SPREADING THE SMILE

NCD *ELITE 1500*

BY MetLife

Product Overview

	In-Network (MetLife PDP Plus PPO Network)	Out-of-Network
Calendar Year Maximum (Per Person)	$1,500	$1,500
Reimbursement	Negotiated Fee Schedule*	Maximum Allowable Charge**
Type A - Preventive	100%	100%
Type B - Basic	80%	80%
Type C - Major	10% - Year 1; 50% - Year 2+	10% - Year 1; 50% - Year 2+
Calendar Year Deductible Applies To: Individual	Type B & C: $50	Type B & C: $50
Calendar Year Deductible Applies To: Family	$150	$150
Implant Calendar Year Maximum (Inside Limit)	$750	$750

Product Details

Type A ***Benefits are payable immediately from the start date of an individual's benefits.***	
Examinations	2 times in 12 months
Examinations - Problem Focused	1 time in 12 months
Prophylaxis: Cleanings	2 times in 12 months
Fluoride	1 time in 12 months for a dependent child under age 14
Bitewing X-Rays	For a child under 19: 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 36 months for a child under age 14
Space Maintainers	1 per lifetime for a child under age 14
Full Mouth X-Rays	Once in 36 months
Amalgam Fillings	1 replacement per surface in 24 months
Labs & Other Tests	No specific frequency or age limitations for this service
Emergency Palliative Treatment	No specific frequency or age limitations for this service
Periapical X-Rays	No specific frequency or age limitations for this service
Other X-Rays	No specific frequency or age limitations for this service
Resin Composite Fillings (Includes coverage composite fillings on molars)	No specific frequency or age limitations for this service
Oral Surgery: Simple Extractions	No specific frequency or age limitations for this service

Products are not available in all states. Please call (800) 485-3855 to verify current state availability.

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Product Details

Type C *Benefits are payable immediately from the start date of an individual's benefits. (In NY/CT: 12 month waiting period.)*	
Consultations	2 in 12 months
Root Canal	1 per tooth per lifetime
Periodontal Maintenance	2 periodontal treatments in 1 calendar year; includes 2 cleanings (total comb: 2)
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 84 months
Crown Buildups / Post Core	1 per tooth in 84 months
Repairs	1 in 12 months
Recementations	1 in 12 months
Dentures	1 in 60 months
Dentures - Rebases / Relines	1 in 36 months
Denture Adjustments	1 in 6 months
Fixed Bridges	1 in 84 months
Inlays / Onlays / Crowns	1 replacement per tooth in 84 months
Implant Services (Available Year 3)	1 per tooth position in 60 months
Implant Repairs	1 per tooth in 12 months
Implant Supported Prosthetic	1 per tooth in 84 months
Tissue Conditioning	1 in 36 months
Occlusal Adjustments	1 in 12 months
General Anesthesia	No specific frequency or age limitations for this service
Pulpotomy	No specific frequency or age limitations for this service
Pulp Capping	No specific frequency or age limitations for this service
Pulp Therapy	No specific frequency or age limitations for this service
Apexification & Recalcification	No specific frequency or age limitations for this service
Periodontal Surgery - Soft & Connective Tissue Grafts	No specific frequency or age limitations for this service
Periodontics - Non-Surgical	No specific frequency or age limitations for this service
Oral Surgery: Surgical Extractions	No specific frequency or age limitations for this service
Other Oral Surgery	No specific frequency or age limitations for this service
General Services	No specific frequency or age limitations for this service

Agent Name:

Phone #:

Email:

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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 employer 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, nonintravenous 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.

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.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.

*Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

**Payment for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

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