GROUP DENTAL

GIC Active Dental Plan Handbook

For Commonwealth of Massachusetts Employees

MetLife

Your Dental Benefit Plan

Effective 7/1/2016

Commonwealth of Massachusetts
Group Insurance Commission

Dear Member,

Effective July 1, 2016, the following change has been made to the GIC Active Classic and Value plans:

*Mouth guards for Bruxism (teeth grinding). This is a major service covered at 50%.

Please review the handbook carefully and save it for future reference. This handbook is a summary of benefits and does not include all covered services and exclusions. Any given procedure is subject to MetLife's review. If you have any additional questions about your GIC Active Dental Plan benefits, please visit www.metlife.com/GIC or call the customer service toll-free number 1-866-292-9990.

Commonwealth of Massachusetts

DENTAL PLANS offered through the Group Insurance Commission

Welcome

As a Commonwealth of Massachusetts employee eligible to receive dental benefits through the GIC, you can choose between two dental plans insured by MetLife:

The GIC Classic Dental Plan (Indemnity Plan)

The GIC Value Dental Plan (PPO Plan)

Both plans offer access to a network of participating dentists that have agreed to accept a schedule of reduced fees.

Although you are free to use any dentist whether or not he or she participates in the network, the Value Plan will pay benefits at a lower level when you choose to go to a dentist who does not participate in the network.

Please review the handbook carefully and save it for future reference. This handbook is a summary of benefits and does not include all covered services and exclusions. Any given procedure is subject to MetLife's review. If you have any additional questions about your GIC Retiree Dental Plan benefits, please visit www.metlife.com/GIC or call the customer service toll-free number, 1-866-292-9990.

COMMON QUESTIONS…IMPORTANT ANSWERS

Group Number: 122749

Who is eligible to enroll in the GIC Dental Plans?

You are eligible to enroll in the GIC Plan if you meet all of the following conditions:

- Are eligible for life and/or health benefits through the GIC and
- Are not otherwise eligible for dental benefits through a separate appropriation or the provisions of a contract or collective bargaining agreement and
- Are not employed by an authority, municipality, higher education or the judicial trial court system.

When does coverage take effect?

If you complete the enrollment process within 31 days of becoming eligible, your coverage will take effect on the first day of the second month following your hire date or promotion or on a date determined by the GIC.

If you do not complete the enrollment process within 31 days of becoming eligible, you will not be able to enroll for insurance until the next annual GIC enrollment period.

What Dental Plans are offered by the GIC?

The GIC offers all eligible employees a choice between two plans. Both offer access to the network.
For the GIC Classic Plan, the benefit levels are identical regardless of whether you use a participating ("in-network") or non-participating ("out-of-network") dentist. The Value Plan pays benefits at a lower level when services are provided by a non-participating dentist. Please see the benefit summary for further details.

When can I change plans?

You can change from one plan to the other only during the GIC annual enrollment. Changes are effective July 1st.

Can coverage be dropped?

You can drop the plan with a documented qualifying event. Please keep in mind that if you withdraw from the plan or are terminated from the plan because of non-payment of premium, you will be unable to re-enroll in the plan until the July 1st following 24 months from the date your coverage ended.

When will my insurance end?

Your coverage will continue as long as you meet the GIC eligibility requirements, unless you drop your coverage or fail to pay your monthly premium. If you fail to meet the eligibility requirements, your coverage will end on the last day of the month following the month in which you cease to be eligible provided that your premium is paid to date.

Are family members eligible for coverage?

Your spouse and your dependent children can be covered under this plan. Dependent eligibility for the GIC dental program mirrors the eligibility rules for the GIC medical plans.

COMMON QUESTIONS…IMPORTANT ANSWERS

When can I add my spouse or dependent to my GIC Dental plan?

You can add a spouse or dependent during Annual Enrollment or within 60 days of a qualifying event. Acceptable documentation of the qualifying event and the Enrollment/Change form must be received at the GIC within 60 days of the qualifying event. Qualifying events include:

Marriage

Birth

Adoption

Court order/Judgment

Spouse's Annual Enrollment

Loss of eligibility of Medicaid or CHIP coverage

Active employees return forms to their GIC Coordinator. Forms and documentation must be received at the GIC within 60 days of the qualifying event. Documents and forms received after 60 days of the qualifying event will be denied and you must wait until the next Annual Enrollment to add your spouse/dependent(s) to your coverage.

Can coverage be continued even when you no longer meet the eligibility requirements?

If you have a "qualifying event," you and/or your dependents may be eligible to continue your dental coverage under COBRA. For more information about COBRA, please contact the GIC.

What is a Pretreatment Estimate of Benefits?

If a planned dental service is expected to cost more than $300, you have the option of requesting a pretreatment estimate of benefits. The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, you and your dentist are responsible for choosing the services to be performed.

Do I Need an ID Card?

Although an ID card is not necessary, MetLife administers a Dental ID Card upon enrollment with your group number 122749. If you need a duplicate ID Card, please call 1-866-292-9990.

What happens when I reach my annual maximum?

You are responsible for any charges over the annual maximum. However, when you use an in-network provider you may continue to receive the benefit of negotiated fees. The negotiated fees may continue to apply to amounts over the maximum, and for any services that exceed frequency limits or are otherwise not eligible under the plan.

What if I have dental coverage through another family member?

If you are covered by more than one plan, coordination of benefits rules will apply. Please notify MetLife of the other coverage and we will coordinate benefits with the other carrier. Total payments from both carriers cannot exceed the allowable charge for the service.

COMMON QUESTIONS…IMPORTANT ANSWERS

Classic and Value Plan Comparison

Dental	Classic		Value	
Type of Service	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive and Diagnostic	100%	100%	100%	80%
Basic	80%	80%	80%	60%
Major	50%	50%	50%	50%
Deductible Per Person	None	None	None	$100
Annual Max. Per Person	$1,250	$1,000	$1,250	$1,000

Orthodontics	Classic		Value	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance	50%	50%	50%	50%
Deductible	None	None	None	None
Lifetime Maximum	$1,250	$1,250	$1,250	$1,250

What is a participating dentist?

A participating dentist is a general dentist or specialist who accepts a schedule of reduced fees for services rendered to individuals covered under the MetLife benefit dental plan. Fees typically range from 15-45% below the average fees charged by dentists in your area for the same or substantially similar services.*

How do I find a participating dentist?

As of January 1, 2016, there were over 317,000 participating dentist locations nationwide, including over 5,000 general dentists and specialists in Massachusetts. You can get a list of these participating dentists and their locations online at **www.metlife.com/GIC** or call the toll free number 1-866-292-9990 to have a list faxed or mailed to you.

Does the Preferred Dentist Program offer fees on non-covered services?

The in-network scheduled fees may extend even to non-covered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these non-covered services as well. You will pay the full cost for non-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 dentist who does not participate in the MetLife network, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment. If you receive services from a participating dentist, you are only responsible for the difference between the in-network fee for the covered service and your plan's payment.

COMMON QUESTIONS…IMPORTANT ANSWERS

What is an Alternate Benefit?

With both the network dentist and the non-participating dentist, benefits are based on the lowest cost of method of treatment so long as it meets generally accepted dental standards. Of course, if you and your dentist agree to the more expensive procedure, you will be liable for the difference between the negotiated fee for the more expensive procedure and the plan benefit.

Can my dentist apply to participate in the Preferred Dentist Program?

Yes. If your current dentist does not participate in the network and you'd like to encourage him or her to apply to become a network provider, tell your dentist to visit **www.metdental.com**, or call 1-877-MET-3379 for an application. Website and phone number are designed for use by dental professionals only.

How are claims processed?

Your dentist may submit your claims for you which helps to reduce your paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at **www.metlife.com/GIC** or request one by calling the toll free number 1-866-292-9990.

*Based on internal analysis by MetLife

**Savings from enrolling in a dental benefits plan will depend on various factors, including how often participants visit the dentist and the cost of services covered. Negotiated Fees refers to the fees that in-network dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums. At the time this handbook was prepared, negotiated fees extended to non-covered services rendered in Massachusetts.

AN EXAMPLE OF SAVINGS WHEN YOU VISIT AN IN-NETWORK DENTIST

Root Canal	Fee	Plan Benefit- 80%	Your Cost
Out-Of-Network Dentist's Usual Charge	$1,146.00	$916.80	$229.20
In-Network Negotiated Fee	$752.00	$601.60	$150.40
YOUR SAVINGS			**$ 78.80**

Let's look at the same example, but assume that you already had exceeded the annual maximum in plan benefits for the year when this charge was incurred.

Root Canal	Total Charge	Plan Benefit- 80%	Your Cost
Out-Of-Network Dentist's Usual Charge	$1,146.00	$0.00	$1,146.00
In-Network Negotiated Fee	$752.00	$0.00	$752.00
YOUR SAVINGS			**$394.00**

Negotiated fees for non-covered services may not apply in all states and at the time this handbook was prepared, negotiated fees extended to non-covered services rendered in Massachusetts. If you have any questions, please contact our customer service toll-free number 1-866-292-9990.

SUMMARY OF COVERED SERVICES - CLASSIC AND VALUE PLANS

Your dental plan provides benefits for any covered service that is necessary as determined by MetLife in terms of generally accepted dental standards.

How Many / How Often

Preventive and Diagnostic Covered Services

1. Oral exams, two in a calendar year.
2. Full mouth or panoramic x-rays once in a 5-year period.
3. Bitewing x-rays one set in a year.
4. Intraoral-periapical and extraoral x-rays.
6. Cleaning of teeth (oral prophylaxis), two in a calendar year.
7. Topical fluoride treatment for a Child to age 19, once in a year.
8. Space maintainers for a Child to age 19.
9. Sealants for a Child to age 19, one application of sealant every 48 months for unrestored permanent molars.

Basic Covered Services

1. Initial placement of amalgam or resin fillings.
2. Replacement of an existing amalgam or resin fillings:
   - Amalgam (silver) fillings – once every 12 months, per surface per tooth.
   - Resin (white) fillings – once every 12 months, per surface per tooth.
3. Sedative Fillings.
4. Oral Surgery except as mentioned elsewhere.
5. Consultations, but not more than twice in a calendar year.
6. Root canal treatment, once per tooth per lifetime.
7. Full mouth periodontal scaling and root planing, once every 24 months.
8. Periodontal surgery, including gingivectomy, gingivoplasty, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period.
9. Simple extractions.
10. Surgical extractions.
11. Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such 12-month period.
12. Pulp capping (excluding final restoration) and therapeutic pulpotomy (excluding final restoration) to age 14.
13. Pulp therapy and apexification/recalcification.
14. Local chemotherapeutic agents.
15. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when we determine such anesthesia is necessary in accordance with generally accepted dental standards.
16. Injections of therapeutic drugs.
17. Relinings and rebasings of existing removable Dentures,
    - if at least 6 months have passed since the installation of the existing removable Dentures, and not more than once in any 36-month period.

How Many / How Often

18. Repairs or Replacements — but not more than once in a 12-month period.
19. Adjustments of Dentures.
20. Tissue Conditioning, but not more than once in a 36-month period.
21. Prefabricated stainless steel crown or prefabricated resin crown, but no more than one replacement for the same tooth surface within 24 consecutive months.
22. Application of desensitizing medications where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed.
23. Emergency palliative treatment to relieve tooth pain.

Major Covered Services

1. Initial installation of full or removable Dentures:
   - when needed to replace congenitally missing teeth; or
   - when needed to replace natural teeth.
2. Replacement of a non-serviceable Denture if such Denture was installed more than 84-months prior to replacement.
3. Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary full Denture.
4. Initial installation of Cast Restorations.
5. Replacement of any Cast Restoration with the same or a different type of Cast Restoration but no more than one replacement for the same tooth surface within 84 months of a prior replacement.
6. Core buildup, but no more than once per tooth in a period of 84 months.
7. Posts and cores, but no more than once per tooth in a period of 84 months.
8. Implants but no more than once for the same tooth position in an 84-month period.
9. Repair of implants, but not more than once in a 12-month period.
10. Implant supported prosthetics but no more than once for the same tooth position in an 84-month period.
11. Repair of implant supported prosthetics, but not more than once in a 12-month period.
12. Labial Veneers limited to once in an 84-month period.
13. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
14. Diagnostic casts and study models.
15. Mouth guards for Bruxism (teeth grinding).

Orthodontic Covered Services

1. X-rays; 2. Study models; 3. Oral images; 4. Metal braces; 5. Placing braces; 6. Monthly visits; 7. Removal of braces; 8. Placing retainers; 9. Retainer visits; 10. Palatal expander; 11. Headgear; 12. Invisalign.

SUMMARY OF SERVICES NOT COVERED BY THE *PLAN*

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

- 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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- 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 which are primarily cosmetic;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by 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 piks, toothbrushes, or dental floss;
- Decoration 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 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;
- 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;
- Caries susceptibility tests;
- Fixed and removable appliances for correction of harmful habits;
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration or Denture;
- Repair or replacement of an orthodontic device;
- Diagnosis and treatment of temporomandibular joint disorders;
- Intra and extraoral photographic images.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy [(Policy form GPNP99)] issued by MetLife. Coverage terminates when your membership ceases; when your dental contributions cease; upon termination of the group policy by the Policyholder; for non-payment of premium; or, if participation requirements are not met. 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.

MetLife

Metropolitan Life Insurance Company
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