



**As a member of the Elks, a new Dental Benefits Program from MetLife is now available to you. Don't delay to enroll in this valuable benefit.**

Dear Member:

A good dental benefits plan can be an important part of good oral health. The Elks is providing you access to a flexible dental benefits plan underwritten by MetLife — because good dental benefits can help protect against unforeseen dental expenses.

**Your acceptance is guaranteed!**

**As an Elks Member, you cannot be denied for coverage. All Elks Members and their eligible family members can enroll, regardless of dental history.** This on-line document is intended for your general knowledge only and is NOT intended to provide complete enrollment information. For an enrollment package with complete plan information, including coverage, rates specific to your geographic area, and exclusions and limitations applicable to coverage you may contact your Elks Sponsored Dental Plan Administrator at 1-888-627-5899.

**Two options are available.**

Select the dental benefits plan that best meets your needs:

- **Plan Option 1 – High Plan** — Covers some of the major, more expensive procedures such as crowns and dentures in addition to preventive and basic services.
- **Plan Option 2 – Low Plan** — Covers preventive and basic dental treatment such as cleanings, X-rays and fillings.

**Flexible billing options to fit your needs.**

- You may select a billing option that fits your budget – Monthly, Quarterly, Semi-annually or Annually. Your initial bill will be quarterly, but you may elect an alternate billing mode at any time. You do not need to send any payment at this time of enrollment.

Monthly payment option requires setup of electronic funds transfer (EFT). All other payment modes (Quarterly, Semi-annually or Annually) will be billed.

Depending on plan experience, premiums may change on the plan anniversary date (January 1) for the entire group, but you cannot be singled out for a rate increase due to age, health or number of claims submitted.

Your initial bill may be pro-rated to January 1<sup>st</sup>. Thereafter, you will be billed for a full year of coverage.

**Elks Sponsored Dental Plan Rates**

These rates<sup>1</sup> are effective through December 31, 2011 and are an example of rates in area code 07111 in NJ. For specific rate information for your area call your administrator.

**Self**

	<b>Plan Option 1</b>	<b>Plan Option 2</b>
<b>Monthly*</b>	\$ 51.00	\$26.00
<b>Quarterly</b>	\$153.00	\$78.00

**Self + 1**

*(Spouse/Domestic Partner/Child)*

	<b>Plan Option 1</b>	<b>Plan Option 2</b>
<b>Monthly*</b>	\$101.00	\$ 52.00
<b>Quarterly</b>	\$303.00	\$156.00

**Self + Family**

*(Spouse/Domestic Partner/Children)*

	<b>Plan Option 1</b>	<b>Plan Option 2</b>
<b>Monthly*</b>	\$140.00	\$ 79.00
<b>Quarterly</b>	\$420.00	\$237.00

\*Requires setup of electronic funds transfer (EFT) if monthly payment, all other payment modes will be billed.

**Get the coverage you need, with the features you deserve.**

- **Competitive group rates.** Competitive costs with negotiated fees that are typically 15–45% less than the average fees charged by dentists in the same community when you visit a dentist in the MetLife Preferred Dentist Program (PDP).<sup>2</sup>
- **Freedom of choice** to visit any dentist, whether they're in our network or not. To find out if your dentist participates in the PDP network with more than 135,000 dentist locations, log on to [www.metlife.com](http://www.metlife.com) to use the dentist locator tool.
- **MetLife's negotiated** fees apply to non-covered services such as cosmetic and adult orthodontia, or services provided after the annual benefit maximum is exceeded.<sup>3</sup>
- **Educational tools and resources** that help you and your dentist make informed choices demonstrate our commitment to your oral health.
- **Little paperwork** and excellent service with easy access to pretreatment estimates, real-time claims processing<sup>4</sup> and 24-hour customer service by phone, fax or online.

**Enrolling is easy.**

- Review the information in this kit, which contains details on your Dental Benefits Plan.
- Complete and mail the enclosed enrollment form.

**More peace of mind.**

When you choose MetLife, you choose a partner that is committed to doing its best to help you meet your benefits needs. And with over 45 years of experience in offering dental benefits, we have the experience to understand what matters most to you.

For more information call the Elks Sponsored Dental Plan Administrator at 1-888-627-5899, Monday through Friday, 8:00 a.m. to 5:00 p.m. Central Time or go to [www.elksbenefits.com](http://www.elksbenefits.com) to learn more. Be sure to take advantage of this important membership benefit.



Michael F. Smith  
Grand Exalted Ruler

P.S. Good oral health means more than just an attractive smile. A visit to your dentist can help diagnose problems early on when treatment is simpler and less expensive. Proper dental care can ensure optimal oral health and will help keep your smile beautiful for a lifetime. Enroll today!

<sup>1</sup> Rates listed are based on your legal address. The address you use on the enrollment form should be the same as any correspondence regarding rates

<sup>2</sup> Savings from enrolling in a dental benefits plan will depend on various factors, including how often participants visit the dentist and the cost of services covered.

<sup>3</sup> Negotiated fees for non-covered services may not apply in all states.

<sup>4</sup> Transactions are in real-time except when systems are undergoing scheduled or unscheduled maintenance or interruption.

Coverage rates are reviewed and updated upon group renewal each year.

Like most group benefit programs, MetLife group benefit programs contain certain exclusions, exceptions, limitations, waiting periods, reductions and terms for keeping them in force. Please contact the Elks Sponsored Dental Plan Administrator for complete details.



## Dental Benefits

Savings, flexibility and service. For healthier smiles.

Plan Design for: Elks members

Original Plan Effective Date: 1/1/11

**For the savings you need, the flexibility you want and service you can trust.**

To help you enroll, the following pages outline your dental plan options and addresses any questions you may have.

Coverage Type	Option 1 - High		Option 2 - Low	
	In-Network <sup>1</sup>	Out-of-Network <sup>1</sup>	In-Network <sup>1</sup>	Out-of-Network <sup>1</sup>
Type A – Preventive	100% of PDP Fee <sup>2</sup>	100% of R&C Fee <sup>4</sup>	100% of PDP Fee <sup>2</sup>	100% of R&C Fee <sup>4</sup>
Type B – Basic Restorative	70% of PDP Fee	70% of R&C Fee	70% of PDP Fee	70% of R&C Fee
Type C – Major Restorative	50% of PDP Fee	50% of R&C Fee	0% of PDP Fee	0% of R&C Fee

Deductible	Option 1 - High		Option 2 - Low	
	In-Network <sup>3</sup>	Out-of-Network <sup>3</sup>	In-Network <sup>3</sup>	Out-of-Network <sup>3</sup>
Individual	\$75	\$75	\$75	\$75
Family	\$225	\$225	\$225	\$225

Annual Maximum Benefits	Option 1 - High		Option 2 - Low	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Per Person	\$1,500	\$1,500	\$750	\$750

- "In-Network Benefits" means benefits under this plan for covered dental services that are provided by a MetLife PDP Dentist.  
"Out-of-Network Benefits" means benefits under this plan for covered dental services that are not provided by a MetLife PDP Dentist.
- PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.
- Deductible for Option 1 applies to both Basic and Major services. Deductible for Option 2 applies to Basic services only.
- Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
  - The dentist's actual charge (the 'Actual Charge'),
  - The dentist's actual charge for the same or similar services (the 'Usual Charge') or
  - The usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the "Customary Charge"). For your plan, the Customary Charge is based on the 80th Percentile. Services must be necessary in terms of generally accepted dental standards.

You may only change plan options you are electing now at the end of your coverage period. Premium costs may change at any time, subject to terms of the group policy. If you cancel your coverage, you will not be able to re-enroll in the future.

## List of Covered Services & Limitations

### Option 1: Standard Offering

Type A - Preventive	How Many/How Often
Prophylaxis - Cleanings Oral Examinations Topical Fluoride Applications Full Mouth X-Rays Bitewing X-Rays (Adult/Child)	<ul style="list-style-type: none"> <li>• One cleaning (oral prophylaxis) in 6 consecutive months.</li> <li>• One oral exam in 6 consecutive months.</li> <li>• One fluoride treatment in 12 months for dependent children up to age 14.</li> <li>• Full mouth and panoramic x-rays: Once per 60 months</li> <li>• One set per calendar year for adults. One set in six consecutive months for children to age 14.</li> </ul>
Type B - Basic Restorative	How Many/How Often
Space Maintainers Sealants Periodontal Maintenance Filling Replacement	<ul style="list-style-type: none"> <li>• Space Maintainers for dependent children up to 14th birthday. Limited to one per lifetime per area.</li> <li>• One sealant per permanent 1st &amp; 2nd non-restored molar in 60 months of a dependent child up to 14th birthday.</li> <li>• Limited to 4 times in any year less the number of teeth cleanings received during such 12-month period.</li> <li>• Limited to 24 months</li> </ul>
Type C - Major Restorative (Option 1 Only)	How Many/How Often
Endodontics – Root Canal Periodontics – Non-Surgical  Periodontics – Surgical  Prefabricated Stainless Steel and Resin  Bridges and Dentures  Denture Relines and Rebase Denture Adjustment Consultation  Implants  Cast Restoration  Core Buildup Posts & Cores Tissue Conditioning	<ul style="list-style-type: none"> <li>• One per 24 months per tooth</li> <li>• Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period</li> <li>• Including gingivectomy, gingival curettage and osseous surgery -- limited to one surgical procedure per quadrant in any 36 month period.</li> <li>• Replacement crown: only for primary teeth, once per tooth in a 60 month period</li> <li>• Initial Installation of full or removable Dentures: (1) after the person was covered under The MetLife Dental Benefits program for 12 months; (2) when needed to replace congenitally missing teeth; or (3) when needed to replace natural teeth lost while the person receiving benefits was covered under the MetLife Dental Benefits program</li> <li>• Addition of teeth to a partial removable Dentures: (1) after the person was covered under The MetLife Dental Benefits program for 12 months; (2) when needed to replace congenitally missing teeth; or (3) when needed to replace natural teeth lost while the person receiving benefits was covered under the MetLife Dental Benefits program</li> <li>• Replacement of non-serviceable Denture if such Denture was installed more than 10 years prior to the replacement</li> <li>• Replacement of an immediate, temporary full Denture with a permanent full Denture if the immediate, temporary denture cannot be made permanent and such replacement is made within 12 months of the installation of the immediate, temporary full Denture</li> <li>• Repairs limited to once in a 12 month period.</li> <li>• Relines and rebases to existing removable Dentures are limited to one per 36 months (minimum is 6 months after initial installation)</li> <li>• Minimum is 6 months after initial installation; not more than once in any 12 month period</li> <li>• Limited to once in 12 consecutive months</li> <li>• Initial Installation of Implants once for the same tooth position in a 10 year period</li> <li>• Repair of implant supported prosthetics; limited to once in a 12 month period</li> <li>• Replacement of any Cast Restoration with same or a different type of Cast Restoration; limited to one replacement for the same tooth surface within 10 years of a prior replacement</li> <li>• Repair or re-cementing of Cast Restorations; limited to once in a 12 month period</li> <li>• Limited to once per tooth in a 10 year period</li> <li>• Limited to once per tooth in a 10 year period</li> <li>• Limited to once in a 36 month period</li> </ul>

\* **Alternate Benefits:** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. Please contact MetLife for details.

# List of Covered Services & Limitations

## Option 2: Standard Offering

Type A - Preventive	How Many/How Often
Prophylaxis - Cleanings Oral Examinations Topical Fluoride Applications Full Mouth X-Rays Bitewing X-Rays (Adult/Child)	<ul style="list-style-type: none"> <li>• One cleaning (oral prophylaxis) in 6 consecutive months.</li> <li>• One oral exam in 6 consecutive months.</li> <li>• One fluoride treatment in 12 months for dependent children up to age 14.</li> <li>• Full mouth and panoramic x-rays: Once per 60 months</li> <li>• One set per calendar year for adults. One set in six consecutive months for children to age 14.</li> </ul>
Type B - Basic Restorative	How Many/How Often
Space Maintainers  Sealants  Periodontal Maintenance  Filling Replacement	<ul style="list-style-type: none"> <li>• Space Maintainers for dependent children up to 14th birthday. Limited to one per lifetime per area.</li> <li>• One sealant per permanent 1st &amp; 2nd non-restored molar in 60 months of a dependent child up to 14th birthday.</li> <li>• Limited to 4 times in any year less the number of teeth cleanings received during such 12-month period.</li> <li>• Limited to 24 months</li> </ul>

\* **Alternate Benefits:** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

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## Exclusions

### 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 primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. 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.

**For NY Sitused Groups, this exclusion does not apply.**

6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
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 picks, toothbrushes, or dental floss.
11. Decoration, personalization 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 Employer, labor union, mutual benefit association, or VA hospital.

**For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**

14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
  - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the member, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
  - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law

**This exclusion only applies for North Carolina Sitused Groups.**

15. Services
  - for which the employer of the person receiving such services is not required to pay; or
  - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

**This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the member/or Dependent received benefits under that law.
 

**This exclusion only applies for Virginia Sitused Groups.**
17. Services:
  - 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.

**This exclusion only applies for Virginia Sitused Groups.**
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.
 

**Government Plan** means any plan, program, or coverage which is established under the laws or regulations of any government.

**The term does not include:**

  - any plan, program or coverage provided by a government as an employer; or
  - Medicare (**For Oregon, Maryland or Missouri Sitused Groups, this exclusion does not apply.**)
  - Medicaid (**This exclusion only applies for Oregon, Maryland or Missouri Sitused Groups**)
24. 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.
25. Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food.
 

**For NY Sitused Groups, this exclusion does not apply.**
26. Caries susceptibility tests.
27. Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
28. Other fixed Denture prosthetic services not described elsewhere in this certificate.
29. Precision attachments, except when the precision attachment is related to implant prosthetics.
30. Initial installation or replacement of a full or removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
31. Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
32. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
33. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
34. Implants supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
35. Fixed and removable appliances for correction of harmful habits.<sup>1</sup>
36. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.<sup>1</sup>
37. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.<sup>1</sup> Orthodontic services or appliances.<sup>1</sup>
38. Repair or replacement of an orthodontic device.<sup>1</sup>
39. Duplicate prosthetic devices or appliances.
40. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
41. Intra and extraoral photographic images.
42. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
43. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner", "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
 

**This exclusion only applies for Maryland Sitused Groups**
44. Major restorative services such as inlays, onlays, veneers, crowns, and Dentures. Denture means a fixed partial denture (bridgework), a removable partial denture, or removable full denture – applicable to Option 2 (Low Plan).

<sup>1</sup> Some of these exclusions may not apply. Please see your plan design and certificate for details. Like most group dental insurance policies, MetLife group insurance policies contain certain exclusions, waiting periods, reductions and terms for keeping them in force. Please contact MetLife for details.