

Dental Benefits

Savings, flexibility and service. For healthier smiles.



MetLife

Overview of Benefits for: CSEA CHILD CARE PROVIDERS TRUST FUND

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The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

| Coverage Type | In-Network: % of Negotiated Fee | Out-of-Network: % of Negotiated Fee |
|---|------------------------------------|--|
| Type A | 100% | 100% |
| Type B | 80% | 80% |
| Type C | 50% | 50% |
| Deductible: Individual/Family | No Deductible | No Deductible |
| Annual Maximum Benefit: Per Individual | \$1000 | \$1000 |

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice —in or out of the network.

- Your plan benefits are based on the percentage of the negotiated fee – the fee that the participating dentists have agreed to accept as payment in full for covered services.

Certain plan benefits are based on a percentage of the negotiated fee. This is the amount that participating dentists have agreed to accept as payment in full. If your plan benefits are based on a percentage of the Reasonable and Customary (R&C) charges, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

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

Selected Covered Services and Frequency Limitations*

| Type A | |
|---|---|
| • Oral Examinations | 1 in 6 months. |
| • Cleanings | 1 in 6 months. |
| • Fluoride | Children to age 14 / 1 in 12 months. |
| • Bitewing X-rays | Adult - 1 in 1 year / Child - 1 in 6 months - Children to age 19 |
| • Full Mouth X-rays | 1 in 60 months. |
| • Periodontal Maintenance | 4 in 1 year less the number of teeth cleanings. |
| • Space Maintainers | |
| • Sealants (1st & 2nd permanent molars) | 1 per tooth in 14 years of a dependent child up to 14 th birthday. |
| Type B | |
| • Emergency Palliative Treatment | |
| • Periodontal Root Planing & Scaling | 1 per quadrant in any 24 months period. |
| • Amalgam & Composite Fillings | 1 per surface in 24 months. |
| • Simple Extractions | |
| • Root Canal | One per tooth per Lifetime. |
| • Surgical Extractions | |
| • Deep Sedation/General Anesthesia | each 15 minutes |
| • Repairs (Crowns) | 1 in 12 months. |
| Type C | |
| • Crowns | 1 in 5 years. |
| • Dentures | 1 in 5 years. |
| • Bridges | 1 in 5 years. |
| • Periodontal Surgery | 1 in 36 months. |
| • Implants | 1 in 60 months. |

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your policyholder. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

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 or appliances which restore or alter occlusion or vertical dimension.
6. Restoration of tooth structure damaged by attrition, abrasion or erosion.
7. Restorations or appliances used for the purpose of periodontal splinting.
8. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
9. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
10. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
11. Missed appointments.
12. 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.
13. Services covered under other coverage provided by the Policyholder.
14. Temporary or provisional restorations.
15. Temporary or provisional appliances.
16. Prescription drugs.
17. Services for which the submitted documentation indicates a poor prognosis.
18. 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.
19. Caries susceptibility tests.
20. 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.
21. Other fixed Denture prosthetic services not described elsewhere in this certificate.
22. Precision attachments.
23. Adjustment of a Denture
24. 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.
25. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.¹
26. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.¹
27. Orthodontic services or appliances.¹
28. Repair or replacement of an orthodontic device.¹
29. Duplicate prosthetic devices or appliances.
30. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
31. Intra and extraoral photographic images.

¹Some of these exclusions may not apply. Please see your plan design and certificate for details.

COMMON QUESTIONS... IMPORTANT ANSWERS

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 services provided to plan members. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

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 who 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.

Does the Preferred Dentist Program offer any discounts on non-covered services?

Negotiated fees may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If permitted, you may only be responsible for the negotiated fee.

* Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

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 expenses may be higher.

He or 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 PDP participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application*. The website and phone number are designed 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 e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits if you are registered on MetLife's MyBenefits. You can also request one by calling 1-800-942-0854.

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

Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of \$300 (This often applies to services such as crowns, bridges, inlays, and periodontics). To receive a benefit estimate, simply have your dentist submit a request for a pre-treatment estimate online at www.metdental.com or call 1-877-MET-DDS9 (638-3379). You and your dentist will receive a benefit estimate online or by fax for most procedures while you are still in the office so you can discuss treatment and payment options and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Do I need an ID card?

No, you do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select?

No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?

Yes, eligible members who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage elected after the 31-day application period is subject to the following waiting periods:*

- No waiting period for Preventive Services
- No waiting period on Basic Restorative (Fillings)
- No waiting period on all other Basic Services
- No waiting period on Major Services
- No waiting period on Orthodontia Services (if applicable)

*If the policy holder participates in a section 125 plan and has an annual open enrollment period, the dental coverage will not be subject to any waiting periods. Please consult your Benefits Administrator or your certificate for this plan information.

Am I eligible for all benefits the first day of coverage?

Your plan may include benefit waiting periods. Please refer to the certificate of insurance or your Benefits Administrator for details about the services that are subject to the waiting periods and the length of time they apply.

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

Yes. Through MetLife's International Dental Travel Assistance program² 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-network³ benefits. Please remember to hold on to all receipts to submit a dental claim.

1 Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, pre-treatment estimates through your dentist will provide the most accurate fee and payment information.

2 International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife, and the services provided are separate and apart from the benefits provided by MetLife.

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