contributions are required);
- Upon termination of the participating employer member agreement by the employer member, with prior written notice to MetLife;
- When the employer member's required contributions cease;
- When the MMA terminates group dental coverage, with prior written notice to MetLife;
- When the employer ceases to be an employer member of the Michigan Manufacturers Association; or
- If the group insurance plan is discontinued by MetLife for non-payment of premium or if participation requirements or minimum lives covered requirements are not met.
- All benefits on account of a dependent will end on the date that dependent ceases to be a dependent.

Note: Your MetLife, MMA-dedicated representative can answer any questions about costs and details of coverage. A full description of the benefits will be provided in the certificate.

Coverage provided by Metropolitan Life Insurance Company. Like most group insurance policies, MetLife group policies contain certain exclusions, limitations, reductions of benefits and terms for keeping them in force. To the extent permitted by applicable law, MetLife reserves the right to refuse coverage to any group which we believe will cause an underwriting risk not supported by our standard rates or for any other reason.



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NETWORK PLAN

The Network Plan helps to minimize out-of-pocket costs for the employee. Dentists who participate in the Preferred Dentist Program (PDP) are reimbursed based on a negotiated schedule of fees (PDP Schedule of Maximum Payments). Non-participating dentists may charge above the network schedule, but reimbursements are based on a Reasonable and Customary (R&C) schedule.

Summary: If an employee goes to a participating dentist, all eligible charges will be covered under the plan because the dentist will not seek reimbursement from participants above the PDP schedule (except of course for applicable coinsurance and deductibles). If an employee goes to a non-participating dentist, he/she will be responsible for charges beyond the R&C schedule.

By selecting an Access Plan, employer members may create a plan similar to an indemnity plan with the additional benefit of having access to MetLife's PDP network. Under this type of plan, employees receive equivalent coverage regardless of the dentist chosen and benefit from lower network rates if a network dentist is used.

ACCESS PLAN

<i>Plan</i>	<i>Deductible¹</i>	<i>Covered Percentage</i>	<i>Calendar Year Maximum</i>	<i>Orthodontia</i>
1	\$0	100/80/50	\$1000 or \$1500	N/A
2	\$0	100/80/50	\$1000 or \$1500	Available
3	\$25	100/80/50	\$1000 or \$1500	N/A
4	\$25	100/80/50	\$1000 or \$1500	Available
5 ²	\$50	100/80/50	\$1000 or \$1500	N/A
6	\$50	100/80/50	\$1000 or \$1500	Available
7	\$0	100/50/50	\$1000	N/A
8	\$0	100/50/50	\$1000	Available
9 ^{2,3}	\$50	100/50/50	\$1000	N/A
10	\$50	100/50/50	\$1000	Available

¹ Deductible waived on Type A services.

² This plan available for new employer groups.

³ This plan available for groups down to five lives when written together with an additional line of coverage.

PREFERRED DENTIST PROGRAM (PDP)

<i>Plan</i>	<i>Deductible⁴</i>	<i>Covered Percentage In Out</i>	<i>Calendar Year Maximum</i>	<i>Orthodontia</i>
11	\$50	100/90/60 100/80/50	\$1500/1000	N/A
12	\$50	100/90/60 100/80/50	\$1500/1000	Available
13	\$0	100/80/50 80/80/50	\$1000	N/A
14	\$0	100/80/50 80/80/50	\$1000	Available
15 ⁵	\$50	100/80/50 80/80/50	\$1000	N/A
16	\$50	100/80/50 80/80/50	\$1000	Available
17 ^{5,6}	\$50	100/80/50 50/50/50	\$1000/800	N/A
18	\$50	100/80/50 50/50/50	\$1000/800	Available

⁴ Same deductible in & out of network on all plans. Deductible waived on Type A services.

⁵ This plan available for new employer groups.

⁶ This plan available for groups down to five lives when written together with an additional line of coverage.



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