



City of Northfield

Employer Sponsored Dental

Proposal produced on August 17, 2016
This quote is valid for 90 days from date of proposal

City of Northfield Rate Summary

Coverage	Participating Lives	Covered Volume	Rates	Annual Premium
Option 1- 100/80/50 1000 and 100/50/5 750 3815206				
Employer Sponsored Dental (per Employee Per Month)	75			
All Active Full Time Employees Electing High Plan				\$30,356
▪ Employee Only	24		\$41.70	
▪ Employee + Spouse	6		\$83.80	
▪ Employee + Child(ren)	2		\$90.06	
▪ Employee + Family	6		\$141.00	
All Active Full Time Employees Electing Low Plan				\$16,168
▪ Employee Only	22		\$20.30	
▪ Employee + Spouse	6		\$38.80	
▪ Employee + Child(ren)	0		\$56.09	
▪ Employee + Family	9		\$74.22	
Rates are guaranteed from January 1, 2017 - December 31, 2017				
2 nd year Rate Cap: The first year's renewal rates will not be increased by more than 6.0% above the current rates.				

Summary of Benefits

Dental Insurance - Option 1- 100/80/50 1000 and 100/50/5 750

Employer Sponsored Dental				
Class Description	All Active Full Time Employees Electing High Plan (30 Hours)		All Active Full Time Employees Electing Low Plan (30 Hours)	
	In-Network	Out-of-Network [‡]	In-Network	Out-of-Network [‡]
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile	Negotiated Fee Schedule	R&C 90th Percentile
Type A – Preventive	100%	100%	100%	100%
Type B – Basic	80%	80%	50%	50%
Type C – Major	50%	50%	5%	5%
Calendar Year Deductible applies to:	B & C	B & C	B & C	B & C
▪ Individual	\$50	\$50	\$50	\$50
▪ Family	\$150	\$150	\$150	\$150
	Aggregate	Aggregate	Aggregate	Aggregate
Calendar Year Maximum (applies to A,B,C services)	\$1,000	\$1,000	\$750	\$750
TMJ Lifetime Maximum	\$500	\$500	\$500	\$500

[‡] 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 (1) the dentist's actual charge (the 'Actual Charge'), or (2) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Employer Sponsored Dental	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
All Active Full Time Employees Electing High Plan				
▪ Employee Only	\$41.70	24	\$2,529	\$30,356
▪ Employee + Spouse	\$83.80	6		
▪ Employee + Child(ren)	\$90.06	2		
▪ Employee + Family	\$141.00	6		
▪ Total		38		
All Active Full Time Employees Electing Low Plan				
▪ Employee Only	\$20.30	22	\$1,347	\$16,164
▪ Employee + Spouse	\$38.80	6		
▪ Employee + Child(ren)	\$56.09	0		
▪ Employee + Family	\$74.22	9		
▪ Total		37		
Rates are guaranteed from January 1, 2017 - December 31, 2017 (12 months)				
2 nd year Rate Cap: The first year's renewal rates will not be increased by more than 6.0% above the current rates.				

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Standard (Flex))

Class Description: All Active Full Time Employees Electing High Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 12 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 12 months
▪ Sealants	▪ 1 per molar in 36 months for a child under age 16
▪ Space Maintainers	▪ No Limit for a child under age 16
▪ Fluoride	▪ 2 times in 12 Months for a dependent child under age 16
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ For a child under 19: 1 time in 1 calendar year ▪ Adult: 1 time in 1 calendar year
▪ Labs & Other Tests	
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Occlusal Adjustments	▪ 1 in 24 months
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings (includes coverage for composite fillings on molars)	
▪ Oral Surgery: Simple Extractions	
▪ General Services	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Consultations	▪ 1 in 12 months
▪ Root Canal	▪ 1 per tooth per lifetime
▪ Periodontal Maintenance	▪ 2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 per tooth in 60 months
▪ Crown Buildups / Post Core	▪ 1 per tooth in 60 months
▪ Repairs	▪ 1 in 24 months
▪ Recementations	▪ 1 in 24 months
▪ Dentures	▪ 1 in 60 months
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 60 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 60 months
▪ Inlays / Onlays / Crowns	▪ 1 replacement per tooth in 60 months
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Tissue Conditioning	▪ 1 in 60 months
▪ Pulpotomy	
▪ Pulp Capping	

▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ TMJ	

Exclusions	
All Active Full Time Employees Electing High Plan	
<ul style="list-style-type: none"> ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless such service is: required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or required for reconstructive surgery because of a congenital disease or anomaly of a Child which has resulted in a functional defect; or (For residents of Texas) 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. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ 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. ▪ 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.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Standard (Flex))

Class Description: All Active Full Time Employees Electing Low Plan	
TYPE A	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ Examinations	▪ 2 times in 12 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 2 times in 12 months
▪ Sealants	▪ 1 per molar in 36 months for a child under age 16
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	▪ Adult: 1 time in 1 calendar year
▪ Labs & Other Tests	
▪ Periapical X-Rays	
▪ Other X-Rays	
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▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Occlusal Adjustments	▪ 1 in 24 months
▪ Emergency Palliative Treatment	
▪ General Anesthesia	
▪ Resin Composite Fillings(includes coverage for composite fillings on molars)	
▪ Oral Surgery: Simple Extractions	
▪ General Services	
TYPE C	
<i>Benefits are payable immediately from the start date of an individual's benefits</i>	
▪ TMJ	

Exclusions
All Active Full Time Employees Electing Low Plan
<ul style="list-style-type: none"> ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless such service is: required for reconstructive surgery which is incidental to or follows surgery which results from a trauma, an infection or other disease of the involved part; or required for reconstructive surgery because of a congenital disease or anomaly of a

Child which has resulted in a functional defect; or (For residents of Texas) 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.
- Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
- 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.
- 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.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Implantology, including repairs.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.
- Pulp Capping.
- Periodontal Maintenance.
- Cast restorations – including inlays, onlays crowns.
- Prefabricated Crowns.
- Implant Supported Prosthetics.
- Repairs.
- Recementations.
- Crown Build-Ups – Post and Cores.
- Root Canal.
- Pulpotomy.
- Pulp Therapy
- Apexification and Recalcification.
- Periodontal Surgery.
- Non-Surgical Periodontal services including Scaling and Root planning.
- Dentures, including complete, partial and Overdentures.

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Base compensation, which may vary from case to case and may change if you renew your Products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business (number of Products sold or dollar value of premium) with MetLife. In addition, supplemental compensation may be payable to your Intermediary. Under MetLife's current supplemental compensation plan, the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on: (1) the number of Products sold through your Intermediary during a prior one-year period; (2) the amount of premium or fees with respect to Products sold through your Intermediary during a prior one-year period; (3) the persistency percentage of Products inforce through your Intermediary during a prior one-year period; (4) premium growth during a prior one-year period; (5) a fixed percentage of the premium for Products as set by MetLife. The supplemental compensation percentage will be set by MetLife prior to the beginning of each calendar year and it may not be changed until the following calendar year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our Products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your Products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (e.g., insurance and employee benefits exchanges, enrollment firms and platforms, consulting agreements, or reinsurance arrangements).

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