# Dental Insurance

Coverage that can help make it easier to visit a dentist and can help lower your dental costs.

## Network: PDP Plus

## Class Description: All Eligible Retirees in ET States

| | In-Network[1] % of Negotiated Fee[2] | Out-of-Network[1] 90% of R&C Fee** |
|---|---|---|
| **Coverage Type** | | |
| **Type A: Preventive** (cleanings, exams, X-rays) | 100% | 100% |
| **Type B: Basic Restorative** (fillings, extractions) | 90% | 90% |
| **Type C: Major Restorative** (bridges, dentures) | 60% | 60% |
| **Deductible†** | | |
| Individual | $50 (Applies to B & C) | $50 (Applies to B & C) |
| Family | $150 (Applies to B & C) | $150 (Applies to B & C) |
| **Annual Maximum Benefit** | | |
| Per Person | $4,000 (Applies to A, B & C) | $4,000 (Applies to A, B & C) |

**Child(ren)'s eligibility** for dental coverage is from birth up to age 19, age 26 if a full-time student.
**Late-enrollment waiting period:** There is a one-year waiting period for all services following date of request.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2]Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

[3]Your plan includes incentive provisions. Deductibles, plan maximums and/or co-insurance percentages may differ by plan member.
**R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife to Type A, B and C Services.

## List of Primary Covered Services & Limitations

The service categories and plan limitations shown represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

| Plan Type | How Many/How Often |
|---|---|
| **Type A — Preventive** | |
| 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 19 |
| Fluoride | 1 time in 12 months for a dependent child under age 19 |
| Full Mouth X-Rays | Once in 36 months |
| Bitewing X-Rays | For a child under 14: 1 time in 12 months<br>Adult: 1 time in 12 months |
| Periapical X-Rays | |
| Other X-Rays | |


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| Type B — Basic Restorative | |
|---|---|
| Amalgam Fillings | 1 replacement per surface in 24 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 36 month period |
| Repairs | 1 in 12 months |
| Labs & Other Tests | |
| Emergency Palliative Treatment | |
| General Anesthesia | |
| Resin Composite Fillings(includes coverage for composite fillings on molars) | |
| Pulpotomy | |
| Pulp Capping | |
| Pulp Therapy | |
| Apexification & Recalcification | |
| Periodontal Surgery – Soft & Connective Tissue Grafts | |
| Periodontics – Non-Surgical | |
| Oral Surgery: Simple Extractions | |
| Oral Surgery: Surgical Extractions | |
| Other Oral Surgery | |
| **Type C — Major Restorative** | |
| Consultations | 1 in 12 months |
| Prefabricated Crowns | 1 per tooth in 84 months |
| Crown Buildups / Post Core | 1 per tooth in 84 months |
| Recementations | 1 in 12 months |
| Dentures | 1 in 84 months |
| Dentures – Rebases / Relines | 1 in 36 months |
| Denture Adjustments | 1 in 12 months |
| Fixed Bridges | 1 in 84 months |
| Inlays / Onlays /Crowns | 1 replacement per tooth in 84 months |
| Tissue Conditioning | 1 in 60 months |
| Occlusal Adjustments | 1 in 12 months |
| General Services | |
| Harmful Habit Appliances | |
| Occlusal Guards / Bruxism Appliances | |

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## Exclusions

**This plan does not cover the following services, treatments and supplies:**

- 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. (For residents of Texas: Services which are primarily cosmetic unless 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.
- 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.
- For residents of 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 employee, 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.
- Services paid or payable 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.
- Implantology, including repairs.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.
- Orthodontia services or appliances.
- Repair or a replacement of an orthodontic appliance.
- Implant Supported Prosthetics.


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## Limitations

**Alternate Benefits:** Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. 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 plan's reimbursement for those services, and your out-of-pocket expense. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.

## Questions & Answers

**Q. Who is a participating dentist?**

**A.** A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.†

**Q. How do I find a participating dentist?**

**A.** There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

**Q. What services are covered under this plan?**

**A.** The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern.

**Q. May I choose a non-participating dentist?**

**A.** Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

**Q. Can my dentist apply for participation in the network?**

**A.** Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.†† The website and phone number are for use by dental professionals only.

**Q. How are claims processed?**

**A.** Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854

**Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?**

**A.** Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

**Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?**

**A.** Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.


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**Q. How does MetLife coordinate benefits with other insurance plans?**

**A.** Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, 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, subject to applicable law.

**Q. Do I need an ID card?**

**A.** No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

## Monthly Cost

The following monthly costs are effective through 12/31/2028. Your premium will be paid through convenient payroll deduction. The monthly costs shown below for “Employee + Spouse + Child(ren)” and “Employee + Family” include the cost for all eligible children.

| | | | |
|---|---|---|---|
| Employee Only | $50.09 | Employee + Child(ren) | $112.18 |
| Employee + Spouse | $101.68 | Employee + Family | $173.32 |

†Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.

Savings from enrolling in a dental benefits plan featuring the MetLife Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit a dentist, and the cost of services rendered.

††Due to contractual requirements, MetLife is prevented from soliciting certain providers.

*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations. Exclusions: The AXA Travel Assistance Program is available for participants in traveling status. Whenever a trip exceeds 120 days, the participant is no longer considered to be in traveling status and is therefore no longer eligible for the services. Also, AXA Assistance USA will not evacuate or repatriate participants without medical authorization; with mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home; or with infections under treatment and not yet healed. Benefits will not be paid for any loss or injury that is caused by or is the result from: pregnancy and childbirth except for complications of pregnancy, and mental and nervous disorders unless hospitalized. Reimbursements for non-medical services such as hotel, restaurant, taxi expenses or baggage loss while traveling are not covered. The maximum benefit per person for costs associated with evacuations, repatriations or the return of mortal remains is US$500,000. Treatment must be authorized and arranged by AXA Assistance’s designated personnel to be eligible for benefits under this program. All services must be provided and arranged by AXA Assistance USA, Inc. No claims for reimbursement will be accepted.

**Refer to your dental benefits plan summary for your out-of-network dental coverage.


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