

Dental

Metropolitan Life Insurance Company

Plan Design for: Ore City Independent School District

Original Plan Effective Date: September 1, 2025

Network: PDP Plus

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 cost-effective protection for a healthier smile and a healthier you.

| Coverage Type: | In-Network ¹ % of Negotiated Fee ² | Out-of-Network ¹ % of R&C Fee ⁴ |
|--|--|--|
| Type A - Preventive | 100% | 100% |
| Type B - Basic Restorative | 70% | 70% |
| Type C - Major Restorative | 0% | 0% |
| Deductible³ | | |
| Individual | \$50 | \$50 |
| Family | \$150 | \$150 |
| Annual Maximum Benefit: | | |
| Per Individual | \$750 | \$750 |
| Dependent Age: | Eligible for benefits until the day that he or she turns 26. | |
| <p>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. Utilizing an out-of-network dentist for care may cost you more than using an in-network dentist.</p> <p>2. Negotiated fees refer 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.</p> <p>3. Applies to Type B and C services only.</p> <p>4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:</p> <ul style="list-style-type: none"> the dentist's actual charge (the 'Actual Charge'), the dentist's usual charge for the same or similar services (the 'Usual Charge') or the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards. | | |

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. .

If you receive in-network services, you will be responsible for any applicable deductibles, cost sharing, negotiated charges after benefit maximums are met, and costs for non-covered services. If you receive out-of-network services, you will be responsible for any applicable deductibles, cost sharing, charges in excess of the benefit maximum, charges in excess of the negotiated fee schedule amount or R&C Fee, and charges for non-covered services.

- Plan benefits for in-network covered services are based on a percentage of the Negotiated fee – the Fee that participating dentists have agreed to accept as payment in full for covered services, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be greater.

Once you're enrolled you may take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

To register, just go to
www.metlife.com/mybenefits
and follow the easy registration instructions.

IMPORTANT RATE INFORMATION

| Monthly Premium Payment | |
|-------------------------|---------|
| Employee | \$23.56 |
| Employee + Spouse | \$54.50 |
| Employee + Child(ren) | \$49.14 |
| Employee + Family | \$75.96 |

Cancellation/Termination of Benefits:

Coverage is provided under a group insurance policy (Policy form GPN99) issued by Metropolitan Life Insurance Company. Subject to the terms of the group policy, rates are effective for one year from your plan's effective date. Once coverage is issued, the terms of the group policy permit Metropolitan Life Insurance Company to change rates during the year in certain circumstances. Coverage terminates when your full-time employment ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder. The group policy may also terminate if participation requirements are not met, or on the date of the employee's death, if the Policyholder fails to perform any obligations under the policy, or at MetLife's option. The dependent's coverage terminates when a dependent ceases to be a dependent. There is a 30-day limit for the following services that are in progress: Completion of a prosthetic device, crown or root canal therapy after individual termination of coverage.

IMPORTANT ENROLLMENT INFORMATION

You may only enroll for Dental Expense Benefits within 31 days of your Personal Benefits Eligibility Date, or if you have a Qualifying Event or during the Plan's Annual Open Enrollment Period.

Qualifying Event: Request to be covered, or to change your coverage, upon a Qualifying Event

If there is a Qualifying Event you may request to be covered, or to change your coverage, only within 31 days of a Qualifying Event. Such a request will not be a late request. Except for marriage or the birth or adoption of a child, you must give us proof of prior dental coverage under your spouse's plan if you are requesting coverage under this Plan because of a loss of the prior dental coverage. If you make a request to be covered under this Plan or request a change(s) in coverage under this Plan within thirty-one days of a Qualifying Event, your coverage or the change(s) in coverage will become effective on the first day of the month following the date of your request, subject to the Active Work Requirement, and provided that the change in coverage is consistent with your new family status.

Selected Covered Services and Frequency Limitations*

Type A - Preventive

How Many/How Often:

| | |
|--------------------------------|---|
| Oral Examinations | 2 in 12 months |
| Full Mouth X-rays | 1 in 60 months |
| Bitewing X-rays (Adult/Child) | 1 in 12 months |
| Prophylaxis - Cleanings | 2 in 12 months |
| Topical Fluoride Applications | 2 in 12 months - Children to age 14 |
| Sealants | 1 in 36 months - Children to age 16 |
| Space Maintainers | 1 per lifetime per tooth area - Children up to age 16 |
| Emergency Palliative Treatment | |
| Harmful Habits Appliances | |

Type B - Basic Restorative

How Many/How Often:

| | |
|-----------------------------------|-----------------------------------|
| Amalgam and Composite Fillings | 1 in 24 months. |
| Prefabricated Crowns | 1 per tooth in 24 months |
| Repairs | 1 in 12 months |
| Periodontal Maintenance | 4 in 1 year, includes 2 cleanings |
| Oral Surgery (Simple Extractions) | |
| Consultations | 1 in 12 months |

Type C - Major Restorative

How Many/How Often:

| | |
|---|--|
| TYPE C SERVICES ARE NOT COVERED WITH THIS COVERAGE TYPE. | |
|---|--|

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

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

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 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.**For NY Sitused Groups, this exclusion does not apply.**
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
8. Restorations or appliances used for the purpose of periodontal splinting.
9. Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
10. Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
11. Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work.
12. Missed appointments.
13. 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.**For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
 - for persons who are covered in 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;
 - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.**This exclusion only applies for North Carolina Sitused Groups.**
15. Services:
 - for which the employer of the person receiving such services is required to pay; or
 - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.
This exclusion only applies for Virginia Sitused Groups.
17. Services:
 - for which the employer of the person receiving such services is not required to pay; or
 - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.**This exclusion only applies for Virginia Sitused Groups.**
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.
24. 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.
For NY Sitused Groups, this exclusion does not apply.
25. Caries susceptibility tests.
26. Other fixed Denture prosthetic services not described elsewhere in this certificate.
27. Precision attachments.
28. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.
29. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.¹
30. Orthodontic services or appliances.¹
31. Repair or replacement of an orthodontic device.¹
32. Duplicate prosthetic devices or appliances.
33. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
34. Intra and extraoral photographic images.

35. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, 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.

This exclusion only applies for Maryland Sitused Groups

¹Some of these exclusions may not apply. Please see your Certificate of Insurance.

Common Questions ... Important Answers

Who is a participating dentist?

A participating, or network, 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, subject to any deductibles, copayments, cost sharing and benefit maximums. Negotiated fees typically range from 30-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

In addition to the standard MetLife network, your employer may provide you with access to a select network of dental providers that may be unique to your employer's dental program. When visiting these providers, you may receive a better benefit, have lower out-of-pocket costs and/or have access to care at facilities at your worksite. Please sign into MyBenefits for more details.

* Based on internal analysis by MetLife. Negotiated fees refer 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. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often members visit a dentist and the cost of services rendered. 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/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan?

Please see your Certificate of Insurance for a list of covered services.

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 (out-of-network) dentist, your out-of-pocket costs may be greater than your out-of-pocket costs when visiting an in-network dentist.

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 or 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/dental or request one by calling 1-800-275-4638.

Can I get an estimate of 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). AXA Assistance provides dental referral services only. AXA Assistance is not affiliated with MetLife and any of its affiliates, 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 Certificate of Insurance 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. 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.

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 a MetLife Dental Plan. 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.

