Dental

Metropolitan Life Insurance Company

Plan Design for North Carolina Medical Society Employee Benefit Trust Dental Plan D with no orthodontia coverage

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network[1]** % of PDP Fee[2]	**Out-of-Network[1]** % of R&C Fee[4]
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Deductible[3]		
Individual	$50	$50
Family	$150	$150
Dental plan covers children to age 26		
Annual Maximum Benefit:		
Per Individual	$1500	$1500

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

200 Park Ave., New York, NY 10166

IMPORTANT RATE INFORMATION

Monthly Premium Payment	
Employee	$53.05
Employee + Spouse	$101.44
Employee + Child(ren)	$130.87
Employee + Family	$177.51

Cancellation/Termination of Benefits:
Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. The dependent's coverage terminates when a dependent ceases to be a dependent. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

IMPORTANT ENROLLMENT INFORMATION

Benefits Plan Effective Date: Please see the enclosed cover sheet for specifics on your Plan's effective date.

Important Enrollment Provisions: If Timely Request Is Made - A timely request for Personal Dental Expense Benefits is one that is made on or prior to the date thirty-one days after your Personal Benefits Eligibility Date.

Qualifying Event:
Request to be covered, or to change your coverage, upon a Qualifying Event
If there is a Qualifying Event you may request to be covered, or to change your coverage, only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under this Plan because of a loss of the prior dental coverage. If you make a request to be covered under this Plan or request a change(s) in coverage under this Plan within thirty-one days of a Qualifying Event, your coverage or the change(s) in coverage will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

Selected Covered Services and Frequency Limitations*

Type A - Preventive	How Many/How Often:
Oral Examinations	1 in 6 months
Full Mouth X-rays	1 in 60 months
Bitewing X-rays (Adult/Child)	2 in 12 months
Prophylaxis - Cleanings	1 in 6 months
Topical Fluoride Applications	1 in 12 months - Children to age 19
Sealants	1 per molar in 60 months - Children to age 14
Space Maintainers	No limit - Children up to age 14

Type B - Basic Restorative	How Many/How Often:
Amalgam and Composite Fillings	1 in 24 months. Anterior teeth only
Prefabricated Crowns	1 per tooth in 60 months
Endodontics Root Canal	1 per tooth in 24 months
Periodontal Maintenance	4 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Emergency Palliative Treatment	
General Anesthesia	
Consultations	2 in 12 months

Type C - Major Restorative	How Many/How Often:
Crowns/Inlays/Onlays	1 per tooth in 10 years
Repairs	No Limit
Periodontal Surgery	1 in 36 months per quadrant
Periodontal Scaling & Root Planing	1 in 24 months per quadrant
Bridges	1 in 10 years
Dentures	1 in 10 years
Implant Services	1 service per tooth in 60 months - 1 repair per 60 months

Benefit Waiting Period

For employees who elect coverage during the 31-day application period, the following Dental Benefits will become effective after the satisfaction of the waiting period(s) shown below. In the case of the transferred business, if employees elected coverage under the prior plan for which the employees were eligible, the following waiting period(s) will not apply.

- Preventive Services.....No waiting period
- Basic Services.....No waiting period
- Major Services .... 12-month waiting period

***Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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 plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. Services for which You would not be required to pay in the absence of Dental Insurance;
3. Services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. Services which are primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. 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.

   For NY Sitused Groups, this exclusion does not apply.
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. 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.

    For North Carolina and Virginia Sitused Groups, this exclusion does not apply.
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    This exclusion only applies for North Carolina Sitused Groups.
15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for North Carolina Sitused Groups.
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.

    This exclusion only applies for Virginia Sitused Groups.
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    This exclusion only applies for Virginia Sitused Groups.
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.
24. 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.

    For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. 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.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. 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.
30. 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.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.

32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
33. 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.
34. Fixed and removable appliances for correction of harmful habits.[1]
35. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
36. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
37. Duplicate prosthetic devices or appliances.
38. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
39. Intra and extraoral photographic images.
40. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
    This exclusion only applies <u>for Maryland Sitused Groups</u>

[1]Some of these exclusions may not apply. Please see your Certificate of Insurance.

Common Questions … Important Answers

Who is a participating dentist?

A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees typically range from 30-45% below the average fees charged in a dentist's community for the same or substantially similar services*

In addition to the standard MetLife network, your employer may provide you with access to a select network of dental providers that may be unique to your employer's dental program. When visiting these providers, you may receive a better benefit, have lower out-of-pocket costs and/or have access to care at facilities at your worksite. Please sign into MyBenefits for more details.

* Based on internal analysis by MetLife. Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit a dentist and the cost of services rendered. Negotiated fees are subject to change.

How do I find a participating dentist?

There are thousands of general dentists and specialists to choose from --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan?

Please see your Certificate of Insurance for a list of covered services.*

May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating (out-of-network) dentist, your out-of-pocket costs may be greater than your out-of-pocket costs when visiting an in-network dentist.

Can my dentist apply for participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.* The website and phone number are for use by dental professionals only.

* Due to contractual requirements, MetLife is prevented from soliciting certain providers.

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 email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/dental or request one by calling 1-800-275-4638.

Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?

Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

*International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. (AXA Assistance). AXA Assistance provides dental referral services only. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife. Referral services are not available in all locations.
** Refer to your Certificate of Insurance for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provisions in dental benefits plans are 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.

Do I need an ID card?

No, You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in a MetLife Dental Plan. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?
No. You and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, during your employer's annual open enrollment month, or as a result of a qualifying event.

Like most group benefits programs, MetLife group benefits programs contain certain exclusions, waiting periods, reductions and terms for keeping them in force. The certificate of insurance sets forth the plan terms and provisions, including the exclusions and limitations.

SCHEDULE OF BENEFITS

NORTH CAROLINA HEALTH BENEFITS (EHB) PLAN

This schedule shows the benefits that are available under the Group Policy. Your Dependents will only be insured for the benefits:

- for which Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS

Dental Insurance For Your Dependents

This certificate only applies to a Child until the end of the Year in which the Child reaches age 19. This certificate describes the benefit available under the Pediatric Dental Essential Health Benefit. However if Your Dependent Child receives a covered service, and is also covered for that covered service under another certificate under the same policy between the Group Policyholder and MetLife, We will pay the higher of the two benefits for that covered service.

Covered Percentage for:	**In-Network based on the Maximum Allowed Charge**	**Out-of-Network based on the Maximum Allowed Charge**
Type A Services	90%	80%
Type B Services	50%	40%
Type C Services	50%	40%
Type D Services (medically necessary Orthodontics)	50%	50%
Deductibles for:	**In-Network**	**Out-of-Network**
Yearly Individual Deductible	$100 for the following Covered Services Combined: Type A, Type B & Type C	$100 for the following Covered Services Combined: Type A, Type B & Type C

Benefits for Covered Services performed by an Out-of-Network Dentist for Emergency Dental Conditions will be paid as if the Covered Service had been performed by an In-Network Dentist. How the benefit is reimbursed is described in the form GCERT2000 den/mac.

Maximum Benefit:	In-Network	Out-of-Network
Annual Maximum	None	$400
Lifetime Individual Maximum for Type D Covered Services (medically necessary Orthodontics)	None	$1,000

Out-of-Pocket Annual Maximum:	In-Network	Out-of-Network
Individual Out-of-Pocket Annual Maximum (for 1 Child)	$350 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None
Family Out-of-Pocket Annual Maximum (for 2 or more Children)	$700 for the following Covered Services: Type A, Type B, Type C & Type D (medically necessary Orthodontics)	None

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams, oral evaluation for a patient under 3 years of age and counseling with a primary caregiver, limited oral evaluation – problem focused, and detailed and extensive oral evaluation – problem focused, by report with a combined frequency limitation of once every 6 months.
2. Full mouth x-rays, but not more than once every 60 months.
3. Bitewing x-rays, but not more than 1 set every 6 months. Periapical films on an emergency or episodic basis are a Covered Service.
4. Dental x-rays except as mentioned elsewhere in this certificate.
5. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation), but not more than once every 6 months including periodontal cleanings.
6. Topical fluoride treatment, but not more than twice in 12 months.
7. Sealants which are applied to non-restored, non-decayed first and second permanent molars, but not more than once per tooth every 36 months.
8. Space maintainers.
9. Diagnostic casts for restorative dentistry.
10. Emergency palliative treatment of dental pain.
11. Preventive resin restoration in a moderate to high caries risk patient – applied to non-restored, non-decayed first and second permanent molars.

Type B Covered Services

1. Fillings: Amalgam and resin composite. Restorations are limited as follows:
   - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is not a Covered Service.
   - Composite resin or acrylic restorations on molar teeth will be benefited as an alternative benefit.
   - Micro filled resin restorations which are non-cosmetic.
   - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is medically necessary.
2. Sedative fillings.
3. Prefabricated crowns, but no more than one replacement for the same tooth within 60 months for a covered person under 15 years of age.
4. Repair of Dentures.
5. Simple repairs of Cast Restorations.
6. Simple extractions.
7. Surgical extractions. Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.
8. Oral surgery except as mentioned elsewhere in this certificate.
9. Pulp capping.
10. Pulp therapy.
11. Therapeutic pulpotomy. (If a root canal is completed within 45 days of the pulpotomy, We will only pay benefits for the root canal therapy.)
12. Recementations.
13. Adjustment of a Denture made 6 or more months after installation by the same Dentist who installed it.
14. Relinings and rebasings of existing removable Dentures made 6 or more months after installation by the same Dentist who installed them, but not more than once in any 36 month period.
15. Tissue conditioning.
16. Consultations.
17. Adjunctive general services.
18. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as gingivectomy, gingivoplasty, and osseous surgery) has been performed. Periodontal maintenance is limited to four times per 12 months less the number of teeth cleanings received during such 12 months.
19. Periodontal, non-surgical treatment.

20. Scaling and root planing, but not more than once per quadrant in any 24 month period.

21. Adding teeth to Dentures.

22. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when such anesthesia is determined to be medically necessary or Dentally Necessary.

23. Injections of therapeutic drugs.

24. Pulp vitality, diagnostic photographs, and bacteriological studies for determination of bacteriologic agents.

Type C Covered Services

1. Periodontal surgery, but not more than one surgical procedure per quadrant in any 36 month period**.**

2. Periodontal soft and connective tissue grafts, but no more than one per unique site per 36 months.

3. Initial installation of Cast Restorations.

4. Replacement of any Cast Restorations with the same or a different type of Cast Restoration is limited to 1 replacement for the same tooth if at least 60 months have passed since the most recent time that:
   - a Cast Restoration was installed for the same tooth; or
   - a Cast Restoration for the same tooth was replaced.

5. Crown buildups/post and core, but no more than once per tooth in a period of 60 months.

6. Root canal treatment, but no more than once per tooth per lifetime.

7. Apexification/recalcification.

8. Full mouth debridements, but no more than once per lifetime.

9. Initial installation of full or removable Dentures, but no more than once every 60 months. Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers are only available if they are Dentally Necessary.

10. Fixed partial dentures, but no more than once every 60 months, and only if they are Dentally Necessary and a partial cannot satisfactorily restore the case. (If fixed partial dentures are used when a partial could satisfactorily restore the case, the benefit determination will be based upon the partial which is the less costly service.)

11. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and only if such replacement is done within 12 months of the installation of the immediate, temporary full Denture.

12. Replacement of a non-serviceable removable Denture, but only if such Denture was installed more than 60 months prior to replacement.

13. Replacement of a non-serviceable fixed Denture, but only if such Denture was installed more than 60 months prior to replacement.

14. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation) but no more than once for the same tooth position in a 60 month period.

15. Repair of implants, but not more than once in a 60 month period.

16. Implant supported prosthetics, but no more than once for the same tooth position in a 60 month period.

17. Occlusal guards including adjustments, but no more than one every 12 months and only for a overed person age 13 and older.

18. Local chemotherapeutic agents.

19. Occlusal adjustments.

Type D Covered Services

Orthodontia, must be medically necessary and must begin while this insurance is in force. If the insurance ends during the course of the treatment, the monthly payments will end. Dental procedures performed in connection with Orthodontia treatment are considered under the Orthodontia benefit.

The Lifetime Individual Maximum Benefit Amount and Out-of-Pocket Annual Maximum for orthodontia is shown in the SCHEDULE OF BENEFITS.

DENTAL INSURANCE: EXCLUSIONS

We will not pay Dental Insurance benefits for charges incurred for:

1. Services which are not Dentally Necessary and/or medically necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.

2. Services for which a Dependent would not be required to pay in the absence of Dental Insurance. For purposes of this exclusion, we will not take into account medical assistance in North Carolina or any other state under section 1396a of Title 42 of the United States Code.

3. Services or supplies received by Your Dependent before the Dental Insurance starts for that person.

4. Services not performed 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.

5. Services which are primarily cosmetic.

6. Replacement of an orthodontic appliance.

7. Services or appliances which restore or alter occlusion or vertical dimension.

8. Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.

9. Restorations or appliances used for the purpose of periodontal splinting.

10. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.

11. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.

12. Decoration or inscription of any tooth, device, appliance, crown or other dental work.

13. Charges for missed appointments.

14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

15. Services:
    - for which the employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.

16. Services covered under other coverage provided by the Employer.

17. Temporary or provisional restorations.

18. Temporary or provisional appliances.

19. Prescription drugs.

20. 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.

21. 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.

22. Intra and extraoral photographic images.

23. Services for which the submitted documentation indicates a poor prognosis.

24. Caries susceptibility tests.

25. Labial veneers.

26. Modification of removable prosthodontic and other removable prosthetic services.

27. Diagnosis and treatment of temporomandibular joint (TMJ) disorders.

28. Application of desensitizing agents.

29. Fixed and removable appliances for correction of harmful habits, unless part of overall treatment plan for medically necessary Orthodontia.

30. Precision attachments associated with fixed and removable prostheses.

31. Biopsies of hard or soft oral tissue.

32. Duplicate prosthetic devices or appliances.

33. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.

34. Composite resin or acrylic restorations for posterior molars.

35. The prophylactic removal of third molars is not a Covered Service. Asymptomatic third molar removal or removal due to malocclusion or for orthodontic reasons is not covered. Third molar removal when there is no pathology present is not covered.

36. Any procedures not specifically listed as a Covered Service.

37. The following services are not Covered Services:
    - a connector bar;
    - a stress breaker; or
    - coping.

LANGUAGE ASSISTANCE PROGRAM: NOTICE TO INSUREDS

If you, or someone you're helping, have questions about the MetLife Pediatric Dental Essential Health Benefit Plan, you have the right to get help and information in your language at no cost. To arrange for language assistance services, call (800) 275-4638.

Si usted, o alguien que esta ayudando, tiene preguntas sobre MetLife Pediatric Dental Essential Health Benefit Plan (Plan de Beneficios de Salud de MetLife Odontologia Pediatrica Esencial), usted tiene el derecho a obtener ayuda e informaci6n en su idioma sin costo alguno. Para coordinar los servicios de ayuda con el idioma, llame al (800) 275-4638.

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N u quy vi ho.jic ai d6 ma quy vi dang giup do, c6 th c m c ve MetLife Pediatric Dental Essential Health Benefit Plan (ChLI'ang Trinh Phuc Lqi YT Thi ! Y u Nha Khoa Tre Em cua Metlife), quy vi c6 quyen nh n mien phi *trq* giup va thong tin theo ng6n ngCr cua quy vi.0e s p x p cho cac dich v1,1 ho *trq* ng6n ngCr, xin g9i s6 (800) 275-4638.

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Si ou, oubyen yon moun w ap ede, genyen kesyon sou MetLife Pediatric Dental Essential Health Benefit Plan (Plan Benefis Sante Dante Esansyel Pedyatri MetLife) ou gen dwa resevwa ed ak enfomasyon nan pwop lang paw san peye anyen. Pou aranjman asistans sevis lang, rele (800) 275-4638.

Si vous-meme, ou une personne que vous aidez, avez des questions concernant le MetLife Pediatric Dental Essential Health Benefit Plan (Programme de Prevoyance d'Urgence pour la Sante Dentaire des Enfants), vous etes en droit d'obtenir gratuitement une assistance et ces informations dans votre langue maternelle. Pour contacter les services de traduction, appelez le (800) 275-4638.

Jesli Ty, lub osoba, kt6rej udzielasz pomocy, ma pytania odnosnie planu MetLife Pediatric Dental Essential Health Benefit Plan (Podstawowy plan swiadczeri zdrowotnych MetLife obejmujqcy pomoc pediatrycznq i stomatologicznq), przysluguje warn prawo do otrzymania informacji lub pomocy w ojczystym j zyku bez zadnych koszt6w. Aby skorzystac z pomocy j zykowej, prosimy dzwonic pod nr (800) 275-4638.

Ecr,111 y Bae IIIJIIII y KOro-TO, KOMY Bbl noMoraeTe, eCTb BOnpOCbl no noBOAY MetLife Pediatric Dental Essential Health Benefit Plan (6a30Bbllii neA111aTp1114ecK1111ii CTOMaTonor1114ecK1111ii MeA1114111HcK1111ii CTpaxosolii nnaH Mernaliicp), y Bae eCTb npaso nony4111Tb noMOlJ..lb 111 IIIHcpOpMa4111110 Ha POAHOM l13b1Ke 6ecnnaTHO. ,Qnl1 nony4eHl/ll1 ycnyr l13blKOBOlii noMOlJ..1111 no3BOHIIITe (800) 275-4638.

Kung ikaw o ang tinutulungan mo, ay mayroong mga tanong tungkol sa MetLife Pediatric Dental Essential Health Benefit Plan (Plan ng Mga Benepisyo para sa Mga Mahalagang Bagay sa Kalusugan ng Ngipin na mula sa MetLife), mayroon kang karapatang humingi ng tulong at impormasyon na nasa wika mo at nang wala kang babayaran. Para ayusin ang mga serbisyo para sa tulong sa wika, tumawag sa (800) 275-4638.

Wenn Sie oder jemand, dem Sie helfen, Fragen zum MetLife Pediatric Dental Essential Health Benefit Plan (Allgemeinen Padiatrisch-zahnarztlichen Krankenversicherungsplan von MetLife) haben, so stehen Ihnen kostenlos Hilfe und Information in Ihrer Sprache zu. Um Sprachunterstutzung anzufordern, rufen Sie bitte (800) 275-4638 an.

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