Mindlance, Inc.

Dental

Metropolitan Life
Insurance Company

Network: PDP Plus

Coverage Type	In-Network Negotiated Fee*	Out-of-Network Negotiated Fee* MAC
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures)	50%	50%
Type D: Orthodontia	50%	50%

Deductible†		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit		
Per Person	$1,500	$1,500
Orthodontia Lifetime Maximum		
Per Person	$1,000	$1,000

Child(ren)'s eligibility for dental coverage is from birth up to age 26, 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.

* Negotiated Fee refers to the fees that participating 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.

Monthly Cost

The following monthly costs are effective 08/01/2021 through 07/31/2022. Your premium will be paid through convenient payroll deduction. Monthly cost covers all eligible children.

Employee Only	$32.39	**Employee + Child(ren)**	$74.43
Employee + Spouse	$64.40	**Employee + Family**	$114.24

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	One time in 6 months
Examinations	One time in 6 months
Examinations – Problem Focused	Combined with Examinations Limit
Fluoride	One time in 12 months for a dependent child under age 14
Bitewing X-rays	For a child under 19: one time in 12 months; Adult: One time in 12 months
Labs & Other Tests	
Type B - Basic Restorative	**How Many/How Often**
Amalgam Fillings	One replacement per surface in 24 months
Full Mouth X-Ray	Once in 60 months
Space Maintainers	One per lifetime for a child under age 14
Sealants	One per molar in 60 months for a child under age 16
Periodontal Maintenance	Two periodontal treatments in one calendar year, includes two cleanings (total comb.:2)
Scaling & Root Planning	One per quadrant in any 24 months period
Emergency Palliative Treatment	
Periapical X-Rays	
Other X-Rays	
Resin Composite Fillings (excluding coverage for composite fillings on molars)	
Pulpotomy	
Pulp Capping	
Pulp Therapy	
Periodontics – Non-Surgical	
Oral Surgery: Simple Extractions	
General Services	
Type C - Major Restorative	**How Many/How Often**
Consultations	Two in 12 months
Root Canal	One per tooth per lifetime
Periodontal Surgery	One per quadrant in any 36 month period
Prefabricated Crowns	One per tooth in 84 months
Crown Buildups/ Post Core	One per tooth in 84 months
Repairs	One in 12 months
Recementations	One in 12 months
Dentures	One in 84 months
Dentures – Rebases / Relines	One in 36 months
Denture Adjustments	One n 12 months
Fixed Bridges	One in 84 months
Inlays / Onlays / Crowns	One replacement per tooth in 84 months
Implant Services	One per tooth position in 60 months
Implant Repairs	One per tooth in 12 months
Implant Supported Prosthetic	One per tooth in 60 months
Tissue Conditioning	One in 36 months

Occlusal Adjustments	One in 12 months
General Anesthesia	
Apexification & Recalcification	
Periodontal Surgery – Soft & Connective Tissue Grafts	
Oral Surgery: Surgical Extractions	
Other Oral Surgery	
Type D - Orthodontia	**How Many/How Often**
Orthodontic Diagnostics	
Orthodontic Treatment	

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.

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 15%-45% below the average fees charged in a dentist's community for the same or substantially similar services.†

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 1-800-942-0854 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. Please review the enclosed plan benefits to learn more.

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.

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 1-800-942-0854.

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.

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?
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.

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

Exc lus io ns

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 unless required for the treatment of a congenital defect or birth anomaly.
- 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, orVA 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;

- 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;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;

Initial installation of a full or removable 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;

Addition of teeth to a partial removable 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;

Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;

- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- Implants supported prosthetics to replace one or more natural teeth which were missing before such
- person was insured for Dental Insurance, except for congenitally missing natural teeth;
- 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;

Repair or replacement of an orthodontic device;

Duplicate prosthetic devices or appliances;

Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and

Intra and extraoral photographic images

L i m i t a t i o ns

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, wesuggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated

Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) 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 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

This dental benefits plan is made available through a self-funded arrangement. MetLife administers this dental benefits plan, but has not provided insurance to fund benefits.

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. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.