Preferred Dentist Program

Introduction and Special Instructions
INTRODUCTION

MetLife’s Table of Maximum Allowable Charges or Fee Schedule applies to dental procedures performed on eligible members participating in MetLife’s Preferred Dentist Program (PDP). The allowances represent the maximum amount you are contractually allowed to collect from the plan participant for dental services rendered (including all amounts reimbursed by MetLife). These allowances may also be referred to as the “plan allowance.”

MetLife administers many different benefit plan designs, which result in various levels of benefit reimbursement and covered services. Whenever a participant receives any services from a participating dentist, the plan allowance applies. When the plan allowance is not reimbursed in full or in part by the benefit plan, any difference is the responsibility of the participant up to the plan allowance. The participant is not responsible for any amount that exceeds the plan allowance. Pretreatment estimates are strongly recommended to avoid misunderstandings regarding the maximum amount that can be billed to a participant for services, whether covered or not covered by the dental plan.

Not all dental procedures are reflected in the Table of Maximum Allowable Charges. Pre-treatment estimates are strongly recommended for services not listed to avoid misunderstandings regarding the maximum amount that can be billed to eligible members participating in the program. For procedures not listed in the Table of Maximum Allowable Charges, Dentist agrees to accept payment in an amount determined by MetLife, comparable to listed procedures of similar complexity and technique.

Submit your normal charges when sending claims to MetLife. Our claims payment system will adjust the fees so that the Explanation of Benefits (EOB) shows both the submitted charge and the allowable charge. This allows MetLife to maintain accurate data for Reasonable and Customary charges and your usual charge on our claim payment system. When your usual charge for a procedure is lower than the plan allowance, your usual charge will become the maximum amount you may bill a participant. Claims should be submitted regardless of if the office feels there will be coverage or not. This helps the patient understand the co-payment due for the dental services provided.

When a service is denied and the reason for denial is considered “integral to another dental service”, the participating dentist agrees to the negotiated fee as adjudicated and cannot charge the participant for the denied integral service.

Plan participants may not always inform a dental office of their participation in the MetLife PDP program. However, you should understand that our claim payment system automatically recognizes both the dentist’s and the member’s participation in the program and determines applicable plan allowances when the claim is processed. The EOB will reflect the appropriate plan allowances and the dental office should adjust its records accordingly when billing the participant. If benefits have been assigned to the dental office, the EOB will assist the dental office by showing participation and level of reimbursement. This will help avoid any confusion regarding the billing. It is important to remember that benefits are determined based on the date services are rendered, regardless of when they are submitted for payment. Plan designs are subject to change.

QUALITY INITIATIVES

MetLife’s Quality Initiatives Program (QIP)
The mission of the QIP is to assist dentists in promoting the oral health of their patients through education and research. MetLife is accomplishing this through dentist and patient education and communication, as well as industry feedback and oversight by our Dental Advisory Council.

Continuing Education - ADA / CERP Recognized Continuing Education (CE) Credits are available at NO CHARGE to dentists and office staff participating in the program. Simply log on to www.metdental.com to access the continuing education opportunities available. Review the guide(s) and once you are familiar with the topic(s), you can take the online post-test. Upon successfully passing a post-test, you will have immediate access to your CE certificate. MetLife will keep your certificate(s) on file electronically until it’s time for your license renewal then you can print them all at once.
MetLife’s Oral Health Library is an online (www.oralfitnesslibrary.com) resource for patients that include educational content and tools. In addition to MetLife-produced material, the library contains articles and information from the National Institutes of Health, the American Academy of Periodontology, and the National Institute of Dental and Craniofacial Research. To assist you in helping patients understand their risk for dental disease, a comprehensive dental health risk assessment (HRA) is available on the Oral Health Library. Patients, who complete on the online HRA, are encouraged to print and bring their results to their next dental visit.

Patient Risk Assessment Guides can help patients understand their risk for dental disease. These guides are located online at www.oralfitnesslibrary.com. They may be helpful to you and your patients when discussing appropriate prevention or treatment options. Guides available:

- Childhood Tooth Decay Risk Guides
- Are You at Risk for Tooth Decay?
- Are You at Risk for Periodontal Disease?

Multi-Language Health History Forms - MetLife offers access to health history forms in 40 different languages to address the needs of patients and dentists who do not speak the same language. Each health history form has the same questions and numbering sequence. This means that if you speak English and a patient who speaks Vietnamese comes to your practice, you can access a health history form in Vietnamese for your patient to complete. You can compare the patient’s answers to your English version. Access the Multi-Language Health History Forms library 24 hours a day at www.metdental.com in the resource center section or at www.oralfitnesslibrary.com in the tools section.

- Go to www.metdental.com
- Click Resource Center
- Click Tools for Dentists and Office Staff
- Click Multi-Language Health History Forms

CLAIM SUBMISSION

ELECTRONIC CLAIMS

MetLife encourages the submission of electronic claims and electronic attachments. Submitting electronically reduces the risk of manual data entry errors and delays that can be caused by routing paper claims. Plus, you’ll get claim verification and notification if additional information is needed. Our Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) program simplifies and streamlines the account management and enrollment process for providers. MetLife provides dental offices with EnrollHub™, the solution from nonprofit alliance CAQH that enables you to sign up for EFT and ERA with multiple payers at one time. For information on how to get started with electronic claims, go to www.metdental.com or call 1-877-MET-DDS9 (1-877-638-3379).

PAPER CLAIMS: The general claims address for mailing paper claims is:
MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

SPECIAL INSTRUCTIONS

FASTFAX BENEFIT SUMMARY*

A customized summary that provides information about a patient’s benefit plan can be faxed to your office by calling the dedicated toll-free provider customer service number 1-877-MET-DDS9 (1-877-638-3379). Our computer voice response system will request the eligible employee’s nine-digit ID number. If your fax machine is busy or off, the system will try 5 times before abandoning the transmission.

* A small percentage of customers have unique plan designs that cannot be accommodated through this service

PRE-TREATMENT ESTIMATES

Pre-treatment estimates are strongly recommended for crowns, inlays, onlays, veneers, fixed bridgework, implants, implant prosthetics, periodontal treatment and any time charges are expected to exceed $300.00. The process can be a useful tool in providing the plan participants with an estimate of their out-of-pocket expenses, whether a service is covered or not covered by the dental plan, or if an alternate benefit will be applied. This can help avoid any potential billing disputes.
Information regarding specific plan design information can generally be obtained by contacting MetLife through www.metdental.com or over the phone at 1-877-METDDS0 (638-3379). Most dental plans administered by MetLife pay benefits for restorative, prosthetic, periodontal or surgical services only when there is evidence of dental necessity as validated by the submitted clinical documentation associated with the claim or pre-estimate.

Additionally, in cases where there is more than one course of treatment that meets generally accepted dental standards, most plans consider benefits for the least expensive alternate treatment that meets generally accepted standards of care. **These benefit determinations are not intended to be, nor should they be construed as, treatment decisions.** All choices with respect to treatment are left to the participant and dentist. If a more expensive treatment is provided, the participant will be responsible for any differences between the plan allowance for actual treatment rendered and the benefit amount issued. Actual payments may vary depending upon annual maximums, annual deductibles, plan frequency limitations, plan exclusions, and other plan limits at the time of payment.
NON-COVERED PROCEDURES: A procedure could be a covered service under one plan and a non-covered service under another plan. The plan allowance applies in both situations (except as noted in Appendix A for certain states) and a participant cannot be billed any amount in excess of the plan allowance. Many situations may cause a service to not be covered, but regardless of the reason, the allowance applies. The plan allowance applies to all services rendered to dental plan participants and their eligible dependents whether or not the service is covered under the applicable plan.

- **Exclusion:** Dental Services not covered under a particular dental benefit program. (Certain states** have laws that allow the dentist to charge their original fee for non-covered expenses.)
- **Non-covered:** These are services that are declined for benefits based upon a patient’s plan such as but not limited to a frequency limitation but are still subjected to the MetLife PDP fee as by definition they are covered but not payable due to the plan limits.

*Pre-treatment estimates are strongly recommended to avoid any misunderstandings regarding the applicable benefit payment.

** Refer to Appendix A

UNBUNDLED/INTEGRAL PROCEDURES: If it is determined by MetLife that the submitted CDT services were unbundled then they will be rebundled to the appropriate CDT service code and the participating dentist can only charge the patient up to the rebundled CDT service contracted amount.

DUPLICATE PROCEDURES: If MetLife determines that a submitted service is a duplicate procedure then the dentist is not allowed to charge for the duplicate procedure. This includes but is not limited to when claims or estimates are submitted for multiple D9910 desensitizing medicaments which is a per visit service and not per tooth or for D2951 pin retention which is a per tooth service and not per pin.

ALTERNATE PROCEDURES DETERMINATION: If a benefit determination is made that an alternate dental service meets the plan design contract provisions then the participating dentist can only charge up to the contracted schedule amount for the originally submitted service. The plan benefit will be based upon the alternate procedure.

INFECTION CONTROL, LOCAL ANESTHESIA, and IRRIGATION: Infection control, local anesthesia, and irrigation (code D4921) are not considered a separate billable dental procedure or service and cannot be billed to a participant or to MetLife.

TRAY OR SURGICAL TRAY: Tray set-up or surgical tray preparation is not considered a separate billable dental procedure or service and cannot be billed to a participant or to MetLife.

MATERIALS AND LABORATORY COSTS: MetLife has taken into consideration the costs involved for materials and laboratory services when establishing the plan allowances for dental procedures. A participant cannot be billed a separate charge for materials and/or laboratory costs since MetLife considers them included in the services provided including Invisalign or any other specialized orthodontic system.

COORDINATION OF BENEFITS: In most cases, coordination of benefits (COB) occurs when a patient is covered by more than one dental benefits plan. One payer will be represented as the “primary carrier,” and benefits from that plan will be paid first. Then the “secondary carrier” will determine the benefits payable towards the remaining balance. To determine primary and secondary coverage for a patient, use the following steps:

- Identify if the patient has coverage under his/her employer. If the patient has dental coverage through his or her own employer, the patient’s plan is “primary coverage.” When the patient also has dental coverage under a spouse’s plan, then the spouse’s is the “secondary coverage.” For children covered under the plans of both parents, the primary coverage belongs to the parent whose birthday falls earlier in the calendar year.²

- If MetLife is the primary carrier, submit claims as you normally would. MetLife will process the claim based upon the full amount of the benefits that would normally be available under the plan.

- If MetLife is the secondary carrier, submit the claim to the primary carrier first. Submit a copy of the primary carrier’s Explanation of Benefits form to us. Most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.
In most cases, the total of all plan benefit payments is eligible for benefits under another PPO or dental plan in which you participate; you may not bill the patient more than the other PPO or plan's maximum allowable charge. When submitting your MetLife claim form, provide the primary carrier's fee-schedule fee and notify us of this relationship with the other carrier so we can evaluate our payment responsibility.

When state law or contractual requirements require MetLife to process a claim using a fee higher than the plan allowance, amounts payable in Coordination of Benefits cases in these circumstances that exceed the plan allowance may be paid directly to the participant rather than the Dentists regardless of any signed assignment of benefits agreement.

For the Federal Dental Plans, the MetLife fee will prevail regardless of the primary carrier status.

* Birthday refers only to the month and day in a calendar year, not the year in which the person was born.
* This rule is referred to as the “birthday rule.” It is also applied to parents with joint custody if no court order assigns responsibility for health care expenses to a particular party.

**DENTAL CLAIM REVIEW:** In certain circumstances, x-rays and other diagnostic information relevant to claims and pretreatment estimates are reviewed by licensed dentists, who provide consulting services to MetLife. Based on the documentation submitted, these dentists may make recommendations to MetLife to assist the claim staff in making benefit determination recommendations. For example, they may advise if there is a less expensive treatment that meets generally accepted dental standards of care that could be considered for benefit determination purposes. For some clinical scenarios a service may be listed as covered however dental claim review may recommend that an alternate dental service that is less costly and meets standards of care will be the covered benefit.

Diagnostic documentation is required for review by our dental consultant staff and should be included with initial claim submission and pre-treatment estimates involving but not limited to crowns, onlays, veneers, fixed bridgework, implants, implant prosthetics and periodontal treatment.

Occasionally, x-rays will be requested for procedures other than the ones specified above. Although digital x-rays and paper reproductions of x-ray images can be submitted, all x-rays submitted should be of good diagnostic quality, labeled clearly and dated. Duplicate x-rays and paper x-ray reproductions should be dated and labeled, indicating the “right” and “left” sides.

**PROCEDURES THAT REQUIRE SUPPORTING INFORMATION:** Refer to the following chart for guidance on when x-rays/information is needed for dental claim review. Your submission of x-rays should be the most recent available to you. MetLife does not require you to take x-rays that you did not require in your professional judgment. X-rays should be dated, labeled with patient name and R/L side and of diagnostic quality. These are general guidelines and MetLife may request x-rays for these or other procedure codes, as needed.

**Important Reminder:** MetLife will not mail back file or digital print X-rays sent in by dental offices to support claim consideration. If you are required to send supporting X-rays with a claim, please submit a duplicate and retain the originals for your files. **PHOTOCOPIES AND FAXES OF FILES SHOULD NOT BE SUBMITTED.** Photocopies or scans of paper images are okay, as are prints of digital images.

**WHAT TYPE OF SUPPORTING INFORMATION IS NEEDED?**

<table>
<thead>
<tr>
<th>Prosthesis services and implants</th>
<th>Code D4249</th>
<th>Crown, onlay, veneers and code D42.49</th>
<th>Recent dated pre-op x-rays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent dated pre-op x-rays of entire arch(s) and date of extraction(s)</td>
<td>For initial fixed bridges, implants, implant prosthetics and dentures, indicate extraction dates on the submitted claim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For replacement fixed bridges, implants, implant prosthetics and dentures, indicate the date of placement for the original fixed bridge, implants, implant prosthetics or dentures</td>
<td>Code D6080: submit a detailed clinical narrative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Code D3331</td>
<td>Treatment of Root Canal Obstruction; non-surgical; submit pre and post-operative x-rays showing the obstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codes D4270, D4273, D4275, D4276, D4277, D4278, D4283 and D4285</td>
<td>Soft Tissue Grafts; submit a narrative indicating location, nature &amp; extent of the mucogingival problem. Include dated periodontal charting and a narrative report indicating the amount of recession, the remaining amount of attached gingiva, and any history of progression for the tooth or teeth involved. Pretreatment radiographs are not required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If duplicate x-rays are submitted: Please indicate right or left.

Recent, Dated Preoperative X-Rays
- D2542 – D2544 Onlays
- D2642 – D2644 Onlays
- D2662 – D2664 Onlays
- D2710 – D2799 Crowns
- D2960 – D2962 Veneers
- D3460 Endo Implants
- D4249 Crown Lengthening
- D5862 Precision Attachments
- D6950 Precision Attachments

Recent, Dated Preoperative X-Rays of Entire Arch(es) and the Date(s) of Extraction(s)
- D5860 – D5861 Overdentures
- D6010 – D6199 Implants / Related Services
- D6210 – D6793 Bridgework

Recent, Dated Pretreatment Periodontal Charting as well as Full-Mouth X-Ray or Bitewings, if available
- D4210 – D4245 Periodontal Treatment
- D4260 – D4268 Periodontal Treatment
- D4274 Periodontal Treatment
- D4341 – D4342 Scaling and Root Planing
- D4381 Periodontal Treatment

CLAIM REVIEW APPEAL PROCESS
A participating dentist may, on a participant's behalf, submit an appeal of a benefit recommendation rendered by our dental consultants by following these guidelines, which will expedite the appeal process:
- Submit a copy of the original Explanation of Dental Benefits (EOB);
- Submit original and any additional diagnostic information;
- Submit a narrative report clearly identifying the reason for the appeal and indicating the dental necessity for the procedure.
Please be aware of the various components and required documentation elements of evaluations as per CDT below

**Periodic Oral Evaluation – established patient (D0120):** An evaluation performed on a patient of record to determine any changes in the patient’s dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. Report any additional diagnostic procedures separately. MetLife considers a non-emergency oral evaluation performed on eligible plan participants as a Periodic Oral Evaluation.

**Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver (D0145):** Diagnostic and preventive services performed for a child under the age of three, preferable within the first six months of the eruption of the first primary tooth, including recording the oral and physical health history, evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling of the child’s parent, legal guardian and/or primary caregiver.

**Comprehensive Oral Evaluation – new or established patient (D0150):** Used by a general dentist and/or a specialist when evaluating a patient comprehensively. This applies to new patients, established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient’s dental and medical history and a general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies. MetLife considers this evaluation to include the elements contained in the CDT descriptor. It will be allowed for the initial evaluation of a participant by either a general dentist or an appropriate specialist. MetLife will regard subsequent evaluations as a periodic oral evaluation procedure (0120).

**Comprehensive Periodontal Evaluation – new or established patient (D0180):** This procedure is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient’s dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation.

**Intraoral Complete Series of Radiographic Images (D0210):** For benefit determination purposes, MetLife considers a Complete Series of radiographic images (D0210) as: 9 or more periapical radiographic images (D0220 - D0230) with or without bitewing radiographic images (D0270 - D0274); or, vertical bitewings (D0277) with 4 or more periapical radiographic images, or with 3 or more additional bitewing radiographic images; or, a combination of panoramic film (D0330) and bitewing radiographic images or periapical radiographic images taken on the same date of service. Submission of any of the above combinations may result in a benefit determination for a D0210. Whenever we determine that a complete series of radiographic images has occurred, no additional allowance will be made for any periapicals, or bitewings, taken during that visit. The dentist should only bill the participant up to the plan allowance for a D0210. Panoramic radiographic images (D0330) and Complete Series of Radiographic Images (D0210) are not payable on the same date of service.

**Bacteriologic Studies (D0415):** Procedure D0415 cannot be billed as a separate charge to a participant when performed in conjunction with an oral evaluation or endodontic therapy. This fee does not include the charges for the independent laboratory's evaluation of the specimen.

**Pulp Vitality Tests (D0460):** Procedure D0460 submitted on the same date of service as an evaluation or performed in conjunction with root canal therapy cannot be billed as a separate charge to participants.
PREVENTIVE (D1000-D1999)

Infection Control: Infection control is not considered a separate billable dental procedure or service and cannot be billed to a participant or the plan.

RESTORATIVE (D2000-D2999)

Surface Combinations: When MetLife combines surfaces for restorations for benefit determination performed on the same tooth and same date of service, the dentist can only bill the participant for the approved code based upon current CDT code descriptions.

Composites on Molar Teeth: When a composite restoration is submitted on a molar tooth, MetLife may apply an alternate benefit of an equivalent amalgam restoration for payment determination based upon a specific plan design. The dentist may bill the participant any difference up to the plan allowance for the equivalent composite restoration provided.

Porcelain Fused to Metal Crown, All Porcelain Crown, or Onlay on Molar Teeth: When porcelain fused to metal crown or any type of veneer material is submitted on a molar tooth, MetLife may apply an alternate benefit of a full gold crown. The dentist may bill the participant any difference up to the plan allowance for the service actually rendered.

- Materials and Laboratory Costs
  MetLife has taken into consideration the costs involved for materials and laboratory services when establishing the plan allowances for dental procedures. There is no additional plan allowance and a participant cannot be billed a separate charge for materials and/or laboratory costs, including Cerec or any other specialized porcelain systems, since MetLife considers them included in the services provided.

Sedative Filling (D2940): Procedure D2940 cannot be billed to a participant when performed in conjunction with any restorative procedure or root canal therapy on the same tooth during the same participant visit.

Core Build-Up, including any pins (D2950): A Core Buildup should be submitted with a pretreatment estimate for the crown or with the service date of the final crown with a dated, labeled pre-treatment x-ray to ensure accurate determination of benefits. Core buildups may be payable based upon dental necessity when the permanent crown is inserted or as long as we have an approved pretreatment estimate.

Crown Removal: The removal of a crown is considered to be included in the cost of the other service being performed (i.e. re-cementation, replacement, etc.). Participants may not be billed separately for the crown removal.

ENDODONTICS (D3000-D3999)

Root Canal Therapy: The following procedure(s) cannot be billed as a separate charge to a participant when performed in conjunction with root canal therapy on the same tooth:
- Intra-operative treatment radiographic images (D0220/D0230)
- Pulp Testing (D0460)
- Sedative filling (D2940)
- Pulpotomy (D3220)
- Canal Preparation (D3950)
- Palliative Treatment (D9110)
- Surgical procedure for isolation of a tooth with rubber dam (D3910).

Pulp Cap – indirect (D3120) and direct (D3110) (excluding final restoration): Procedure in which nearly exposed pulp or exposed pulp is covered with a protective dressing to protect the pulp from additional injury and to promote healing and repair via formation of secondary dentin. This code is not to be used for bases and liners when all caries has been removed.

Treatment of Root Canal Obstruction; non-surgical access (D3331): In lieu of surgery, the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies, included but not limited to separated instruments, broken posts or calcification of 50% or more of the roots. A dated pre-treatment x-ray should be submitted for this procedure.
Apexification/Recalcification (D3351-D3353): This procedure is performed in (at minimum) three stages consisting of an initial visit, interim visit(s) and a final visit, which includes completed root canal therapy. It is important to submit all visits along with your fee for each stage to ensure accurate claim processing.

Canal Preparation and Fitting of Preformed Dowel or Post (D3950): Procedure D3950 cannot be billed as a separate charge to a participant when performed in conjunction with a post and core (D2952/D2954) or root canal therapy on the same tooth.

PERIODONTICS (D4000-D4999)

Per Quadrant Scaling/Root Planing: MetLife defines a full quadrant as 4 or more teeth for scaling/root planing. Procedures involving 1 to 3 teeth per quadrant will have their own CDT codes and fees. Quadrant indicators (UR, UL, LL, and LR) are required on claim submissions. MetLife will determine the benefit on a quadrant-related procedure for scaling/root planing based upon the number of teeth which require that procedure. This is based on our dental consultant's review of submitted documentation. If the benefit determination is for a partial quadrant procedure, you will be limited to bill the participant the fee for the lower of your submitted charge, or plan allowance, for a partial quadrant. The participant is only responsible for the partial quadrant scheduled amount if that is the final benefit determination.

MetLife provides benefits for the procedure being performed, regardless of the method(s) and instruments utilized. Use of lasers during dental procedures cannot be billed as a separate charge to the patient or MetLife.

Per Quadrant Periodontal Surgical Procedures: MetLife defines a full quadrant as 4 or more teeth, or bounded spaces for surgical procedures. Procedures involving 1 to 3 teeth, or bounded spaces, per quadrant will have their own CDT codes and fees. Quadrant indicators (UR, UL, LL, and LR) are required on claim submissions. MetLife will determine the benefit on a quadrant-related procedure for surgical procedures based on the number of teeth, or bounded spaces, which require that procedure. This is based on our dental consultant's review of submitted documentation. If the benefit determination is for a partial quadrant procedure, you will be limited to bill the participant the fee for the lower of your submitted charge, or plan allowance, for a partial quadrant. The participant is only responsible for the partial quadrant scheduled amount if that is the final benefit determination.

Periodontal Charting: MetLife considers periodontal charting part of the evaluation process and a participant cannot be billed a separate charge for periodontal charting.

Gingivectomy or Gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant (D4210): It is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. A participating dentist may not charge for the 4211 if performed on the same date of service/same tooth as a restorative procedure. When performed with a crown, it is considered part of the preparation for the crown. The participant may not be balance billed.

Gingivectomy or Gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant (D4211): It is performed to eliminate suprabony pockets or to restore normal architecture when gingival enlargements or asymmetrical or unaesthetic topography is evident with normal bony configuration. A participating dentist may not charge for the 4210 if performed on the same date of service/same tooth as a restorative procedure. When performed with a crown, it is considered part of the preparation for the crown. The participant may not be balance billed.

Gingival Flap Procedure, Including Root Planing – four or more contiguous teeth or bounded teeth spaces per quadrant (D4240): A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure — may include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, Widman surgery, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, and to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.
Gingival Flap Procedure, Including Root Planing – one to three contiguous teeth or bounded teeth spaces per quadrant (D4241): A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure — may include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fratured root, or external root resorption. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique code.

Crown Lengthening (D4249): A participating dentist may not charge for a 4249 if performed on the same date of service as the crown. The participant may not be balance billed.

Osseous Surgery (Including Flap Entry and Closure) – four or more contiguous teeth or tooth bounded spaces per quadrant (D4260): This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique code.

Osseous Surgery (Including Flap Entry and Closure) – one to three contiguous teeth or tooth bounded spaces per quadrant (D4261): This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4261 and should be reported using their own unique code.

Bone Replacement Graft – first site in quadrant (D4263): This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration of barrier membranes. Other separate procedures may be required concurrent to D4263 and should be reported using their own unique codes.

Bone Replacement Graft – each additional site in quadrant (D4264): This procedure involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure, wound debridement, osseous contouring, or the placement of biologic materials to aid in osseous tissue regeneration or barrier membranes. This code is used if performed concurrently with D4263 and allows reporting of the exact number of sites involved.

Biologic Materials to Aid in Soft and Osseous Tissue Regeneration (D4265): Biologic materials may be used alone or with other regenerative substrates such as bone and barrier membranes, depending upon their formulation and the presentation of the periodontal defect. This procedure does not include surgical entry and closure, wound debridement, osseous contouring, or the placement of graft materials and/or barrier membranes. Other separate procedures may be required concurrent to D4265 and should be reported using their own unique codes.

Guided Tissue Regeneration – resorbable barrier, per site (D4266): This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri-implant defects.

Guided Tissue Regeneration – non-resorbable barrier, per site (includes membrane removal) (D4267): This procedure does not include flap entry and closure, or when indicated, wound debridement, osseous contouring, bone replacement grafts, and placement of biologic materials to aid in osseous regeneration. This procedure can be used for periodontal and peri-implant defects.
Benefit Determination Guidelines for: Full Mouth Debridement (D4355): For benefit determination purposes, MetLife will reimburse claims for full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit as submitted and based upon the individual dental plan’s frequency limitation for this service. This procedure will be counted against the Dental Plan’s frequency limitation for a prophylaxis. D4355 is not to be completed on the same day as D0150, D0160 or D0180.

Localized Delivery of Antimicrobial Agents via a Controlled Release Vehicle into Disease Crevicular Tissue, per tooth (D4381): Code 4381 is by definition PER TOOTH, therefore the participating dentist may not charge per site.

Special Notes Regarding “Per Site” Periodontal Codes: MetLife has traditionally considered allowances for procedures D4263, D4264, D4266, D4267, and D4381 on the basis of one site = one tooth. Our documented fee data has been based on this. Therefore, future allowances will continue to be considered on this historical model. Procedures for soft tissue grafting have traditionally been considered on a “per site” basis. Our fee data has been based upon this established precedent and plan allowances for these procedures will therefore continue to follow this. For benefit determination purposes, MetLife considers tissue-grafting procedures (D4270, D4273, D4275, D4276, D4277, D4278, D4283 and D4285) that encompass 2 contiguous teeth or areas to be one site and therefore benefits will be determined accordingly.

Irrigation (code D4921): Irrigation is not included in the descriptor for Code D9630 and cannot be submitted for payment under this code. Irrigation (code D4921) is normally included within other services rendered to the participant and cannot be billed as a separate charge to a participant.

PROSTHODONTICS, REMOVABLE (D5000-D5899)

Initial and Replacement Dentures: For initial dentures, please indicate extraction dates on the submitted claim. For replacement dentures, please indicate date of fabrication of the original dentures on submitted claim.

Materials and Laboratory Costs: A participant cannot be billed a separate charge for materials and laboratory costs including specialized procedures or “upgraded” materials since they are included in the services provided.

Complete Denture Adjustments (D5410-D5411): For benefit determination purposes, MetLife considers all adjustments performed on complete/immediate dentures within the first 6 months to be a part of the total treatment of inserting the denture. A participant cannot be billed for an adjustment to the complete/immediate denture within the first 6 months following insertion of the denture. When a reline is performed on an immediate denture within the first 6 months of placement, a participant cannot be billed for the reline.

Partial Dentures (D5211-D5282)
The negotiated fee for partial dentures includes an allowance for all teeth and all clasps. A participant cannot be billed a separate charge for any additional teeth or clasps.

IMPLANT SERVICES (D6000-D6199)

Placement of Implants and Implant Prosthetics (crowns, bridges, dentures): MetLife recommends that pre-treatment estimates be submitted for these procedures to assist the participant and the dentist in treatment decisions. This will assist in determining to what extent implant services are covered under the dental plan, as well as determining the participant’s financial responsibility.

Bridge Removal: The removal of a bridge is considered to be included in the cost any other service being performed (e.g. Re-cementation, replacement, etc.). Participants may not be billed separately for the bridge removal.

PROSTHODONTICS, FIXED (D6200-D6999)

Diagnostic Documentation Requirements: Most recent dated and labeled, pre-operative x-rays of the remaining teeth in the respective complete upper or lower arch are required for fixed bridgework and should be included on initial claim submission and pretreatment estimates.
ORAL AND MAXILLOFACIAL SURGERY (D7000-D7999)

Tray/Surgical Tray: Tray set-up or surgical tray preparation is not considered a separate billable dental procedure or service and cannot be billed to a participant or to MetLife.

Bone Replacement Graft for Ridge Preservation – per site (D7953): Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g. clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used should be reported separately.

Repair of Maxillofacial Soft and/or Hard Tissue Defect (D7955): Reconstruction of surgical, traumatic, or congenital defects of the facial bone, including the mandible, may utilize autograft, allograft, or alloplastic materials in conjunction with soft tissue procedures to repair and restore the facial bones to form and function. This does not include obtaining the graft and these procedures may require multiple surgical approaches. This code does not include edentulous maxilla and mandibular reconstruction for prosthetic considerations. See Code D7950.

ORTHODONTICS (D8000-D8999)

The allowance for orthodontic treatment (including Invisalign, Bioliner and Myobrace, and any other specialized orthodontic system) represents the Maximum amount that a dentist can collect for each full course of orthodontic treatment rendered to a participant. This fee includes all appliances (except Herbst, which can be charged separately as long as the patient/parent agrees to it in writing), office visits and follow-up visits (including retention).

Other Orthodontic Services: Procedures D8670 and D8680 cannot be billed to a patient as a separate charge when the dentist has provided Limited, Interceptive or Comprehensive Treatment to the same participant.

Full Course of Orthodontic Treatment: This allowance represents the maximum amount that a dentist can collect for each full course of orthodontic treatment rendered to a participant. This fee includes all appliances, office visits and follow-up visits (including retention). There is no limitation on the total number of months necessary for orthodontic treatment.

The negotiated fee in effect at the time active treatment is started applies for the entire treatment time based on the appropriate plan allowance, regardless of any change in the participant's status as an eligible participant and regardless of any change in the provider's status.

To ensure quicker processing when submitting a claim for a full course of orthodontic treatment, submit the following information: Appropriate CDT code, your fee for the total treatment and the total projected treatment time. Under the current CDT code set, the initial orthodontic work-up services will be considered when valid CDT codes and your office charges are submitted. The combined total allowable charge for these services will be equal to the lesser of $250 and the total of the submitted charges for the work-up services.

ADJUNCTIVE GENERAL SERVICES (D9000-D9999)

Palliative (emergency) Treatment of Dental Pain: Palliative Treatment (D9110) cannot be billed to a participant as a separate charge when performed during the same visit with definitive treatment.

Regional Block Anesthesia (D9211): Generally, this procedure is included in the allowable charge for the specific service presented on the claim. Participating dentists cannot charge separately for this service.

Local Anesthesia (D9215): Local Anesthesia (D9215) done in conjunction with definitive treatment cannot be billed as a separate charge to a participant.

Other Drugs and/or Medicaments, by report (D9630): The plan allowance for code D9630 applies for the administration of the drug and/or medicaments. In most cases, actual drug charges would be considered under the participant's medical plan or prescription drug plan and not subject to a plan allowance. This code is not to be used to submit for irrigation per the CDT descriptor.
Application of Desensitizing Medicament (D9910): This service is not allowed with a filling, crown or bridge - If a participating dentist uses 9910 with a filling, it is considered part of the filling, crown or bridge and the participating dentist may not charge for it or balance bill the plan participant. Denied with a crown – If a dentist uses 9910 with a crown, it is considered part of the crown and the dentist cannot charge for it. Duplicate charges on the same date of service – A participating dentist can only charge for one (1) 9910 on the same date of service. This code is considered as a per-visit allowable charge.

Behavior Management (D9920): This code is payable as an allowable charge based on increments of 15 minutes to a maximum of one (1) hour.

Occlusal Adjustment – limited (D9951): May also be known as equilibration; reshaping the occlusal surfaces of teeth to create harmonious contact relationships between the maxillary and mandibular teeth. Presently includes discing/odontoplasty/enamoplasty. Typically reported on a “per visit” basis, this should not be reported when the procedure only involves bite adjustment in the routine post-delivery care for a direct/indirect restoration or fixed/removable prosthodontics.

Occlusal Adjustment – limited/complete (D9951-D9952): Procedures D9951 and D9952 cannot be billed to a participant in conjunction with the placement of restorations or prostheses. MetLife considers an occlusal adjustment as part of the restorative process when performed during the same participant visit.

Appendix A

Non-covered Services
Current as of June 1, 2018

The fee schedule may not apply to some or all non-covered services in the following states: Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.
We’re here to help.
Keep this MetLife Dental contact list handy when you need to reach us

<table>
<thead>
<tr>
<th>Contact Category</th>
<th>Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Provider Customer Service Line</td>
<td>1-877-MET-DDS9 (638-3379)</td>
<td>Our automated system can speak the information you need, or fax it to you via Fast Fax. Customer Service Consultants are available: Monday – Friday, 8AM – 11PM (ET).</td>
</tr>
<tr>
<td>Internet</td>
<td><a href="http://www.metdental.com">www.metdental.com</a></td>
<td>Designated Provider website; access to most of your dental benefits and plan questions. Not a registered user - Select the ‘register now’ link on the home page and follow the four (4) easy steps.</td>
</tr>
<tr>
<td>Participating Provider Service Line</td>
<td>1-866-438-5472</td>
<td>Application Status, Network Effective Dates, Copies of Standard Fee Schedules, Eligibility, and Claims</td>
</tr>
<tr>
<td>Application Materials</td>
<td><a href="http://www.metdental.com">www.metdental.com</a> - OR - 1-866-737-6895</td>
<td></td>
</tr>
</tbody>
</table>

**Reporting changes to your participating locations and/or associated dentists** - Promptly report any changes in practice name/DBA, address, NPI, tax identification number (a W-9 is required and must accompany the update request) and/or telephone number, to avoid delays in claim reimbursement. Making the change on a submitted dental claim form MAY NOT update MetLife’s claim payment system. You can submit a formal request to update your participating locations and/or associated dentists by calling 1-800-942-0854, or by sending an email to providervalidation@metlife.com. The subject line should read: **Provider Update.**