MetLife

Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)

Part I: GENERAL INFORMATION

Insurer Name: MetLife
Policy Type: PPO
Effective Date: Beginning on or after 01/01/2022

Plan Name: J. PAUL GETTY TRUST
Insurer Phone #: 800-942-0854
Insurer 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 800-942-0854.

THIS MATRIX IS NOT A GUARANTEE OF EXPENSES OR PAYMENT.

Part II: DEDUCTIBLES

Deductible	All Providers
Dental	$50 per individual $150 per family

- **The deductible applies to the following services Basic, Major**
- 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	$2,000	$1,000 Yes, the cost-sharing will be higher. Contact your Plan.

Lifetime Maximum for Orthodontia	$2,000	$1,000 Yes, the cost-sharing will be higher. Contact your Plan.

- **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	Preventative & Diagnostic	0%, deductible does not apply	10%, deductible does not apply	• **For all procedures in this table, additional limitations and exclusions may apply. It is important to review the "Dental Insurance: Description of Covered Services" and "Dental Insurance: Exclusions" sections of your Certificate of Insurance for full details. In the event of a conflict with this document, the terms of your insurance certificate will govern. If you do not have access to the Certificate of Insurance, you may obtain this information directly from your employer or by calling Customer Service at the number listed on the first page of this document.** • Frequency limitations may apply

Bitewing X-ray	Preventative & Diagnostic	0%,deductible does not apply	10%, deductible does not apply	• Frequency limitations may apply
Cleaning	Preventative & Diagnostic	0%, deductible does not apply	10%, deductible does not apply	• Frequency limitations may apply
Filling	Basic	10%	30%	• Frequency and other limitations may apply to replacement fillings
Extraction, Erupted Tooth or Exposed Root	Basic	10%	30%	
Root Canal	Basic	10%	30%	
Scaling and Root Planing	Basic	10%	30%	• Frequency limitations may apply
Ceramic Crown	Major	50%	50%	• Replacement may be limited by age of existing crown • Exclusion may apply for replacement of lost or stolen crowns.
Removable Partial Denture	Major	50%	50%	• Replacement may be limited by age of existing crown • Relinings and rebasings of existing dentures may be limited based on time that has elapsed since installation of denture • Exclusions may apply to: • Initial installation or replacement teeth added to existing partial dentures to replace natural teeth that were missing prior to having coverage • Replacement of lost or stolen removeable partial dentures • Precision attachments • Adjustments within 6 months after installation by same dentist who provided removable partial dentures

Erupted Tooth with Bone Removal	Basic	10%	30%	
Orthodontia	Orthodontia	50%, deductible does not apply	50%, deductible does not apply	

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 (FMX) 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: Not Applicable Out-of-network: Not Applicable	Deductible	In-network: $50 Out-of-network: $50	Deductible	In-network: $50 Out-of-network: $50
Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000	Annual Maximum (Plan Will Pay)	In-network: $2,000 Out-of-network: $1,000
Patient Cost (copayment or coinsurance)	In-network: 0% Out-of-network: 10%	Patient Cost (copayment or coinsurance)	In-network: 10% Out-of-network: 30%	Patient Cost (copayment or coinsurance)	In-network: 50% Out-of-network: 50%

In this example, Dana would pay (includes copays/ coinsurance and deductible, if applicable):	**In-network:** $0 **Out-of-network:** $55	**In this example, Sam would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $60 **Out-of-network:** $95	**In this example, Maria would pay (includes copays/ coinsurance and deductible, if applicable):**	**In-network:** $675 **Out-of-network:** $900
Summary of what is not covered or subject to a limitation:	Frequency limitations may apply	Summary of what is not covered or subject to a limitation:	Replacement may be limited by age of existing denture Relinings and rebasings of existing dentures may be limited based on time that has elapsed since installation of denture Exclusions may apply to:Initial installation or replacement teeth added to existing partial dentures to replace natural teeth that were missing prior to having coverage Replacement of lost or stolen removeable partial dentures Precision attachments Adjustments within 6 months after installation by same dentist who provided removable partial dentures	Summary of what is not covered or subject to a limitation:	Replacement may be limited by age of existing crown Exclusion may apply for replacement of lost or stolen crowns.