University of Maryland Baltimore – 6 month plan Plan Summary

- **100% coverage** for preventive care for in-network exams, cleanings and X-rays[1]
- **Freedom to visit any dentist** you want whether they are in the MetLife network or not[2]
- **Typical savings of 35% - 50%** on covered services when you use a participating dentist[3]

Eligibility

All currently enrolled students[4]

Plan Benefit

6 Month Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of MAC**
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures, crowns)	50%	50%
Type D: Orthodontia (orthodontic diagnostics and orthodontic treatment) If you no longer have insurance with MetLife your orthodontic coverage will terminate and you may be responsible for the remaining orthodontia payment(s).	50%	50%
Deductible (applied to type B & C services)		
Individual (per plan period)	$50	$50
Family (per plan period)	$150	$150
Plan Period Maximum Benefit (applied to type A, B & C services)		
Per Person	$1,000	$1,000
Orthodontia Lifetime Maximum		
Per Person	$1,500	$1,500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.[5]

§Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY. *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. *MAC refers to the Maximum Allowed Charge, which is a scheduled amount determined by MetLife.

**Maximum Allowable Charge: The out-of-network Maximum Allowable Charge is equal to the in-network negotiated fee. 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.

†Applies only to Type B and C Service

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 plan period

- Oral Examinations - Two exams per plan period
- Topical Fluoride Applications – One fluoride treatment per plan year for dependent children under age 14
- X-rays –
  - Bitewings X-rays; one set for adults and children per plan year

Type B: Basic Restorative

- Fillings, initial placement – One per surface in 24 months
- Periodontal maintenance – Two periodontal treatments per plan year, includes two cleanings (total combined: 2)
- Space Maintainers – One per lifetime for dependent children up to their 14th birthday.
- Sealants - One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to their 16th birthday

Type C: Major Restorative

- Consultations – One per plan period
- Simple and Surgical extractions
- Oral Surgery
- Implant Services- One per tooth in 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 84 months
  - 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
- Crown buildups/post core – one per tooth in 84 months
- Prefabricated crowns (temporary crown)– one per tooth in 84 months

- Inlays/Onlays/Crowns – one per tooth in 84 months
- Crown, Denture, Implant and Bridge Repair/Recementations – once in a 12 month period
- Endodontics - Root canal treatment limited to once per tooth in your lifetime
- General Anesthesia - When dentally necessary in connection with oral surgery, extractions or other covered dental services
- Periodontics-
  - Periodontal scaling and root planning once per quadrant, every 24 months
  - Periodontal surgery once per quadrant, every 36 months

Type D: Orthodontia - If you no longer have insurance with MetLife your orthodontic coverage will terminate and you may be responsible for the remaining orthodontia payment(s).

- You, your spouse and your children, up to age 26, 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
- 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: waterpicks, 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 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 associated with fixed and removable prostheses, 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.
- Repair or replacement of an orthodontic device;
- 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.

- 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. To avoid any misunderstandings, 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. 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 GPNP15-2T / GCERT2015-DENTAL) issued by MetLife. Coverage terminates when your membership ceases, the participating association ceases to participate in the trust, 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 MetLife data. 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. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.
4. You must be a student of the University of Maryland Baltimore to qualify for this insurance plan.
5. Refers to your dependent children through age 26.

Coverage may not be available in all states. Please contact your plan administrator, HUB International at 1-877-247-8817 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 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 your plan administrator, HUB International at 1-877-247-8817 for costs and complete details.

Policy form GPNP15-2T
Certificate form GCERT2015-DENTAL

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