

# Monroe County Bar Association 2020 Plan Summary and Cost of Coverage

With MetLife Dental Insurance, your acceptance is guaranteed.

- **100% coverage** for preventive care for in-network exams, cleanings and X-rays<sup>1</sup>
- **Freedom to visit any dentist** you want whether they are in the MetLife network or not<sup>2</sup>
- **Typical savings of 30%- 45%** on covered services when you use a participating dentist<sup>3</sup>

## Eligibility

All Members of the Monroe County Bar Association<sup>4</sup>

## Plan Benefits

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee**
<b>Type A: Preventive</b> (cleanings, exams, X-rays)	100%	100%
<b>Type B: Basic Restorative</b> (fillings, extractions)	90%	80%
<b>Type C: Major Restorative</b> (bridges, dentures)	60%	50%
<b>Type D: Orthodontia</b>	50%	50%
<b>Deductible†</b>		
<b>Individual</b> (per calendar year)	\$0	\$50
<b>Family</b> (per calendar year)	\$0	\$150
<b>Annual Maximum Benefit</b>		
Per Person	\$1,000	\$1,000
<b>Orthodontia Lifetime Maximum</b>		
Per Person (for children up to age 19 only)	\$1,000	\$1,000

**Child(ren)'s eligibility** for dental coverage is from birth up to age 19 and unmarried or age 23 if a full-time student.

\*Negotiated Fee refers 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.

\*\*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 to Type A, B and C Services

## Rates at a glance

The following **monthly** costs are effective through **December 31, 2020**. Monthly cost covers all eligible children.

<b>Member Only</b>	\$48.79	<b>Member + Family</b>	\$132.12
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## List of Primary Covered Services & Limitations

The services and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

### Type A: Preventive

- Prophylaxis (cleanings) – Two per calendar year
- Oral Examinations - Two exams per calendar year
- Topical Fluoride Applications - One fluoride treatment per calendar year for dependent children up to their 16<sup>th</sup> birthday
- X-rays –
  - Full mouth X-rays; one per 60 months
  - Bitewings X-rays; one set per calendar year for adults and children up to 19<sup>th</sup> birthday
- Space Maintainers - Space maintainers for dependent children up to their 16<sup>th</sup> birthday
- Sealants - One application of sealant material every 5 years for each non-restored, non-decayed 1<sup>st</sup> and 2<sup>nd</sup> molar of a dependent child up to their 19<sup>th</sup> birthday



## **Type B: Basic Restorative**

- Fillings
- Oral Surgery
- General Anesthesia - When dentally necessary in connection with oral surgery, extractions or other covered dental services

## **Type C: Major Restorative**

- Crown, Denture and Bridge Repair/Recementations
- Implants- Replacement once every 5 years
- 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 and Onlays - Replacement once every 5 years
- Endodontics - Root canal treatment limited to once per tooth per 24 months
- Periodontics-
  - Periodontal scaling and root planning once per quadrant, every 12 months
  - Periodontal surgery once per quadrant, every 36 months
  - Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year

## **Type D: Orthodontia**

- Your children, up to age 19, are covered while Dental insurance is in effect.  
All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary
- Orthodontic benefits end at cancellation of coverage



## 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 covered person would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by a covered person 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by a 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 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 policyholder 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;
- 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;
- 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.
- 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;

- 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;
- 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;
- 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;
- 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;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of New Mexico. This exclusion does not apply to residents of Minnesota;
- 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.

## Limitations

**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. 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 plan's 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 dialing 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

**Cancellation/Termination of Benefits:** Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, insurance ceases for your class, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

1. Preventive services (Type A) are 100% covered when you visit an in-network participating dentist. Subject to frequency limitations.
2. Your out-of-pocket costs may be greater when you visit a dentist who does not participate in the MetLife network.
3. Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.
4. You must be a member of the Monroe County Bar Association to qualify for this insurance plan.

Coverage may not be available in all states. Please contact the Third-Party Administrator Ahrens Bar Association Marketplace at 1-800-852-5570 for more information.

Rates may be changed on the entire group plan or on a class basis and on any premium due date on which benefits are changed. A class is a group of people defined in the group policy. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization.

The association and/or the plan administrator incurs costs in connection with providing oversight and administrative support for this sponsored plan. To provide and maintain this valuable membership benefit, MetLife may compensate the association and/or the plan administrator for these and/or other costs.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact the Third-Party Administrator at 1-800-852-5570 for costs and complete details.

Policy form GPNP99

Policy number 162818-1-G

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