# Dental

**Network: PDP Plus**

## PLAN OPTION 1
**Basic Option PPO Plan**

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A: Preventive (cleanings, exams)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Type B: Basic Restorative (fillings)</td>
<td>50%</td>
<td>50%</td>
<td>80%</td>
<td>70%</td>
</tr>
<tr>
<td>Type C: Major Restorative (bridges, dentures)</td>
<td>Not covered</td>
<td>Not covered</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Type D: Orthodontia</td>
<td>Not covered</td>
<td>Not covered</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Deductible†**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$50</td>
<td>$150</td>
</tr>
</tbody>
</table>

**Annual Maximum Benefit**

<table>
<thead>
<tr>
<th></th>
<th>Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$2,000</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**Orthodontia Lifetime Maximum**

<table>
<thead>
<tr>
<th></th>
<th>Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**Child(ren)’s eligibility** for dental coverage is from birth up to 12/31 of the year they turn age 26.

Negotiated Fee refers to the fees that in-network dentists have agreed to accept as payment in full, for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

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 usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

† Basic Option PPO plan - Applies only to Type B Services. High Option PPO plan - Applies only to Type B & C Services.

Deductibles & Maximums will cross accumulate for In and Out of Network benefits up to the limits indicated.

## Monthly Cost

The following monthly costs are effective from January 1, 2019 through December 31, 2019. Your premium will be paid through convenient payroll deduction. Monthly cost covers all eligible children.

### Basic Option PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>$20.69</th>
<th>Employee + Child(ren)</th>
<th>$48.16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$44.19</td>
<td>Employee + Family</td>
<td>$72.62</td>
</tr>
</tbody>
</table>

### High Option PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>$67.79</th>
<th>Employee + Child(ren)</th>
<th>$132.84</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$136.80</td>
<td>Employee + Family</td>
<td>$188.96</td>
</tr>
</tbody>
</table>
### 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 Option 1: Basic Option PPO Plan

<table>
<thead>
<tr>
<th>Type A – Preventive</th>
<th>How Many/How Often</th>
<th>Type B – Basic Restorative</th>
<th>How Many/How Often</th>
<th>Type C – Major Restorative</th>
<th>How Many/How Often</th>
<th>Type D – Orthodontia</th>
<th>How Many/How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prophylaxis (cleanings)</td>
<td>Two per calendar year</td>
<td>Fillings</td>
<td>Covered</td>
<td>Crown, Denture and Bridge Repair/ Recementations</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>Two exams per calendar year</td>
<td>Simple Extractions</td>
<td>Covered</td>
<td>Oral Surgery</td>
<td>Includes removal of bony impacted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Applications</td>
<td>One fluoride treatment per calendar year for dependent children under age 16</td>
<td>Oral Surgery</td>
<td>Covered</td>
<td>Implants</td>
<td>Initial placement to replace one or more natural teeth, once for the same tooth position in a 60 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays</td>
<td>Full mouth X-rays, once per 3 years</td>
<td>Endodontics</td>
<td>Root canal treatment</td>
<td>Bridges and Dentures (see plan booklet for additional details)</td>
<td>Initial placement to replace one or more natural teeth, which are lost while covered by the plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers</td>
<td>Space maintainers for dependent children, once per lifetime per tooth area</td>
<td>Gingivectomy</td>
<td>Once per quadrant in any 3 year period</td>
<td>General Anesthesia</td>
<td>When dentally necessary in connection with oral surgery, extractions or other covered dental services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>One application of sealant material every 3 years for child under age 16</td>
<td>Periodontics</td>
<td>Periodontal scaling and root planing once per quadrant, every 24 months</td>
<td>Periodontics</td>
<td>Periodontal surgery once per quadrant, every 36 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Plan Option 2: High Option PPO Plan

<table>
<thead>
<tr>
<th>Type A – Preventive</th>
<th>How Many/How Often</th>
<th>Type B – Basic Restorative</th>
<th>How Many/How Often</th>
<th>Type C – Major Restorative</th>
<th>How Many/How Often</th>
<th>Type D – Orthodontia</th>
<th>How Many/How Often</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Two per calendar year</td>
<td>Fillings</td>
<td>Covered</td>
<td>Crown, Denture and Bridge Repair/ Recementations</td>
<td>Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Examinations</td>
<td>Two exams per calendar year</td>
<td>Simple Extractions</td>
<td>Covered</td>
<td>Oral Surgery</td>
<td>Includes removal of bony impacted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical Fluoride Applications</td>
<td>One fluoride treatment per calendar year for dependent children under age 16</td>
<td>Oral Surgery</td>
<td>Covered</td>
<td>Implants</td>
<td>Initial placement to replace one or more natural teeth, once for the same tooth position in a 60 month period</td>
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<td></td>
</tr>
<tr>
<td>X-rays</td>
<td>Full mouth X-rays, once per 3 years</td>
<td>Endodontics</td>
<td>Root canal treatment</td>
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<td>Periodontal surgery once per quadrant, every 36 months</td>
<td></td>
<td></td>
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The service categories and plan limitations shown above 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.
Go Green with MetLife Dental – If you are already enrolled in the MetLife dental program, simply register on the MyBenefits website at:

www.metlife.com/mybenefits

As a MetLife dental participant, you are automatically sent a paper Explanation of Benefits (EOB) statement for your dental claims. In addition, the MyBenefits website houses electronic EOB statements for viewing, printing, etc. To discontinue the mailing of your paper EOBs, login to the MyBenefits website, click on “I want to. . .” and select “Go Green! Online Dental EOB”. Under Explanation of Benefits, click the radio button next to Paperless (E-Alert). Don't forget to click the Save Preferences button to ensure we have your approval.

This is just one of the many items available to you on the MyBenefits website

Enrollment Period Lock –

For Enrollment Period January 1, 2019, you are able to enroll in the MetLife Basic or High Option Dental plans. For those currently enrolled in a MetLife Dental plan, you may change your plan for January 1, 2019. If enrollment is waived at your initial eligibility period or at this Enrollment Period for January 1, 2019, the next available Enrollment Period would be the next opportunity to enroll, unless a Qualifying Event occurs. After January 1, 2019, the next available Enrollment Period will be January 1, 2021.

Frequently Asked Questions

Who is a participating dentist?
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.*

*Based on internal analysis by MetLife. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

How do I find a participating dentist?
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 1-866-832-5756 to have a list faxed or mailed to you.

What services are covered under this plan?
All services defined under the group dental benefits plan are covered.

May I choose a non-participating dentist?
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. He/she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.
Can my dentist apply for participation in the network?
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.

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

How are claims processed?
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 1-866-832-5756.

Can I find out what my out-of-pocket expenses will be before receiving a service?
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.

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

*International dental travel assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services they provide are separate and apart from the benefits provided by MetLife. Referral services are not available in all locations.

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

How does MetLife coordinate benefits with other insurance plans?
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.

Do I need an ID card?
Once your enrollment is confirmed, MetLife will mail to your home an ID card. The card includes a unique ID number that can be used in place of your SSN. You can give your unique ID number to your provider who can submit claims to MetLife on your behalf. The ID number can also be used when registering on the MyBenefits website and when corresponding with MetLife regarding your eligibility, benefits and claims.

How does Alternate Benefits impact claim reimbursement?
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. Procedure charge schedules are subject to change each plan year. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.
Exclusions – Basic Option PPO Plan

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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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 or biting of food;
- Caries susceptibility tests;
- Labial veneers;
- Precision attachments associated with fixed and removable prostheses;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture;
- Intra and extraoral photographic images;
- Core buildup and cast post and core;
- Periodontal surgery, including gingivoplasty, gingival curettage and osseous surgery;
- Guided tissue regeneration;
- Local chemotherapeutic agents;
- Initial installation or replacement of Dentures or Implants;
- Initial installation of, or repairs to, Cast Restorations (inlay, onlay or crowns);
- Addition of teeth to a partial Denture;
- Tissue conditioning;
- Modification of removable prosthodontics and other removable prosthetic services;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- Fixed partial Dentures;
- Other fixed Denture services;
- 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;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Other removable prosthetic services not described elsewhere;
- Surgical Extractions;
- Orthodontic services or appliances; and
- Repair or replacement of an orthodontic device.
Exclusions – High Option PPO Plan

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 you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - 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 or biting of food;
- Caries susceptibility tests;
- Initial installation of a 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;
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
- 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;
- Local chemotherapeutic agents;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device; and
- Other removable prosthetic services not described elsewhere.
Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 90 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.