

## MetLife Dental Cost and Benefit Summary for Episcopal Diocese of Dallas

### General Information

Effective Date:	01/01/2007
Proposal Date:	11/29/2006
Number of Covered Employees:	161
Class Description:	All Active Full Time Employees
Eligible Dependent(s):	A Child is covered up to age 25; A student is covered up to age 25.
Employee Contribution:	1% for employee coverage
Dependent Contribution:	1% for dependent coverage
Employee Participation	This quote assumes employee participation of at least 95%.
Dependent Participation	This quote assumes dependent participation of at least 95%.
Eligibility Requirements	All Active Full Time Employees (30 Hours)

### Schedule of Benefits – Class 1

	In-Network	Out-of-Network
Coverage Option	Comprehensive	Comprehensive
Basis of Reimbursement – Network	Negotiated PDP fee <sup>1</sup>	90th percentile of Reasonable & Customary (R&C) <sup>2</sup>
Type A – Preventive	100%	100%
Type B – Basic	80%	80%
Type C – Major	50%	50%
Type D – Orthodontia – Child Up to Age 19	50%	50%
Individual Deductible (Annual)	\$50	\$50
Family Deductible (Annual)	3x aggregate	3x aggregate
Deductible Applies To	Type B & C	Type B & C
Calendar Year Maximum	\$1,500	\$1,500
Lifetime Orthodontic Maximum	\$1,000	\$1,000

### Rate Information

	Lives	Rate
Employee Only	64	\$31.44
Employee + Spouse	54	\$62.88
Employee + Child(ren)	4	\$65.40
Employee + Family	39	\$106.77
Total Number of Lives	161	
Estimated Total Monthly Premium	<b>\$9,833.31</b>	
Rate Guarantee Period	01/01/2007 - 12/31/2007	

### Highlights

<ul style="list-style-type: none"> <li>• For the <b>Effective Date Shown Above</b>, proposal is effective for up to 90 days from proposal date.</li> <li>• Final rates will be based on actual enrollment, participation, contribution levels, and the effective date of coverage.</li> <li>• If the actual enrollment averages 3 or more children per family unit, we reserve the right to revise these rates.</li> <li>• State Laws - For covered employees residing in any state outside the situs state, which validly exercises extraterritorial jurisdiction, the plan will be modified to meet applicable laws.</li> <li>• Individuals 70 years of age and older must submit proof of full time employment.</li> </ul>
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<sup>1</sup> In Network Benefits provided under this plan for covered dental services provided by a dentist who is a participating provider.

<sup>2</sup> 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 (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge'), or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

**PLAN DESIGN FEATURES – Class 1**

**ALLOCATION OF SERVICES: COMPREHENSIVE PLAN (Subject to Exclusions and Limitations.)**

<b>TYPE A PREVENTIVE SERVICES</b>	<b>TYPE B BASIC SERVICES</b>	<b>TYPE C MAJOR SERVICES</b>	<b>TYPE D ORTHODONTICS</b>
<ul style="list-style-type: none"> <li>• Oral Exam</li> <li>• Full Mouth X-Rays</li> <li>• Periapical X-rays and other X-rays</li> <li>• Bitewing X-Rays</li> <li>• Bacteriological studies for determination of pathological agents</li> <li>• Genetic test for susceptibility to oral disease</li> <li>• Caries susceptibility tests</li> <li>• Pulp vitality tests</li> <li>• Diagnostic casts</li> <li>• Prophylaxis/Cleaning</li> <li>• Fluoride Treatments</li> <li>• Sealants</li> <li>• Space Maintainers</li> <li>• Emergency Palliative Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Fillings</li> <li>• Prefabricated Stainless Steel and Resin Crowns</li> <li>• Pulp capping</li> <li>• Therapeutic Pulpotomy</li> <li>• Pulpal therapy</li> <li>• Root canal treatment</li> <li>• Apexification/ recalcification</li> <li>• Periodontics</li> <li>• Scaling &amp; Root Planing</li> <li>• Periodontal Surgery</li> <li>• Periodontal Maintenance</li> <li>• Relines/Rebases</li> <li>• Repairs</li> <li>• Extractions</li> <li>• Oral Surgery</li> <li>• Injections of Antibiotic Drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Inlays/Onlays</li> <li>• Crowns</li> <li>• Dentures</li> <li>• Bridges</li> <li>• General Anesthesia</li> <li>• Consultations</li> </ul>	<ul style="list-style-type: none"> <li>• Orthodontic Diagnostics</li> <li>• Orthodontic Treatment</li> </ul>

**LIMITATIONS / PROVISIONS ON DENTAL SERVICES– Class 1**

**Type A (Preventive Services)**

- Oral exams but not more than once every 6 months.
- Full mouth X-rays but not more than once every 60 months.
- Bitewing X-rays but not more than once every 6 months for Dependent children under 19 years of age; and once every 12 months for all other Covered Persons.
- Scaling and polishing of teeth (oral prophylaxis) but not more than once every 6 months.
- Topical fluoride treatment for a Dependent child under 19 years of age but not more than once every 6 months.
- Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for Dependents up to 15 years of age once per tooth per lifetime.
- Space Maintainers for a Dependent under 19 years of age.

**Type B (Basic Services)**

- Initial placement of amalgam or composite fillings.
- Replacement of an existing amalgam or composite filling; and
  - at least 24 months have passed since the existing filling was placed; or
  - a new surface of decay is identified on that tooth.
- Prefabricated stainless steel crowns or prefabricated resin crowns, in either case, only for primary teeth but not more than once in any 60 month period.
- Endodontics
  - Root canal treatment not more often than once every 24 months for the same tooth.
- Periodontics
  - Periodontal scaling and root planing but not more than once per quadrant or area every 24 months.
  - Periodontal surgery, including gingivectomy or gingivoplasty, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant or area every 36 months.
- Periodontal maintenance but limited to 2 times in a year less the number of teeth cleanings received during such year.
- Relining and Rebasing of existing removable dentures but not more than once in 36 months.

**Type C (Major Services)**

- Initial installation of Cast Restorations.
  - Cast Restoration means an inlay, onlay, or crown.
  - Replacement of any Cast Restoration with the same or a different type of Cast Restoration but not more than one

replacement for the same tooth within 60 months.

- Core buildup, labial veneers and post and cores, but not more than one of each service for a tooth in a period of 60 months.

- Those services needed to replace one or more natural teeth which are lost while Dental Expense Benefits for the Covered Person are in effect for:
  - installation of fixed bridgework done for the first time.
  - Installation for the first time of a partial removable denture; or a full removable denture.
- Administration of general anesthesia, when dentally necessary as determined by Metropolitan in terms of generally accepted dental standards in connection with oral surgery, extractions, or other covered dental services.
- Consultations, not more than 2 in any 12 months.
- Replacing an existing removable denture or fixed bridgework if:
  - it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or
  - it is needed because the existing denture or bridgework can no longer be used and was installed more than 60 months prior to its replacement.

- Replacing an existing immediate temporary full denture by a new permanent full denture when:
  - the existing denture cannot be made permanent; and
  - the permanent denture is installed with 12 months after the existing denture was installed.

- Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth removed after the existing denture or bridgework was installed.

#### **Type D (Orthodontic Services)**

- Benefit for initial preparation, work up & installation of Orthodontic appliance is 20% of the total covered expense.
- All dental procedures performed in connection with Orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis (monthly installments).
- Benefits end at cancellation.

#### EXCLUSIONS ON DENTAL SERVICES - Class 1

- Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
- 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.
- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if:
  - otherwise is a Covered Dental Expense; and
  - is required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or
  - is required for reconstructive surgery because of a congenital disease or anomaly of a dependent child which has resulted in a functional defect.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
- Services or supplies which are covered by any employers' liability laws.
- Services or supplies which any employer is required by law to furnish in whole or in part.
- Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
- Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
- Services or supplies for which a Covered Person is not required to pay.
- Services or supplies which are deemed experimental in terms of generally accepted dental standards.
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
- Adjustment of a denture or a bridgework which is made within 6 months after installation by the same Dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
- 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.
- Implantology.
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person or as a replacement for congenitally missing natural teeth.
- Charges for broken appointments.
- Charges by the Dentist for completing dental forms.
- Sterilization supplies.
- Services or supplies furnished by a family member.
- Treatment of Temporomandibular Joint Disorders. This exclusion does not apply to residents of Minnesota.
- Repair or a replacement of an orthodontic appliance.

### **IMPORTANT INFORMATION:**

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**This proposal is based on the contractual provisions and requirements included in the Group Policy, Form GPNP99 situated in TEXAS with certificates of insurance (Form G.23000) issued to each insured employee.**

This cost and benefit summary is only to be used as part of the Benefits Description for Dental.