

# GIC Retiree Dental Plan Handbook



# MetLife



**Your Dental Benefit Plan**



# Commonwealth of Massachusetts

## RETIREE DENTAL PLAN offered through the Group Insurance Commission

Group Number: 144492

### Who can enroll in the GIC Retiree Dental Plan?

All Commonwealth of Massachusetts retirees, survivors, retired municipal teachers in the GIC RMT program, and Elderly Governmental Retirees and certain municipal retirees can enroll. Dependents of eligible retirees are eligible if they are covered under the retiree's GIC health plan. If you have questions about whether or not you or your dependents are eligible, please contact the Group Insurance Commission at 617-727-2310. If you have questions about the dental plan benefits, please call MetLife at 1-866-292-9990.

### When can you enroll?

You can enroll in the dental plan:

- Upon retirement
- When your COBRA Dental coverage ends
- During the GIC's Annual Enrollment
- When you become a survivor of a GIC member

### When does Coverage Begin?

Coverage begins the first of the month following acceptance by the GIC of a completed and signed enrollment form.

### When does coverage end?

Your insurance will end on the earliest of:

- the date the Group Policy ends;
- the date you cease to be eligible;
- the last day of the calendar month in which premium was paid.

**If you drop your Dental coverage, you will never be allowed to rejoin the Plan. Please see question 8 on page 3 for further details.**

### 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 144492. If you need a duplicate ID Card, please call 1-866-292-9990.

### What happens if my claims exceed the annual maximum of \$1,250?

You are responsible for any charges above the annual maximum. If you use a network dentist, you may continue to benefit from the negotiated fees, even after you exceed the \$1,250 annual plan maximum.

### Dental Plan Features

The GIC Dental Group number is **144492**.

The complete list of Covered Services with the maximum amounts payable is provided in this handbook.

The annual benefit maximum is \$1,250 per member, per calendar year.

Orthodontic Coverage is not available under the GIC Retiree Dental Plan.

Pre-treatment estimates are recommended for any treatment that costs more than \$300.

There are no individual or family deductibles.

# SUMMARY OF PRIMARY COVERED SERVICES

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

	<b>How Many/How Often</b>
Prophylaxis (cleanings) Oral Examinations Topical Fluoride Applications X-rays Sealants	<ul style="list-style-type: none"> <li>• Two cleanings per calendar year.</li> <li>• Two oral exams per calendar year.</li> <li>• Fluoride treatment for children once per calendar year to age 19.</li> <li>• One complete X-rays series or panoramic film: one every five years.</li> <li>• One bitewing X-rays series per calendar year: Single x-rays as required.</li> <li>• Sealants for children to age 19, once per permanent non restored molars in a 48 month period.</li> </ul>
Fillings Emergency/Palliative Dentures, Crowns and Bridges	<ul style="list-style-type: none"> <li>• Fillings – Amalgam (silver) fillings on all teeth;</li> <li>• Fillings – Composite (white) on front teeth; For the back teeth, plan pays for what would have been paid for an amalgam filling. All fillings are limited to one tooth in a 12 month period.</li> <li>• Procedures necessary to relieve acute pain.</li> <li>• Repairs and recementing to existing partial or complete dentures once every 12 months.</li> <li>• Relining and rebasing of existing removable partial or complete 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.</li> </ul>
Extractions Dentures, Crowns and Bridges Bridges and Dentures Endodontics General Anesthesia Periodontics	<ul style="list-style-type: none"> <li>• Simple extractions and other routine oral surgery.</li> <li>• Bridges, build ups, post and core replacements limited to once every 84 months.</li> <li>• Crown lengthening, once per site every five years.</li> <li>• Crowns over natural teeth, build ups, post and core replacements limited to once every 84 months.</li> <li>• Partial and complete dentures, replacement limited to once every 84 months.</li> <li>• Root canal therapy once per lifetime per tooth.</li> <li>• General anesthesia or intravenous (I.V.) sedation for complex surgical procedures.</li> <li>• Gingivectomies once every 24 months.</li> <li>• Periodontal scaling and root planing not more than once per quadrant in 24 months.</li> <li>• Osseous (bone) surgery once per quadrant every 36 months (bone grafts excluded).</li> <li>• Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during the calendar year.</li> </ul>

*If you use a PDP dentist, you may continue to benefit from the negotiated fees, even after you exceed the \$1,250.00 annual plan maximum.*

# COMMON QUESTIONS...IMPORTANT ANSWERS

## 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 Preferred Dentist Program. Negotiated 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, 2015, there were approximately 256,925 participating network 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](http://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 negotiated fees on non-covered services?

The in-network scheduled fees may extend to non-covered services, such as cosmetic dentistry or orthodontia, providing participants with savings on these non-covered services. 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.

## 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.

## Does this plan cover dental Implants?

Yes. Effective 7/1/2015 the dental plan will cover implants and implant related services.

## Can my dentist apply for the Preferred Dentist Program?

Yes. If your current dentist does not participate in the Preferred Dentist Program and you'd like to encourage him or her to apply to become a network dentist, tell your dentist to visit [www.metdental.com](http://www.metdental.com) or call 1-877-MET-3379 for an application. The 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](http://www.metlife.com/GIC) or request one by calling the toll free number 1-866-292-9990.

## What happens if I terminate my dental coverage?

If you and/or your dependent enroll in the dental plan and cancel coverage, re-enrollment will be prohibited.

\* Based on internal analysis by MetLife

\*\* Negotiated fees for non-covered services may not apply in all states. At the time this handbook was prepared, negotiated fees extended to non-covered services rendered in Massachusetts. Please contact our customer service toll free number 1-866-292-9990.

## SERVICES NOT COVERED BY THE *PLAN*

### We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. 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;
5. services which are primarily cosmetic, (For residents of Texas, see notice page section).
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. 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;
14. services covered under other coverage provided by the Policyholder;
15. temporary or provisional restorations;
16. temporary or provisional appliances;
17. prescription drugs;
18. services for which the submitted documentation indicates a poor prognosis;
19. 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;
20. caries susceptibility tests;
21. fixed and removable appliances for correction of harmful habits;
22. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
23. precision attachments associated with fixed and removable prostheses;
24. duplicate prosthetic devices or appliances;
25. replacement of a lost or stolen appliance, Cast Restoration or Denture;
26. repair or replacement of an orthodontic device;
27. diagnosis and treatment of temporomandibular joint disorders;
28. intra and extraoral photographic images.
29. Orthodontia.

**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.

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
00120	Periodic Oral Evaluation	\$32.00
00140	Limited Oral Evaluation - problem focused	\$50.00
00145	Oral Evaluation for patient under age of 3	\$33.00
00150	Comprehensive Oral Evaluation - new or established patient	\$50.00
00160	Detailed and Extensive Oral Evaluation - problem focused, by report	\$52.00
00170	Limited Oral Re-evaluation - problem focused	\$32.00
00180	Comprehensive Periodontal Evaluation - new or established patient	\$50.00
00210	Intraoral - complete series (including bitewings)	\$99.00
00220	Intraoral - periapical first film	\$18.00
00230	Intraoral - periapical each additional film	\$15.00
00240	Intraoral - occlusal film	\$28.00
00250	Extraoral - first film	\$32.00
00260	Extraoral each Additional Film	\$24.00
00270	Bitewing - single film	\$16.00
00272	Bitewings - two films	\$32.00
00273	Bitewings - three films	\$39.00
00274	Bitewings - four films	\$47.00
00277	Vertical Bitewings - 7 to 8 films	\$45.00
00290	Skull/Facial Bone X-Ray	\$62.00
00330	Panoramic Film	\$79.00
00350	Oral/Facial Images	\$69.00
00415	lab test - collection of microorganisms for culture and sensitivity	\$40.00
00421	lab test - genetic test for susceptibility to oral diseases	\$18.00
00460	Pulp Vitality Tests	\$40.00
00470	Diagnostic Casts	\$68.00
01110	Prophylaxis - Adult	\$77.00
01120	Prophylaxis - Child	\$59.00
01203	Topical Application of Fluoride (Prophylaxis Not Included) - Child to age 14	\$26.00
01204	Topical Application of Fluoride (Prophylaxis Not Included) - Age 15 to 19	\$26.00
01206	Topical Fluoride Varnish	\$26.00
01351	Sealant - Per Tooth	\$40.00
01510	Space Maintainer - Fixed - Unilateral	\$84.00
01515	Space Maintainer - Fixed - Bilateral	\$140.00
01520	Space Maintainer - Removable - Unilateral	\$95.00
01525	Space Maintainer - Removable - Bilateral	\$149.00
01550	Recementation of Space Maintainer	\$20.00
02140	Amalgam - One Surface, Primary or Permanent	\$56.00
02150	Amalgam - Two Surfaces, Primary or Permanent	\$71.00
02160	Amalgam - Three Surfaces, Primary or Permanent	\$86.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
02161	Amalgam - Four or More Surfaces, Primary or Permanent	\$92.00
02330	Resin-Based Composite - One Surface, Anterior	\$64.00
02331	Resin-Based Composite - Two Surfaces, Anterior	\$88.00
02332	Resin-Based Composite - Three Surfaces, Anterior	\$109.00
02335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$116.00
02390	Resin-Based Composite Crown, anterior	\$116.00
02391	Resin-Based Composite - one surface, posterior	\$64.00
02392	Resin-Based Composite - two surfaces, posterior	\$81.00
02393	Resin-based Composite, three surfaces, posterior	\$78.00
02394	Resin-Based Composite, four or more surfaces, posterior	\$92.00
02510	Inlay - Metallic - One Surface	\$50.00
02520	Inlay - Metallic - Two Surfaces	\$62.00
02530	Inlay - Metallic - Three or More Surfaces	\$77.00
02542	Onlay - Metallic - Two Surfaces	\$288.00
02543	Onlay - Metallic - Three Surfaces	\$339.00
02544	Onlay - Metallic - Four or More Surfaces	\$339.00
02610	Inlay - Porcelain/Ceramic - One Surface	\$50.00
02620	Inlay - Porcelain/Ceramic - Two Surfaces	\$62.00
02630	Inlay - Porcelain/Ceramic - Three or More Surfaces	\$77.00
02642	Onlay - Porcelain/Ceramic - Two Surfaces	\$288.00
02643	Onlay - Porcelain/Ceramic - Three Surfaces	\$339.00
02644	Onlay - Porcelain/Ceramic - Four or More Surfaces	\$339.00
02650	Inlay - Resin-Based Composite - One Surface	\$50.00
02651	Inlay - Resin-Based Composite - Two Surfaces	\$62.00
02652	Inlay - Resin-Based Composite - Three or More Surfaces	\$77.00
02662	Onlay - Resin-Based Composite - Two Surfaces	\$288.00
02663	Onlay - Resin-Based Composite - Three Surfaces	\$339.00
02664	Onlay - Resin-Based Composite - Four or More Surfaces	\$339.00
02710	Crown - Resin Based Composite (Indirect)	\$158.00
02712	Crown - 3/4 Resin Based Composite (Indirect)	\$158.00
02720	Crown - Resin With High Noble Metal	\$326.00
02721	Crown - Resin with Predominantly Base Metal	\$275.00
02722	Crown - Resin with Noble Metal	\$298.00
02740	Crown - Porcelain/Ceramic Substrate	\$385.00
02750	Crown - Porcelain Fused to High Noble Metal	\$385.00
02751	Crown - Porcelain Fused to Predominantly Base Metal	\$333.00
02752	Crown - Porcelain Fused to Noble Metal	\$356.00
02780	Crown - 3/4 Cast High Noble Metal	\$326.00
02781	Crown - 3/4 Cast Predominantly Base Metal	\$275.00
02782	Crown - 3/4 Cast Noble Metal	\$298.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
02783	Crown - 3/4 Porcelain/Ceramic	\$326.00
02790	Crown - Full Cast High Noble Metal	\$385.00
02791	Crown - Full Cast Predominantly Base Metal	\$333.00
02792	Crown - Full Cast Noble Metal	\$356.00
02794	Crown - Titanium	\$385.00
02910	Recent Inlay, Onlay, or Partial Coverage Restoration	\$37.00
02915	Recent Cast or Prefabricated Post and Core	\$37.00
02920	Recent Crown	\$37.00
02930	Prefabricated Stainless Steel Crown - Primary Tooth	\$70.00
02931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$70.00
02932	Prefabricated Resin Crown	\$70.00
02933	Prefabricated Stainless Steel Crown with Resin Window	\$84.00
02934	Prefabricated Esthetic Coated Stainless Steel Crown - primary tooth	\$84.00
02940	Sedative Filling	\$37.00
02950	Core Buildup, Including Any Pins	\$59.00
02951	Pin Retention - Per Tooth, in Addition to Restoration	\$21.00
02952	Cast Post and Core in Addition to Crown	\$116.00
02953	Each additional indirectly fabricated post - same tooth	\$55.00
02954	Prefabricated Post and Core in Addition to Crown	\$91.00
02957	Each additional prefabricated post - same tooth	\$26.00
02960	Labial Veneer (resin laminate) - chairside	\$125.00
02961	Labial Veneer (resin laminate) - laboratory	\$300.00
02962	Labial Veneer porcelain laminate) - laboratory	\$350.00
02971	Additional procedures to construct new crown under existing partial denture framework	\$47.00
02980	Crown Repair, by Report	\$78.00
03110	Pulp Cap - direct (excluding final restoration)	\$20.00
03120	Pulp Cap - indirect (excluding final restoration)	\$20.00
03220	Therapeutic Pulpotomy (Excluding Final Restoration)	\$46.00
03221	Pulpal Debridement, primary and permanent teeth	\$42.00
03230	Pulpal Therapy (restorable filling) - anterior, primary tooth (excluding final restoration)	\$84.00
03240	Pulpal Therapy (restorable filling) - posterior, primary tooth (excluding final restoration)	\$90.00
03310	Root Canal Therapy Anterior, excluding final restoration	\$199.00
03320	Root Canal Therapy Bicuspid, excluding final restoration	\$242.00
03330	Root Canal Therapy Molar, excluding final restoration	\$350.00
03331	Treatment of root canal obstruction; non-surgical access	\$60.00
03332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$120.00
03333	Internal root repair of perforation defects	\$100.00
03346	Retreatment of Previous Root Canal Therapy - Anterior	\$215.00

## LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
03347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$267.00
03348	Retreatment of Previous Root Canal Therapy - Molar	\$382.00
03351	Apexification/Recalcification - Initial Visit	\$41.00
03352	Apexification/Recalcification - Interim Medication Replacement	\$25.00
03353	Apexification/Recalcification - Final Visit	\$41.00
03410	Apicoectomy/Periradicular Surgery - Anterior	\$161.00
03421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$161.00
03425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$161.00
03426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$108.00
03430	Retrograde Filling - Per Root	\$54.00
03450	Root Amputation - Per Root	\$113.00
03920	Hemisection (Including Any Root Removal)	\$108.00
04210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$161.00
04211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Bounded Tooth Spaces Per Quadrant	\$47.00
04240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant	\$215.00
04241	Gingival Flap Procedure, Including Root Planing - one to three contiguous teeth or bounded teeth spaces, per quadrant	\$129.00
04245	Apically Positioned Flap	\$88.00
04249	Clinical Crown Lengthening - Hard Tissue	\$226.00
04260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$377.00
04261	Osseous Surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	\$226.00
04263	Bone Replacement Graft - First Site in Quadrant	\$89.00
04264	Bone Replacement Graft - Each Additional Site in Quadrant	\$81.00
04265	Biologic Materials to aid in soft and osseous tissue regeneration	\$124.00
04266	Guided Tissue Regeneration - restorable Barrier, per Site	\$188.00
04267	Guided Tissue Regeneration - Nonrestorable Barrier, per Site	\$188.00
04268	Surgical Revision Procedure - per tooth	\$168.64
04270	Pedicle Soft Tissue Graft Procedure	\$226.00
04271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$226.00
04273	Subepithelial Tissue Graft per tooth	\$262.00
04274	Distal or Proximal Wedge Procedure	\$106.00
04275	Soft Tissue Allograft	\$262.00
04276	Combined Tissue and Double Pedicle Graft, per tooth	\$228.00
04341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	\$63.00
04342	Periodontal Scaling and Root Planing - one to three teeth, per quadrant	\$38.00
04355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$28.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
04381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$30.00
04910	Periodontal Maintenance	\$43.00
05110	Complete upper denture	\$374.00
05120	Complete lower denture	\$374.00
05130	Immediate upper denture	\$396.00
05140	Immediate lower denture	\$396.00
05211	Partial upper denture resin base	\$315.00
05212	Partial lower denture resin base	\$315.00
05213	Partial upper denture cast metal frame	\$425.00
05214	Partial lower denture cast metal frame	\$425.00
05225	Partial upper denture flexible base (incl. clasps, rests and teeth)	\$425.00
05226	Partial lower denture flexible base (incl. clasps, rests and teeth)	\$425.00
05281	Removable unilateral partial denture - One Piece Cast Metal (Including Clasps and Teeth)	\$218.00
05410	Adjust complete upper denture	\$32.00
05411	Adjust complete lower denture	\$32.00
05421	Adjust partial upper denture	\$32.00
05422	Adjust partial lower denture	\$32.00
05510	Repair broken complete denture base	\$62.00
05520	Replace missing or broken teeth - complete denture (each tooth)	\$56.00
05610	Repair resin denture Base	\$60.00
05620	Repair Cast Framework	\$95.00
05630	Repair or Replace Broken Clasp	\$95.00
05640	Replace Broken Teeth - Per Tooth	\$52.00
05650	Add tooth to existing partial denture	\$86.00
05660	Add clasp to existing partial denture	\$86.00
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$159.00
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$159.00
05710	Rebase complete upper denture	\$159.00
05711	Rebase complete lower denture	\$159.00
05720	Rebase partial upper denture	\$155.00
05721	Rebase partial lower denture	\$155.00
05730	Reline complete upper denture chairside	\$112.00
05731	Reline complete lower denture chairside	\$112.00
05740	Reline partial upper denture chairside	\$99.00
05741	Reline partial lower denture chairside	\$99.00
05750	Reline complete upper denture lab	\$164.00
05751	Reline complete lower denture lab	\$164.00
05760	Reline partial upper denture lab	\$159.00
05761	Reline partial lower denture lab	\$159.00
05820	Interim partial upper denture	\$149.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
05821	Interim partial lower denture	\$149.00
05850	Tissue Conditioning upper denture	\$51.00
05851	Tissue Conditioning lower denture	\$51.00
05860	Overdenture - complete, by report	\$400.00
05861	Overdenture - partial, by report	\$340.00
06010	Endosteal Implant	\$376.00
06012	Placement of Interim Implant	\$369.00
06040	Epoosteal Implant 171	\$344.00
06050	Transosteal Implant 2	\$420.00
06053	Implant/Abutment supported removable denture for completely edentulous arch	\$492.00
06054	Implant/Abutment supported removable denture for partially edentulous arch	\$418.00
06056	Prefab Implant Abutment	\$52.00
06057	Custom Implant Abutment	\$76.00
06058	Implant Crown - Porcelain	\$249.00
06059	Implant Crown- Porcel-High Noble	\$269.00
06061	Implant Crown - Porcel Noble Metal	\$224.00
06062	Implant Crown - Cast High Noble	\$191.00
06064	Implant Crown - Cast Noble Metal	\$178.00
06065	Implant Crown - Porcelain	\$240.00
06066	Implant Crown - Porcelain-Metal	\$254.00
06067	Implant Crown - Metal	\$241.00
06092	Recement Crown	\$37.00
06093	Recement Fixed Denture	\$46.00
06104	Graft Implant Placement	\$89.00
06205	Pontic - indirect resin based composite	\$210.00
06210	Pontic - Cast High Noble Metal	\$373.00
06211	Pontic - Cast Predominantly Base Metal	\$322.00
06212	Pontic - Cast Noble Metal	\$345.00
06214	Pontic - Titanium	\$373.00
06240	Pontic - Porcelain Fused to High Noble Metal	\$367.00
06241	Pontic - Porcelain Fused to Predominantly Base Metal	\$322.00
06242	Pontic - Porcelain Fused to Noble Metal	\$345.00
06245	Pontic - porcelain/ceramic	\$345.00
06250	Pontic - Resin with High Noble Metal	\$322.00
06251	Pontic - Resin with Predominantly Base Metal	\$272.00
06252	Pontic - Resin with Noble Metal	\$294.00
06545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis	\$128.00
06548	Retainer - Porcelain/Ceramic for resin bonded fixed prosthesis	\$180.00
06600	Inlay, porcelain/ceramic, two surfaces	\$450.00
06601	Inlay, porcelain/ceramic, three or more surfaces	\$450.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
06602	Inlay, cast high noble metal, two surfaces	\$65.00
06603	Inlay, cast high noble metal, three or more surfaces	\$81.00
06604	Inlay - Cast predominantly base metal, two surfaces	\$130.00
06605	Inlay - Cast predominantly base metal, three or more surfaces	\$170.00
06606	Inlay - cast noble metal, two surfaces	\$250.00
06607	Inlay - cast noble metal, three or more surfaces	\$250.00
06608	Onlay, porcelain/ceramic, two surfaces	\$320.00
06609	Onlay, porcelain/ceramic, three or more surfaces	\$375.00
06610	Onlay - cast noble metal, two surfaces	\$250.00
06611	Onlay, cast high noble metal, three or more surfaces	\$339.00
06612	Onlay - Cast predominantly base metal, two surfaces	\$130.00
06613	Onlay - Cast predominantly base metal, three or more surfaces	\$170.00
06614	Onlay - cast noble metal, two surfaces	\$125.00
06615	Onlay - cast noble metal, three or more surfaces	\$250.00
06624	Inlay -Titanium	\$240.00
06634	Onlay - Titanium	\$339.00
06710	Crown - Indirect resin based composite	\$160.00
06720	Crown - Resin with High Noble Metal	\$326.00
06721	Crown - Resin with Predominantly Base Metal	\$275.00
06722	Crown - Resin with Noble Metal	\$298.00
06740	Crown - (porcelain/ceramic)	\$326.00
06750	Crown - Porcelain Fused to High Noble Metal	\$385.00
06751	Crown - Porcelain Fused to Predominantly Base Metal	\$337.00
06752	Crown - Porcelain Fused to Noble Metal	\$356.00
06780	Crown - 3/4 Cast High Noble Metal	\$326.00
06781	Crown - 3/4 Cast Predominantly Base Metal	\$275.00
06782	Crown - 3/4 Cast Noble Metal	\$298.00
06783	Crown - 3/4 Porcelain/Ceramic	\$245.00
06790	Crown - Full Cast High Noble Metal	\$385.00
06791	Crown - Full Cast Predominantly Base Metal	\$333.00
06792	Crown - Full Cast Noble Metal	\$356.00
06794	Crown - Titanium	\$385.00
06920	Connector Bar	\$120.00
06930	Recement Fixed Partial Denture	\$46.00
06970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	\$116.00
06971	Cast Post as part of Fixed Partial Denture Retainer	\$91.00
06972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	\$91.00
06973	Core Buildup for Retainer, Including any Pins	\$59.00
06976	Cast Post - Each additional indirectly fabricated post - same tooth	\$35.00
06977	Steel Post - Each additional prefabricated post - same tooth	\$35.00
06980	Fixed Partial Denture Repair, by Report	\$86.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
07111	Extraction, Coronal Remnants - deciduous tooth	\$36.00
07140	Extraction, Erupted Tooth or Exposed Root	\$40.00
07210	Surgical removal of erupted tooth requiring elevation of Mucoperiosteal flap and removal of bone and/or section of tooth	\$59.00
07220	Removal of Impacted Tooth - Soft Tissue	\$89.00
07230	Removal of Impacted Tooth - Partially Bony	\$116.00
07240	Removal of Impacted Tooth - Completely Bony	\$143.00
07241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	\$154.00
07250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$79.00
07260	Fistula/Root Surgery	\$175.00
07261	Primary Closure of a Sinus Perforation	\$240.00
07270	Tooth replantation	\$100.00
07272	Tooth transplantation	\$80.00
07280	Surgical access of an unerupted tooth	\$120.00
07282	Mobilization of erupted or malpositioned tooth to aid eruption	\$110.00
07287	Cytology Sample	\$25.00
07288	Brush Biopsy	\$25.00
07290	Surgical repositioning of teeth	\$130.00
07310	Alveoloplasty, in Conjunction with Extractions - per quadrant	\$59.00
07311	Alveoloplasty in Conjunction with Extractions, one to three teeth or tooth spaces, per quadrant	\$35.00
07320	Alveoloplasty Not in Conjunction with Extractions - per quadrant	\$86.00
07321	Alveoloplasty Not in Conjunction with Extractions - one to three teeth or tooth spaces, per quadrant	\$52.00
07340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$300.00
07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$490.00
07450	Remove Oodontogenic CYST/Tumor - diameter up to 1.25 cm	\$150.00
07451	Remove Oodontogenic CYST/Tumor - diameter greater than 1.25 cm	\$300.00
07471	Removal of lateral exostosis	\$150.00
07472	Removal of Torus Palatinus	\$200.00
07473	Removal of Torus Mandibularis	\$175.00
07485	Surgical reduction of osseous tuberosity	\$130.00
07510	Incision and drainage of abscess - intraoral soft tissue	\$60.00
07511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$75.00
07520	Incision and drainage of abscess - extraoral soft tissue	\$95.00
07521	Incision and drainage of abscess - extraoral soft tissue (complicated)	\$100.00
07951	Sinus Augmentation-Lateral	\$272.00
07952	Sinus Augmentation-Vertical	\$272.00
07953	Bone Graft	\$89.00

# LIST OF COVERED SERVICES – MAXIMUM PAYMENT

Procedure Code	Description	Maximum Payment Effective July 2015
07960	Frenulectomy - separate	\$90.00
07963	Frenuloplasty	\$120.00
07970	Excision of Hyperplastic tissue	\$90.00
07971	Excision of Pericoronal gingiva	\$45.00
07972	Surgical reduction of fibrous tuberosity	\$135.00
09110	Palliative (Emergency) Treatment of Dental Pain, Minor Procedure	\$37.00
09220	Deep Sedation/General Anesthesia - first 30 minutes	\$81.00
09221	Deep Sedation/General Anesthesia - each additional 15 minutes	\$22.00
09241	Intravenous Conscious Sedation/Analgesia - first 30 minutes	\$76.00
09242	Intravenous Conscious Sedation/Analgesia - each additional 15 minutes	\$19.00
09310	Consultation	\$50.00
09610	Therapeutic Parenteral Drug - single administration	\$18.00
09612	Therapeutic Parenteral Drug - two or more administrations, different medication	\$18.00
09910	Application of desensitizing medicine	\$12.00
09911	Application of desensitizing resin	\$15.00
09951	Occlusal Adjustment - limited	\$25.00
09952	Occlusal Adjustment - complete	\$100.00

## EXAMPLES OF POTENTIAL SAVINGS

EXAMPLES OF POTENTIAL SAVINGS WHEN YOU USE A PARTICIPATING PDP DENTIST						
PROCEDURE	OUT-OF-NETWORK			IN-NETWORK		
	Dentist's Usual Charge	Plan Payment	Your Cost	PDP Fee	Plan Payment	Your Cost
#1110 - Cleaning	\$123.00	\$77.00	\$46.00	\$100.00	\$77.00	\$23.00
#2160 - Filling	\$263.00	\$86.00	\$177.00	\$150.00	\$86.00	\$64.00
<b>TOTAL for the Visit</b>	<b>\$386.00</b>	<b>\$163.00</b>	<b>\$223.00</b>	<b>\$250.00</b>	<b>\$163.00</b>	<b>\$87.00</b>

*If you had used a PDP dentist, you would have saved \$136.00*

*Let's assume you need a crown but you have already exceeded the plan's annual maximum benefits. No additional benefits are payable under the plan in the remainder of the calendar year*

PROCEDURE	OUT-OF-NETWORK			IN-NETWORK		
	Dentist's Usual Charge	Plan Payment	Your Cost	PDP Fee	Plan Payment	Your Cost
#2750 - Crown	\$1,785.00	\$0.00	\$1,785.00	\$999.00	\$0.00	\$999.00

*If you had used a PDP dentist, you would have saved \$786.00. You continue to benefit from the PDP Discounts, even when you have exceeded the plan's annual maximum of \$1,250.00. Negotiated fees for non-covered services may not apply in all states. 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 services toll free number 1-866-292-9990.*

# NOTES

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NOTES

**MetLife**

**Metropolitan Life Insurance Company**  
200 Park Avenue  
New York, NY 10166  
[www.metlife.com/GIC](http://www.metlife.com/GIC)



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