MetLife

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Plan Name: SafeGuard Health Plans, Inc.
Type of Product Line: DHMO
Effective Date: Beginning on or after 7/30/2010

Name of Product: MET185
Plan Phone #: 800-880-1800
Plan Website: www.metlife.com

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND WHAT YOU WILL PAY FOR COVERED SERVICES. THIS IS A SUMMARY ONLY AND DOES NOT INCLUDE THE PREMIUM COSTS OF THIS DENTAL BENEFITS PACKAGE. PLEASE CONSULT YOUR EVIDENCE OF COVERAGE AND DENTAL CONTRACT FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. FOR MORE INFORMATION ABOUT YOUR COVERAGE, VISIT THE PLAN WEBSITE www.metlife.com OR CALL 800-880-1800.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	In-Network	Out-of-Network
Dental	None	None
Orthodontia	None	None

- **There is no deductible.**
- A **deductible** is the amount you are required to pay for covered dental services each plan year before the plan begins to pay for the cost of covered dental treatment.
- **In-network services** are dental care services provided by dentists or other licensed dental care providers that contract with your plan to provide dental services.
- **Out-of-network services** are dental care services provided by dentists or other licensed dental care providers that are not contracted with your plan.

Part III: MAXIMUMS PLAN WILL PAY

Maximums	In-Network	Out-of-Network
Annual Maximum	Not Applicable	Not Applicable
Lifetime or Annual Maximum for Orthodontia	Lifetime $0	Lifetime $0

- **Annual maximum** is the maximum dollar amount your plan will pay toward the cost of dental care within a specific period of time, usually a consecutive 12-month or calendar year period. **Not all services accrue to the annual maximum.**
- **Lifetime maximum** means the maximum dollar amount your plan providing dental benefits will pay for the life of the enrollee. Lifetime maximums usually apply to specific services, such as orthodontic treatment.

Part IV: WAITING PERIODS

Waiting Periods: A waiting period is the amount of time that must pass before you are eligible to receive benefits or services for all or certain dental treatments. **Your dental benefit package does not include a waiting period.**

Part V: WHAT YOU WILL PAY

All copayments and coinsurance costs shown in this chart apply after your deductible has been met, if a deductible applies. The Common Dental Procedures fit into one of the following applicable categories: Preventive & Diagnostic, Basic or Major. The Benefit Limitations and Exclusions column includes common limitations and exclusions only. For a full list, see the full disclosure document referenced in the Benefit Limitations and Exclusions column.

Common Dental Procedures	Category	In-Network	Out-of-Network	Benefit Limitations and Exclusions
Oral Exam	Preventive & Diagnostic	$0	Not Covered	Additional Exclusions and limitations apply. Refer to your Schedule of Benefits for a complete list.
Bitewing X-ray	Preventive & Diagnostic	$0	Not Covered	Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary.

Cleaning	Preventive & Diagnostic	$0	Not Covered	Limited to 2 per year unless medically necessary.
Filling	Basic	$10	Not Covered	
Extraction, Erupted Tooth or Exposed Root	Basic	$0	Not Covered	The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.
Root Canal	Basic	$200	Not Covered	Your cost for endodontic procedures does not include the cost of the final restoration.
Scaling and Root Planing	Basic	$40	Not Covered	Once per Quadrant in any 24 month period.
Ceramic Crown	Major	$225	Not Covered	• An additional charge will be applied for any procedure using noble or high noble metal. • $75 fee per crown unit above co-pay for porcelain on molars. • Replacement limit 1 every 5 years.
Removable Partial Denture	Major	$260	Not Covered	• Delivery of removable and fixed Prosthodontics includes up to 3 adjustments within 6 months of delivery date of service. • Relinings and rebasings are limited to one (1) every twelve (12) months. • Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. • Replacemen
Erupted Tooth with Bone Removal	Major	$30	Not Covered	The removal of asymptomatic third molars is not a covered benefit unless pathology (disease) exists.
Orthodontia	Orthodontia	$1695	Not Covered	• Plan benefits cover 24 months of usual and customary orthodontic treatment. • Retreatment of orthodontic cases is excluded.

Part VI: COVERAGE EXAMPLES

THESE EXAMPLES DO NOT REPRESENT A COST ESTIMATOR OR GUARANTEE OF PAYMENT. The examples provided represent commonly used services in the categories of Diagnostic and Preventive, Basic and Major Services for illustrative purposes and to compare this product to other dental products you may be considering. Your actual costs will likely be different from those shown in the chart below depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and the summary of excluded services under the plan.

Dana Has a Dental Appointment with a New Dentist	**Sam Needs a Tooth Filled**	**Maria Needs a Crown**
New patient exam, x-rays (full-mouth x-ray) and cleaning	Resin-based composite – one surface, posterior	Crown – porcelain/ceramic substrate

Dana's Visit	**Dana's Cost**	**Sam's Visit**	**Sam's Cost**	**Maria's Visit**	**Maria's Cost**
Total Cost of Care	In-network: $**400** Out-of-network: $**550**	Total Cost of Care	In-network: $**150** Out-of-network: $**200**	Total Cost of Care	In-network: $**1,300** Out-of-network: $**1,750**
Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable	Deductible	In-network: None Out-of-network: Not Applicable
Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: **Not Applicable**	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: **Not Applicable**	Annual Maximum (Plan Will Pay)	In-network: Not Applicable Out-of-network: **Not Applicable**

Dana's Visit	Dana's Cost	Sam's Visit	Sam's Cost	Maria's Visit	Maria's Cost
Patient Cost (copayment or coinsurance)	In-network: $0 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $30 Out-of-network: Not Covered	Patient Cost (copayment or coinsurance)	In-network: $225 Out-of-network: Not Covered
In this example, Dana would pay (includes copays/coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $550	**In this example, Sam would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network:** $30 **Out-of-network:** $200	**In this example, Maria would pay (includes copays/coinsurance and deductible, if applicable):**	**In-network: $**225 **Out-of-network:** $1,750
Summary of what is not covered or subject to a limitation:	• Full-mouth X-rays: Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary. • Cleaning: Limited to 2 per year unless medically necessary.	Summary of what is not covered or subject to a limitation:		Summary of what is not covered or subject to a limitation:	• An additional charge will be applied for any procedure using noble or high noble metal. • $75 fee per crown unit above co-pay for porcelain on molars. • Replacement limit 1 every 5 years.