

A guide to your Explanation of Dental Benefits statement

Plan Participant EOB Guide



Explanation of Dental Benefits

This shows how we determined your benefits after a recent visit to the dentist. Please save this explanation for your taxes.

Go Green! Please visit www.metlife.com/mybenefits to register for paperless EOB delivery and confirm your email address for electronic delivery notifications.

1

Claim summary

Your dentist submitted	\$	160.00
MetLife paid your dentist	\$	98.00
You owe your dentist	\$	0.00

This is not a bill. You may receive a bill from your dentist. Please refer to the claim detail for more information.

2

Note: Because your Dentist is part of the Preferred network, all in network services are billed at a negotiated rate. This means your services cost \$62.00 less than your dentist non-negotiated rates. Your dentist has to honor the negotiated in-network fee.

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Have an Employee Spending Account?

If you are eligible / enrolled in the Employee Spending Account program, the unpaid portion of your Dental claim has been referred for further consideration.

3

We're here to help. Please visit us at metlife.com/mybenefits for additional information on your Dental Program, benefits, and claim details, or call 800-942-0854, Monday - Friday, 8am-11pm ET.

4

Your information

Name/Relationship

John A. Smith/Self

Name

John A. Smith

Employer

ABC COMPANY

Group

3333333

Claim

0001234567 89

Dentist

Dr. Pam Brown, DDS

Date processed

September 12, 2014

METLIFE
PO BOX 981282
EL PASO TX 79998

JOHN A. SMITH
123 MAIN STREET
ANYCITY, USA 00000

Name/Relationship: **Elys A. Argend/Self**
 Claim: **4090600001 99**
 Dentist: **Dr. Eric Berger, DDS**

Name: **Elys A. Argend**
 Employer: **HSBC BANK USA**
 Group: **0117000**

5 Plan overview

Individual - John A. Smith/Self



6 Claim detail

Date of service	Service code, description	7 Your dentist submitted	8 Your dentist submitted	9 Negotiated in-network fee	10 Allowed amount	11 100%	12 MetLife paid	13	14 You owe your dentist
09/11/14	D0150, Comprehensive oral evaluation	\$60.00	\$60.00	\$39.00	\$39.00	100%	\$39.00		\$0.00
09/11/14	D1110, Cleaning - adult	100.00	100.00	59.00	59.00	100%	59.00		0.00
15 Totals		\$160.00	\$160.00	\$98.00	\$98.00		\$98.00		\$0.00

16 Additional Information:

- Please review the services/supplies on this EOB. If you find that MetLife has paid for any services that you did not receive or that you were charged for by a health care professional you did not see, please contact the MetLife Fraud and Abuse Hotline at 1-800-462-6565.

17 Your rights if benefits are denied

While we always process claims according to the terms of your Employee Benefit Plan, you have the right to appeal our benefits decision up to two times at no cost to you.

Please send any request for review in writing within 180 days of the date on this explanation of benefits to:

MetLife Group Claims Review
 P.O. Box 14589, Lexington, KY 40512

In your request for a review, please include:

- Whether this is your first or second request for a review
- The reason you believe the claim for benefits was improperly denied
- Any comments, questions, documents or information that support your reason.

We'll review your claim within 30 days of receiving it and send you a clear, understandable explanation by mail or email. If we deny your first appeal in whole or in part, you may request a second-level appeal and we'll respond to that request within a 30-day time period.

How we promise a full and fair review

- The review will be made by someone who didn't make the initial review of your benefits, including anyone who reports to that person. If you're requesting a second review, the reviewer also won't be the person who conducted the first review.
- You have the right to request free copies of all documents, records and other information we used to evaluate your claim.
- If deciding an appeal relies at all on a medical judgment, we'll consult a health care professional with appropriate training and experience.
- If our benefits decision is based on an internal rule, guideline or other standard, you may request a copy of the document free of charge.
- If we determine that a procedure or treatment was unnecessary or experimental or had a similar exclusion or limit, you may ask us to provide an explanation of the scientific or clinical judgment free of charge.

What you can do after two appeals

If you're not satisfied with our decision after a second level appeal, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. You may also have rights under Section 502 (a) of ERISA to bring a civil action. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance agency.

Understanding your Explanation of Dental Benefits statement

- 1 — The **claim summary** provides a quick overview of the claim, including the dentist's submitted charges, amount MetLife paid you or the dentist and amount policyholder owes the dentist.
 - 2 — If needed, **notes** will be listed here based on different situations. For example, if services were rendered by an out-of-network dentist, we'll let the policyholder know they can save money by using a participating dentist.
 - 3 — **We're here to help** instructs policyholders where to go if they need more information about this claim.
 - 4 — The **your information** section includes the:
 - Patient's name followed by the patient's relationship to the policyholder — If the claim is for the policyholder, the relationship is listed as self. If the claim is for another family member, the relationship is listed as dependent.
 - Policyholder's name.
 - Name of policyholder's employer.
 - Group number — The number MetLife uses to identify the policyholder's employer.
 - Claim number.
 - Dentist's name.
 - Date the claim was processed.
 - 5 — The **plan overview** section gives the policyholder an overview of the status of important plan features, including:
 - The total amounts, how much has been paid to date and remaining balances for the plan deductible, procedure deductible, plan maximum and procedural maximum, if applicable.
- The **claim detail** section provides details for each service rendered, including:
- 6 — Date of service.
 - 7 — Service code, tooth #, surface, area, units, and description — Service code/description is the American Dental Association code and description that describes the treatment rendered. Tooth #/surface indicates the tooth and area on which treatment was performed (if applicable). Some services are measured in units delivered. If applicable, the number of units used would be indicated here.
 - 8 — Dentist submitted charge — The amount charged by the dentist.
 - 9 — Negotiated in-network fee — The fee participating dentists in your area have agreed to accept as payment-in-full for covered services. Your out-of-pocket costs should never be more than the difference between this amount and the plan benefit for all covered services. You may be responsible for any coinsurance amounts or deductibles required by your plan.
 - 10 — The allowed amount is the maximum allowable benefit amount that your plan will consider for this service.
 - 11 — The percentage at which the covered expense is payable.
 - 12 — Amount MetLife paid.
 - 13 — This field will be used to indicate when a deductible is taken or any other message related to the applicable service (i.e., charge not covered, duplicate bill, etc.).
 - 14 — The amount you owe your dentist for each service rendered.
 - 15 — A totals row, which includes the totals for your dentist's submitted charges, negotiated in-network fees, allowed amount, what MetLife paid, and the total amount you owe.
 - 16 — This section is reserved for **additional information** that needs to be conveyed to the policyholder.
 - 17 — The **notice to employees** provides information about handling adverse benefit determinations.

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