California School Employees Association
PPO 0919 Plan Summary and Cost of Coverage

With the PPO Plan 0919 Dental Insurance, your acceptance is guaranteed.

- **100% coverage** for preventive care for in-network exams, cleanings and X-rays[1]
- **Freedom to visit any dentist** you want whether they are in the MetLife network or not[2]
- **Typical savings of 30% - 45%** on covered services when you use a participating dentist[3]

Eligibility

All California School Employees Association members[4] in good standing, their spouses/domestic partners, and dependent children* may apply.

Plan Benefits

PPO Plan 0919 - Network: Preferred Dental Provider (PDP) Plus

Coverage Type	In-Network % of Negotiated Fee**	Out-of-Network % of Negotiated Fee**
Type A: Preventive cleanings, exams, X-rays	100%	50%
Type B: Basic Restorative -no waiting period – sealants, amalgam fillings, resin composite fillings (excludes coverage for composite fillings on molars)	80%	50%
Type B: Basic Restorative – benefits are payable after a 12 month waiting period from the start date of an individual's benefits - root canal, prefabricated crowns, crown buildups/post core, recementations, general anesthesia, pulpotomy, pulp capping pulp therapy, apexification and recalcification, oral surgery: simple and surgical extractions oral surgery and general services	80%	50%
Type C: Major Restorative -benefits are payable after a 12 month waiting period from the start date of an individual's benefits - periodontal maintenance and surgery, scaling and root planing, repairs, dentures, dentures – rebases/relines, denture adjustments, fixed bridges, inlays/onlays/crowns, and tissue conditioning	50%	50%
Type D: Orthodontia benefits are payable after a 12 month waiting period from the start date of an individual's benefits (orthodontic diagnostics and orthodontic treatment)	50%	50%

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

Deductible†		
Yearly Individual Deductible	$50	$50
Annual Maximum Benefit		
Yearly Individual Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum		
Per Person	$1,000	$1,000

† Applies to only to Type B and C Services.

Rates at a glance

The following monthly costs are effective through December 31, 2021. Monthly cost covers all eligible children.

PPO Plan 0919: Monthly Rates

Member Only: $49.52	**Member + One Dependent: $89.05**	**Member + Family: $159.40**

List of Primary Covered Services & Limitations

The services 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.

Type A: Preventive

1. Oral exams and problem-focused exams, but no more than two exams (whether the exam is an oral exam or problem-focused exam) in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice in a Year.
4. Full mouth or panoramic x-rays once every 5 Years.
5. Bitewing x-rays:
   - 2 sets every Year for a Child under age 19; and
   - 1 set every Year for everyone else.
6. Intraoral-periapical x-rays.
7. X-rays, except as mentioned elsewhere.
8. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
9. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
10. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) twice in a Year.
11. Emergency palliative treatment to relieve tooth pain.

12. Topical fluoride treatment for a Child under age 14 twice in a Year.
13. Space maintainers for a Child under age 14 once per lifetime per tooth area.
14. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
15. Other consultations, but not more than twice in a 12 month period.

Type B: Basic Restorative

1. Initial placement of amalgam fillings.
2. Replacement of an existing amalgam filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
3. Initial placement of resin-based composite fillings.
4. Replacement of an existing resin-based composite filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
5. Protective (sedative) fillings.
6. Oral surgery, except as mentioned elsewhere in this certificate.
7. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
8. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
9. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
10. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
11. Pulp capping (excluding final restoration).
12. Therapeutic pulpotomy (excluding final restoration).
13. Pulp therapy.
14. Apexification/recalcification.
15. Pulpal regeneration, but not more than once per lifetime.
16. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
17. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
18. Sealants or sealant repairs for a Child under age 15, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 2 Years.
19. Preventive resin restorations, which are applied to non-restored adult teeth, once per tooth every 60 months.
20. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
21. Prefabricated crown, but no more than one replacement for the same tooth within 5 Years.
22. Core buildup, but no more than once per tooth in a period of 5 Years.
23. Post and cores, but no more than once per tooth in a period of 5 Years.

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable, except for Sealants, Amalgam Fillings and Resin Composite Fillings (excludes coverage for composite fillings on molars).

Type C: Major Restorative

1. Initial installation of full or partial Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
2. Addition of teeth to a partial removable Denture to replace teeth removed while this Dental Insurance was in effect for the person receiving such services.
3. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 Years prior to replacement.
4. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 Years prior to replacement.
5. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
6. Relinings and rebasings of existing removable Dentures:
   - if at least 6 months have passed since the installation of the existing removable Denture; and
   - not more than once in any 36 month period.
7. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
8. Initial installation of Cast Restorations (except implant supported Cast Restorations).
9. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least a 5 Year period have passed since the most recent time that:
   - a Cast Restoration was installed for the same tooth; or
   - a Cast Restoration for the same tooth was replaced.
10. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
11. Full mouth debridements, but not more than once per lifetime.
12. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
13. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year less the number of teeth cleanings received during such 1 Year period.
14. Tissue conditioning, but not more than once in a 36 month period.
15. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable.

Type D: Orthodontia

- You, your spouse and your children up to age 26, are covered while Dental insurance is in effect.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia
- Payments are on a repetitive basis
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary.
- Orthodontic benefits end at cancellation of coverage

Exclusions

This plan does not cover the following services, treatments and supplies:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
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 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;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
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 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 required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
    - to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. 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;
21. 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;
22. caries susceptibility tests;
23. implant supported Cast Restorations;
24. labial veneers;
25. local chemotherapeutic agents;
26. modification of removable prosthodontic and other removable prosthetic services;
27. implants including, but not limited to any related surgery, placement, maintenance, and removal;
28. implant supported Dentures;
29. repair of implants;
30. injections of therapeutic drugs;

31. application of desensitizing agents;
32. occlusal adjustments;
33. fixed and removable appliances for correction of harmful habits;
34. appliances or treatment for bruxism (grinding teeth);
35. initial installation of a Denture or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
36. precision attachments associated with fixed and removable prostheses;
37. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
38. duplicate prosthetic devices or appliances;
39. replacement of a lost or stolen appliance, Cast Restoration or Denture;
40. replacement of an orthodontic device;
41. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders;
42. diagnostic casts;
43. intra and extraoral photographic images.
44. cleaning and inspection of a removable appliance.

Limitations

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. 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. You can obtain an updated procedure charge schedule for your area via fax by dialing 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, the last day of the calendar month insurance ceases for your class, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy may be terminated for non-payment of premium and may be terminated 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.

1. Preventive services (Type A) are 100% covered when you visit an in-network participating dentist. Subject to frequency limitations.
2. Your out-of-pocket costs may be greater when you visit a dentist who does not participate in the MetLife network.
3. Based on internal analysis by MetLife. 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.
4. You must be a member in good standing of the California School Employees Association.

Coverage may not be available in all states. Please contact your plan administrator at 1-800-821-7303 for more information.

Rates may be changed on the entire plan or on a class basis and on any premium due date on which benefits are changed. A class is a group of people defined in the group policy/exhibits. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization.

The association and/or the plan administrator incurs costs in connection with providing oversight and administrative support for this sponsored plan. To provide and maintain this valuable membership benefit, MetLife may compensate the association and/or the plan administrator for these and/or other costs.

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 your plan administrator at 1-800-821-7303 for costs and complete details.

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.

Policy form GPNP99

Policy number 220355-1-G

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