Choice 2

A More Traditional Dental Benefit Plan For Retired CSEA Members

MetLife

- **Protect** — yourself and your family from the rising costs of dental expenses by providing coverage for preventive, basic and complex services that help ensure good oral health long-term.
- **Choose** — any dentist you want.[1]
- **Save** — on out-of-pocket expenses by receiving services from participating dentist locations, including more than 55,000 specialist locations nationwide. Participating dentists have agreed to accept negotiated fees as payment in full for services provided to plan participants. Fees typically range from 15-45% less than the average fees charged by out-of-network dentists in the same geographical area for the same or similar services.[2]

PEARL CARROLL

CSEA

CSEA Membership is required to enroll and continue this insurance.

Choice 2

A MORE TRADITIONAL DENTAL BENEFIT PLAN

Choice 2, underwritten by Metropolitan Life Insurance Company, offers a more traditional dental benefit plan that lets YOU select either an in-network or out-of-network dentist. With Choice 2, participating MetLife dentists agree to accept negotiated fees as payment in-full for services they provide to plan participants. The fee typically ranges from 15% to 45% less than average fees charged by dentists in the same geographical area for the same or similar services.[2] Services by non-participating dentists are reimbursed at a percent of the fee schedule based on the service type. Preventive services are important to maintaining good dental health over the long term. That's why Choice 2 provides first-day coverage for Preventive services, such as routine oral exams (once every 6 months), bitewing X-rays (once every 12 months) and full mouth X-rays (once every 60 months).

WITH THAT IN MIND ... CHOOSE CHOICE 2 IF YOU PREFER ...

FREEDOM TO CHOOSE YOUR DENTIST

With Choice 2, you have the freedom to choose any dentist – even if that dentist is not an in-network provider.[1] You don't have to select a primary dentist and you're never locked into any specific dentist. If you choose to visit a participating dentist, it may help you to maximize your benefit plan savings and reduce out-of-pocket expenses. To find out if your dentist participates in MetLife's Preferred Dentist Program, go to www.metlife.com/dental.

ANNUAL DEDUCTIBLE

To help keep down your out-of-pocket expenses, the Choice 2 deductible is $50 per insured person up to a maximum of $150 per family per calendar year. The deductible is waived for preventive care.

REIMBURSEMENT BENEFIT

Reimbursement is based on the negotiated fee schedule – whether you elect to visit a participating dentist or you seek out-of-network services.

In-Network

When you choose to visit a participating dentist you are responsible to pay only the difference between the amount of the negotiated fee and your plan benefit payment.

Out-of-Network

When you chose to visit a non-participating dentist, you are responsible to pay the difference between the dentist's regular fee charged for the services provided and the amount of your plan benefit payment, which is based on the negotiated fee schedule. Since it is likely that the out-of-network dentist's charge is greater than the fee schedule amount, your out-of-pocket expense may be greater.

AVAILABLE TO YOU AT GROUP RATES

If you have looked for quality dental insurance, you probably know how expensive it can be. Because you are eligible for this coverage as part of a group, you have access to a quality group dental plan – at competitive group insurance rates.

CHOICE 2 BENEFITS

Deductible:	(Each Calendar Year) $50 per insured person Maximum $150 per family No Deductible for Preventive (Type A) services
Annual Maximum:	$1,000 per person

IMPORTANT COVERAGE INFORMATION

Who is Eligible

You are eligible to enroll if you are a retired CSEA member.

You may also enroll your spouse, and/or unmarried children, stepchildren and adopted children whom you support and who are under age 19 (age 25 if a full-time student in some states) and where permitted by law, your dependents may also include your domestic partner. To qualify as domestic partners, the member and partner must be registered as domestic partners or members of a civil union or submit a domestic partner declaration to the policyholder.

Calendar Year Maximum

The maximum amount this insurance will pay for all Eligible Dental Expenses in any calendar year is $1,000 per person for all covered services.

When Coverage Begins

Your dental coverage will become effective on the first day of the calendar month following receipt of the enrollment form, provided it is received prior to the 15th of the month.

Cancellation/Termination

Coverage is subject to the terms and provisions of the Group Policy (FormGPNP99) and Certificates of Insurance (Form G.23000) issued to each insured member. In any state exercising extraterritorial jurisdiction, the plan will be modified to meet applicable laws.

Participating MetLife dentists agree to accept negotiated fees, which typically range from 15-45% less than the average fees charged by participating dentists in your geographic area.[2] These discounts are only available when you see an in-network or participating dentist. This plan is reimbursed based on the fee schedule – whether you elect to stay in-network or out-of-network. Out-of-network dentists have not agreed to accept the negotiated fees as payment in full, so your costs may be higher if you go out of network.

BENEFIT HIGHLIGHTS	IN NETWORK*	OUT-OF-NETWORK*
Type A Preventive		
■ Oral Examinations *(one exam every 6 months)* ■ Prophylaxis – Cleaning & Scaling of teeth *(once every 6 months)* ■ Full mouth X-Rays *(once every 5 years)* and Bitewing X-Rays *(once every 12 months; every 6 months for dependent children under 19 years of age)* ■ Topical fluoride treatment every 12 months for dependent children under age 14 ■ Sealants *(molars only, once per tooth up to age 14)* ■ Space Maintainers *(dependents under age 19)*	**100% of negotiated Fee****	**100% of negotiated Fee****
Type B Basic		
■ Fillings *(amalgam, silicate or resin fillings)* ■ Extractions ■ Endodontics–Root Canal ■ Periodontics ■ Injections of Antibiotic Drugs ■ Anesthesia *(when medically necessary in connection with oral surgery)* ■ Oral Surgery *(except procedures covered under any medical plan)* ■ Emergency Palliative Treatment ■ Repair of Crowns, Dentures, Inlays and Onlays ■ Repair of Bridgework	**80% of negotiated Fee****	**80% of negotiated Fee****
Type C Major *(A 12-month waiting period must be satisfied before expenses for these services are payable.)*		
■ Bridgework *(installation of fixed bridgework for the first time)* ■ Crowns, Onlays, Inlays *(not more than once in 5-year period for the same tooth surface)* ■ Dentures *(installation of a partial or full removable denture for the first time for teeth which are lost while coverage is in effect)*	**50% of negotiated Fee****	**50% of negotiated Fee****

*In-network Benefits means benefits under this plan for covered dental services that are provided by a participating provider. Out-of-network Benefits means benefits under this plan for covered dental services that are not provided by a participating provider.

**Negotiated Fee refers to the negotiated schedule of fees which participating dentists have agreed to accept as payment in-full for services they provide to planparticipants, subject to any co-payments, deductibles, cost sharing, and benefit maximums. When services are provided by a participating dentist, you will be responsible for the difference between the plan's benefit payment and the negotiated fee. When services are provided by an out-of-network dentist, reimbursements are based on the negotiated fee schedule. If you choose to go to a non-participating dentist, you will be responsible for the difference between the non-participating dentist's regular fee charged for such services and the plan's benefit payment, which is based on the fee schedule.

Coverage terminates:

- When membership in the Civil Services Employees Association (CSEA) terminates;
- When the member's contributions cease;
- When The Plan ends;
- All benefits on account of a dependent will end on the date that dependent ceases to be a dependent; or
- All benefits on account of a dependent will end on the date of the member's death, unless the surviving spouse elects to continue dependent benefits, then dependent benefits will end at the earlier of the date of the surviving spouse's death or the date that dependent ceases to be a dependent; or
- MetLife discontinues the Group Insurance Plan:
  1. for nonpayment of premium;
  2. if group's participation requirements are not met; or
  3. for group's failure to meet the minimum number of lives requirement.

Choice 2

Offers you a more traditional dental insurance option, with the freedom to choose your dental provider – in-network or out-of-network. If you'd like more information about CHOICE 2, or you'd like to enroll, please call Pearl Carroll & Associates TOLL-FREE at **1-888-507-1368** and one of our helpful customer service representatives will be happy to assist you.

CSEA Membership is required to enroll and continue this insurance.

Choice 2

EXCLUSIONS

The following expenses are not Covered Dental Expenses:

- Services or Supplies:
  - received by a covered person before the dental expense benefits start for that person;
  - which are covered by any worker's compensation laws or occupational disease laws;
  - which are covered by any employer's liability laws;
  - which an employer is required by law to furnish in whole or in part;
  - received through the medical department or similar facility which is maintained by the covered person's employer;
  - received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;[3]
  - for which a covered person is not required to pay;[4]
  - which are deemed experimental in terms of generally accepted dental standards;
  - received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
  - which are provided by this, or any other plan which the employer (or an affiliate) contributes to or sponsors.
- Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.
- Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a Dependent child which has resulted in a functional defect.
- Orthodontia Services.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Initial installation of a denture or bridgework to replace one or more natural teeth lost before the Dental Expense Benefits started for the Covered Person, or as a replacement for congenitally missing natural teeth.
- Adjustment of dentures or bridgework which is made within six months after it is installed by the same dentist who installed it.
- Any duplicate appliance or prosthetic device.
- Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Myofunctional therapy or correction of harmful habits.
- Implantology.
- Charges by a dentist for completing dental forms.[5]
- Charges for broken appointments.[5]
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Treatment of temporomandibular joint disorders.
- Sterilization supplies.[5]
- Services or supplies furnished by a family member.[5]

A prohibited Referral is one in which a Health Care Practitioner: a) refers a covered person to; or b) directs an employee or person under a contract with a Health Care Practitioner to refer a covered person to a Health Care Entity in which: a) the Health Care Practitioner; or b) the Health Care Practitioner's immediate family; or c) both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this provision, the terms "Referral," "Health Care Practitioner," "Health Care Entity," "Beneficial Interest," and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.

Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.
Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations, reductions of benefits and terms for keeping them in force. Your MetLife representative can answer any questions about costs and details of coverage. A full description of benefits will be provided in the certificate of insurance.

[1] If you go to a dentist who does not participate in MetLife's network, your out-of-pocket costs may be greater.
[2] Based on an internal analysis from MetLife, savings from enrolling in a dental benefits plan will depend on various factors including the cost of the plan, how often participants visit a dentist and the cost of services rendered.
[3] Not applicable in MD.
[4] In MD, these exclusions do not apply to Medicaid. [5] Not applicable in FL, MD, NJ and TN.