Employers Dental Trust©

SALES GUIDE

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MetLife

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About EDT

Employers Dental Trust is an innovative and flexible product for providing comprehensive dental insurance coverage for groups with 2 to 299 employees. EDT has exclusive pricing and plan offerings based on 30 years of experience in the small group dental market.

Special underwriting and rates apply to firms with 100+ eligible employees.

All benefits are subject to the provisions of the group policy under which the individual certificates of insurance are issued.

Underwriting, billing and administration for Employers Dental insurance plans are performed by AmWINS Group Benefits, Inc.

AmWINS Group Benefits, Inc. is one of the fastest growing administrators of employer group plans in the country. AmWINS has arranged a broad portfolio of quality group products specifically designed to meet the needs of employers and their employees.

Employers Dental Trust is insured by MetLife. MetLife has been in the insurance business since 1868. Their impressive industry rating are[1]:

- **A+ (Superior)** for financial strength and operating performance by **A.M. Best Company**.
  This is the second highest of A.M. Best's 16 ratings.
- **AA- (Very Strong)** for financial strength by **Fitch Ratings**.
  This is the fourth highest of Fitch's 19 ratings.
- **Aa3 (High Quality)** for general creditworthiness by **Moody's Investor Services**.
  This is the fourth highest of Moody's 21 ratings.
- **AA- (Very Strong)** for insurer financial strength by **Standard & Poor's**.
  This is the fourght highest of Standard & Poor's 22 ratings.

[1]For current ratings information and a more complete analysis of the financial strength of MLIC, please go to www.metlife.com and click on "About MetLife," "Ratings."

EDT Plan Highlights

- Choice of comprehensive **dental** plans designed to meet the needs of the employer and employee.
- MetLife's PDP Plus Network is available on all plans and offers your employees 373,802 access points. These dentists agree to negotiated fees on covered dental procedures, with no balance billing to patients. PPO available in most states. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or subsantially similar services.[1]
- To find a PDP Plus Network provider please go to metlife.com/dental.
- Out-of-network covered expenses for the **Traditional** and **Enhanced** Plans are based on Reasonable and Customary (R&C)[2] charges at the 90th percentile (what 9 out of 10 dentists in an area charge at or below the plan allowance for a covered procedure).
- Out-of-network claims reimbursement for the **MAC**[3] Plan is based upon the network allowance and out-of-network providers may balance bill patients for claim amounts in excess of the network allowance.
- Coverage may not be available in all states. Contact AmWINS Group Benefits, Inc. for exclusions.
- Comprehensive coverage for all EDT plans.
- Pre-estimate of benefits. If a dental exam reveals that treatment is expected to exceed $300, your dentist is encouraged to submit a pre-treatment estimate claim to **MetLife**. The request needs to describe the proposed treatment and itemize expected charges.
- All plans have the option to offer child-only orthodontia with 5+ enrolled employees.
- 12-month initial rate guarantee for all plans, and 24-month option available.
- Calendar year maximum re-set and deductible credit for qualifying takeover accounts.
- Annual Open Enrollment will be included for groups of 2-99 eligible employees

[1]Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

[2]The Reasonable and Customary charge is based on the lowest of the: "Actual Charge" (the dentist's actual charge); or "Usual Charge" (the dentist's usual charge for the same or similar services); or "Customary Charge" (the 90th percentile charge of most dentists in the same geographic area for the same or similar services as determined by MetLife). When the Actual Charge is greater than either the Usual or the Customary Charge but does not exceed the lower of either of these charges (Usual or Customary) by more than $15, the Actual Charge shall be deemed to be the Reasonable and Customary Charge.

[3]Complete description of MAC Plan can be found in "Plan Designs"

Group Eligibility & Underwriting

- Plans are available for groups of 2+ eligible employees.
- All cases are subject to final underwriting approval.
- Family Businesses: For groups with less than 10 eligible employees, no more than 75% of the group may be members of the same family (spouses, siblings, children and parents).
- Wage and tax statements will be required for non-California groups with more than 50% family members. DE-9C forms will be required for California groups that have greater than 50% family members. If one family, living in the same household, related by blood or marriage, comprises 50% or more of a prospective group, the group is not eligible.
- COBRA participants may not exceed 15% of the enrolled lives.
- Excluded Groups: Carve-out groups, dental offices, voluntary associations with no employer employee relationship, dental laboratories, private households and non-classifiable establishments.
- Retirees, part-time, temporary, seasonal, leased and independent contractors (1099) are not eligible for coverage.
- High Risk Industries[1] require prior approval from EDT.

Employer Contributions

Employer Sponsored	Employer pays 50%-100%
Voluntary	Employer pays less than 50%

Participation Requirements

- All employees who work at least thirty (30) hours a week on a permanent full-time basis are eligible to participate. Dependent child(ren) coverage goes to age 26.
- Employer Sponsored Plan - Employer paying 100% - All full-time employees and their spouses and dependent child(ren) must enroll in this plan. Spousal waivers will be considered with Underwriting approval.
- Employer Sponsored/Contributory Plan - Employer paying 50%-99%

Employee Participation

Number of Eligible Employees	Minimum Participation
2-5	100%
6	100% minus one
7-9	100% minus two
10+	60%* of eligible employees
*50% allowed with signed spousal waivers	

- Employees covered by their spouse's group dental plan are not considered eligible for these contributory participation requirements.
- Dependent Participation / Contributory Plans - 50% of eligible dependent units must be insured. Dependents covered under another group dental plan are not considered eligible for this plan.

Final rates for all plans are based on number of eligible employees.

Voluntary Plan Requirements

Number of Eligible Employees	100% employee paid
2-49	2 enrolled employees
50+	20% of eligible employees

Final rates for all plans are based on number of eligible employees.

Open Enrollment

Open enrollment allows employees who previously waived dental coverage to enroll themselves, or their previously eligible dependents, without late entrant penalties.

You will be able to enroll for insurance during the first annual open enrollment period. When you complete this enrollment process during the first annual enrollment period, such insurance will take effect on the first day of the month coincident with or next following the enrollment period, if you are active at work on that date.

During any subsequent annual enrollment period for dental insurance as determined by the Employer, you may enroll for insurance for which you are eligible. If you are not currently enrolled for Dental Insurance but you enroll or make changes to your insurance during a subsequent enrollment period, the Dental Insurance takes effect on the first day of the month following the enrollment period, if you are active at work on that date.

If you are not actively at work on the date insurance would otherwise take effect, then it will take effect on the day you resume active work.

Late Entrant

A late entrant is any person who becomes insured more than 31 days after he/she is eligible.
Once a late entrant becomes insured, the plan will pay for covered:

Type 1 (Preventive)	Immediately
Type 2 (Fillings)	After 6 months
Type 2 (All Other Basic Services)	After 12 months
Type 3 (Major)	After 12 months
Orthodontia	After 12 Months

These waiting periods will be waived if eligible employees or dependents (who initially waived coverage because they had coverage elsewhere) now enroll because their other coverage has terminated. Proof of prior coverage with the enrollment form is required.

Plan Designs

Employers Dental Trust offers three types of dental insurance plans. All plans offer in- and out-of-network benefits and offer savings through the nationwide MetLife PDP Plus Network.

Traditional Plan (Passive PPO)

Under the Traditional Plan, if an employee visits a participating dentist, they will lower their out-of-pocket costs as the provider has agreed to charge reduced fees. There are 373,802 access points. Employees can choose to see a dentist who is not within the network and will have their claims based upon the Reasonable and Customary (R&C) charge. The coinsurance on this plan is the same for both in- and out-of-network benefits which is 100/80/50%.

Enhanced Plan (Steerage PPO)

The Enhanced Plan has higher in-network coinsurance, allowing greater savings on services performed by a participating provider. Plan has coinsurance of 100/100/60%. The out-of-network benefits also are based upon the Reasonable and Customary (R&C) charges with coinsurances of 100/80/50%.

MAC Plan

The Maximum Allowable Charge (MAC) is associated with an in-network PPO provider. MAC is a **discounted fee per covered procedure** that's based on an area's ZIP code. PPO providers agree to charge only these discounted fees. The plan member is responsible for any deductible and coinsurance. Out-of-network reimbursement (or maximum allowable benefit) also is limited to the network allowance, and out-of-network providers may balance bill patients for claim amounts exceeding the network allowance.

MetLife PDP Plus Network Provider Lookup:

metlife.com/dental

Two Star Plan Summary

Deductible (Waived or Applied)	Calendar Year Deductibe Choose: $0, $25 or $50 per person. 3xFamily		No Deductible
Type 1 Preventive	**Type 2 Basic**	**Type 3 Major**	**Orthodontia Option**
Traditional/MAC Plan 100%	**Traditional/MAC Plan** 80%	**Traditional/MAC Plan** 50%	**Traditional/MAC Plan** 50%
Enhanced Plan 100% In-Network 100% Out-of-Network	**Enhanced Plan** 100% In-Network 80% Out-of-Network	**Enhanced Plan** 60% In-Network 50% Out-of-Network	**Enhanced Plan** 50%
• Periodic routine exams • Exams other than routine • Diagnostic services such as bitewings, panoramic X-rays • Prophylaxis (cleanings) • Fluoride under age 19 • Space maintainers	• Periapical X-rays • Diagnostic services - full mouth series • Minor restorative services such as amalgam, composite fillings, recementation • Prosthodontic services - repair • Oral surgery, Biopsy • Sealants	• Restorative services such as inlays/onlays, crowns, posts • Prosthodontic services such as bridges, dentures • **Endodontics** • **Periodontics** • Implants • General anesthesia	• Child-Only Ortho: 5+ lives
Calendar Year Maximum Choose: $1,000, $1,250, $1,500, $1,750 or $2,000 In and Out-of-Network claim allowance is at the 90th R&C or MAC.			Lifetime Maximum $1,000 $1,500 available for groups of 10+

Waiting Periods for Virgin Coverage

Employer-Sponsored Plans (50%-100% Employer Paid)

Type 1 & 2 (Preventive & Basic)	None
Type 3 (Major)	None
Orthodontia	None

Voluntary Plans (0%-49% Employer Paid)

Type 1 & 2 (Preventive & Basic)	None
Type 3 (Major)	None*
Orthodontia	None*

*Groups with less than 35% participation will have a 12 month waiting period for Type 3 (Major) and Orthodontia.

Three Star Plan Summary

Deductible (Waived or Applied)	Calendar Year Deductibe Choose: $0, $25 or $50 per person. 3xFamily		No Deductible
Type 1 Preventive	**Type 2 Basic**	**Type 3 Major**	**Orthodontia Option**
Traditional/MAC Plan 100%	**Traditional/MAC Plan** 80%	**Traditional/MAC Plan** 50%	**Traditional/MAC Plan** 50%
Enhanced plans only available with 10+ eligible employees.			
Enhanced Plan 100% In-Network 100% Out-of-Network	**Enhanced Plan** 100% In-Network 80% Out-of-Network	**Enhanced Plan** 60% In-Network 50% Out-of-Network	**Enhanced Plan** 50%
• Periodic routine exams • Exams other than routine • Diagnostic services such as bitewings, panoramic X-rays • Prophylaxis (cleanings) • Fluoride under age 19 • Space maintainers	• Periapical X-rays • Diagnostic services - full mouth series • Minor restorative services such as amalgam composite fillings, recementation • Prosthodontic Services - repair • **Endodontics** • **Periodontics** • Oral surgery, Biopsy • Sealants	• Restorative services such as inlays/onlays, crowns, posts • Prosthodontic services such as bridges, dentures • Implants • General anesthesia	• Child-Only Ortho: 5+ lives
Calendar Year Maximum Choose: $1,000, $1,250, $1,500, $1,750 or $2,000 In and Out-of-Network claim allowance is at the 90th R&C or MAC.			Lifetime Maximum $1,000 $1,500 available for groups of 10+

Waiting Periods for Virgin Coverage

Employer-Sponsored Plans (50%-100% Employer Paid)

Type 1 & 2 (Preventive & Basic)	None
Type 3 (Major)	None
Orthodontia	None

Voluntary Plans (0%-49% Employer Paid)

Type 1 & 2 (Preventive & Basic)	None
Type 3 (Major)	None*
Orthodontia	None*

*Groups with less than 35% participation will have a 12 month waiting period for Type 3 (Major) and Orthodontia.

Takeover Plan Requirements

- To qualify as a takeover, a group must have had prior coverage for 12 full months including coverage for Major services.
- To qualify for orthodontia takeover, a group must have had prior coverage with orthodontia for 12 months.

Evidence of Prior Coverage:

- Certificate or plan summary with Schedule of Benefits.
- The current prior carrier's bill. Prior insurance must be continuous with no gap in coverage.

Dental Terminology

Crowns
A tooth shade restoration usually covers the whole exposed (coronal) portion of a tooth. Crowns are made by a laboratory from impressions taken by a dentist. Crowns are frequently used in bridgework or to restore badly damaged teeth. Like fillings, crowns are available in many types - plastic, acrylic, gold, and porcelain in addition to stainless steel.

Dental Implant
A surgical component that interfaces with the jaw or skull to support a dental prosthesis such as a crown, bridge or denture.

Endodontics
Treatment of the dental pulp including root canal therapy.

Extractions
Simple extractions and surgical extractions of the natural teeth.

Fillings
Dental restoration inserted in the teeth. Most common fillings are:
1. Amalgam - used primarily in posterior teeth.
2. Composite Resin - tooth shade restoration used in anterior and posterior teeth

General Anesthesia
When medically necessary and administered in connection with oral surgery.

Periodontics
Treatment of diseases of gums and supporting structure of the teeth.

Prophylaxis
Professional cleaning and scaling of teeth. Benefits paid for one service performed in 6 months.

Prosthodontics
Installation of full and partial dentures (including 6-month post installation care) and fixed bridgework.

Sealants
Mechanically and/or chemically prepared enamel surface sealed to prevent decay.

Space Maintainers
An appliance used on a child after early loss of a first tooth. It prevents teeth from drifting while maintaining sufficient space for permanent tooth to emerge.

Topical Fluoride
Treatments during which a solution of sodium fluoride is applied to the teeth to help prevent tooth decay.

X-Rays
Intra-oral Radiographs
- Posterior-antero and lateral skull and facial bone - Survey Film
- Panoramic-maxillary and mandibular - Single Film

Covered Expenses

1. Covered Expenses refers to expenses incurred by you, your spouse or dependents when visiting a licensed dentist under the plan.
2. Covered dental services are to be provided by a dentist or under his/her direct supervision.
3. Expenses for dental services must be incurred while the insurance is in force.
4. Dates that various charges are incurred:
   For a crown, bridge or cast restoration, charges are incurred on the date the tooth is prepared. For other prosthetic devices, the charge is incurred on the date the master impression is made. For root canals, the charge is incurred on the date the pulp chamber is opened. And, for all other services, the charge is incurred on the date the services are performed.

Exclusions & Limitations

- 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 a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the 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 treatment.
- Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- 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.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services 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.
- 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.
- 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 and biting of food.
- Caries susceptibility tests.

Continued on following page

Exclusions & Limitations (continued)

- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Fixed and removable appliances for correction of harmful habits.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

IMPORTANT NOTE

This sales guide outlines standard benefit and plan provisions. All plans will comply with state-mandated benefits or plan provisions as applicable. This sales guide is a summary only and subject to the terms, conditions and limitations of the MetLife Group Policy under which the individual Certificates of Insurance are issued.

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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 MetLife or your plan administrator for costs and complete details.

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