MetLife DHMO MET100, MET185 and SmileSaver℠ DHMO 3000, 1000 Benefit Summaries

(Also available as Voluntary Plans)

This is a summary of benefits for the MetLife DHMO MET100, MET185 and SmileSaver DHMO 3000, 1000 plans offered through CaliforniaChoice®. To be eligible, your business must be located within the plan service area. Employees enrolling in one of these plans must choose a participating dentist from the MetLife Dental HMO/Managed Care Network. Employees can access the Online Provider Directory at https://www.calchoice.com/ProviderLandingPage.aspx.

Plan Benefits	MetLife Plan MET100	MetLife Plan MET185	SmileSaver Plan 3000	SmileSaver Plan 1000
Exam & Diagnostics				
Office Visits	$5 Copay	$5 Copay	No Charge	No Charge
Initial Oral Exam	No Charge	No Charge	No Charge	No Charge
Periodic Oral Exam	No Charge	No Charge	No Charge	No Charge
Teeth Cleaning	No Charge	No Charge	No Charge	No Charge
X-Rays Bite-Wing (4 films)	No Charge	No Charge	No Charge	No Charge
Oral Surgery				
Removal of Uncomplicated Single Tooth	No Charge	No Charge	$10 Copay	No Charge
Removal of Impacted Tooth – partially bony	$40 Copay	$65 Copay	$50 Copay	No Charge
Removal of Impacted Tooth – completely bony	$75 Copay	$80 Copay	$65 Copay	No Charge
Restorative				
Cavities – Amalgam 1 Surface	No Charge	$10 Copay	$9 Copay	No Charge
Cavities – Amalgam 2 Surfaces	No Charge	$15 Copay	$14 Copay	No Charge
Endodontics				
Single Root Canal	$40 Copay	$80 Copay	$100 Copay	$40 Copay
Bi-Root Canal	$65 Copay	$115 Copay	$135 Copay	$65 Copay
Molar Root Canal	$95 Copay	$200 Copay	$185 Copay	$95 Copay
Periodontics				
Gingivectomy – Per Tooth	$38 Copay	$68 Copay	$30 Copay	No Charge
Periodontal Scaling & Root Planing (quadrant)	$25 Copay	$40 Copay	$26 Copay	$20 Copay
Crowns – Single Restoration				
Porcelain – Base Metal (posterior)	$175 Copay†	$260 Copay†	$225 Copay†	$175 Copay†
Full Cast Noble Metal	$100 Copay†	$185 Copay†	$115 Copay†	$60 Copay†
Orthodontics**				
Child (maximum age 18)	$1,450 Copay	$1,695 Copay	$1,600 Copay	$1,600 Copay
Adult	$1,450 Copay	$1,695 Copay	$1,950 Copay	$1,950 Copay
Prosthodontics				
Complete Upper or Lower Denture	$125 Copay	$210 Copay	$120 Copay	$70 Copay
Partial Upper or Lower Denture	$110 Copay	$240 Copay	$110 Copay	$50 Copay

Note: Copays listed for Plans MET100, MET185, 3000 and 1000 are for services performed by general dentists. Please consult the EOC/SOB for specialist copays and any additional fees that may apply to specific procedures.

† Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

** 24 month treatment.

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

MetLife DHMO MET100 & MET185

Exclusions & Limitations

General

- Specialty Care Dentists will accept the contracted fee for all Covered Services.
- Sterilization and infection control are not billable to Us or You or Your Dependent and are included within the charges for other services provided on that date of service.

Diagnostic

- Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.
- All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

- Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the Co-Payment listed in the SCHEDULE OF BENEFITS. Additional Prophylaxis are available, if Dentally Necessary.

Restorative Treatment
Crowns, Implants and Fixed Bridges

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
- There is a $75 Co-Payment per molar, for the use of porcelain.
- Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.

Prosthodontics

- Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist or Specialty Care Dentist.

Endodontics

- The Co-Payments listed for Endodontic procedures do not include the cost of the final restoration.

Periodontics

- Periodontal scaling and root planing, is limited to not more than once per Quadrant in any twenty-four (24) month period.
- Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.

Orthodontics

- If You or Your Dependent require the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.
- Plan benefits shall cover twenty-four (24) months of usual and customary Orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.

MetLife DHMO MET100 & MET185

Exclusions & Limitations (Continued)

EXCLUSIONS:

- Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS), are not covered.
- Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS (except for out-of-area emergency services).
- Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (the tooth has been opened into the pulp (nerve chamber)), or full or partial Dentures for which an impression has been taken.
- Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.
- Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
- Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.
- Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.
- Dental services considered Experimental in nature.
- Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.
- The following are not included as Orthodontic benefits:
  - Repair or replacement of lost or broken appliances;
  - Retreatment of Orthodontic cases;
  - Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
  - Invisalign services are excluded

This is a summary of Limitations, Additional Charges & Exclusions Only. For a complete listing, refer to the appropriate Schedule of Benefits and Evidence of Coverage.

SmileSaver℠ DHMO Plan 3000 and 1000

Exclusions & Limitations

- Dental treatment must be received from the Member's participating dental office unless exception is specifically authorized in writing by the Plan.
- Routine and periodic examinations are limited to once every 6 months per enrolled Member.
- Prophylaxis procedures are limited to once every 6 months.
- Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one series films in any 12 consecutive month period. Full mouth radiographs (x-rays) in conjunction with periodic examinations are limited to once every 3 years. Panoramic films are limited to once every 3 years.
- Fluoride treatment is limited to enrolled Members under the age of 18 years once every 6 months.
- Periodontal scaling and root planing, and/or sub-gingival curettage, and periodontal maintenance procedures are limited to one course of therapy during any 12 month period.

The following dental services and procedures are not included in the Dental DHMO 3000 or 1000:

- Any procedure not specifically listed as a covered benefit.
- Dental treatment or expenses incurred in connection with any dental procedures started prior to the Member's effective date under this Plan or after termination of the Member's coverage. Example: teeth prepared for crowns, root canal treatment in progress, etc.
- All treatment of fractures and dislocations.
- Extraction for orthodontic purposes.
- Dental procedures and charges incurred as part of implants (placement or removal) and prosthetic devices placed on implants (fixed or removable). Example: bridges, crowns, dentures.
- Replacement of lost or stolen dentures, crown and bridgework or other dental appliances.
- Dental treatment or procedures requiring or associated with fixed prosthodontic restorations (other than those for replacement of structure lost due to decay) when part of extensive oral rehabilitation or reconstruction.
- Diagnosis or treatment by any method of any condition related to the jaw joint, TMJ or associated musculature, nerves or other tissues.
- A dental treatment plan, which, in the opinion of the Participating Dentist, is not medically necessary, will not produce a beneficial result or has a poor prognosis.
- Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dental office or the Plan for completion or compensation.

This is a summary of Exclusions & Limitations only. For a complete listing, please see the Evidence of Coverage.