

Dental

Metropolitan Life Insurance Company

Plan Design for: Powerride Motor Sports, Inc.

Effective Date: January 1, 2006

Amendment Effective Date[±]: December 1, 2016

Date Prepared: October 17, 2022

Choice, Service, Savings.

To help you enroll, the following pages outline your company's dental plan and address any questions you may have.

Coverage Type:	<u>In-Network</u>¹ % of PDP Fee ²	<u>Out-of-Network</u>¹ % of R&C Fee ⁴
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Deductible³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Person	\$2000	\$2000

[±] Changes have been made to your Plan as of the Amendment Effective Date listed above. Please refer to your Certificate of Insurance/Certificate Rider for more details or contact your benefits administrator with any questions.

1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP Provider. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a MetLife PDP Provider.
2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.
3. Applies to Type B and C services only.
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:
 - 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'). Services must be necessary in terms of generally accepted dental standards.

List of Covered Services & Limitations*

Type A - Preventive	<u>How Many/How Often:</u>
Oral Examinations X-rays Bitewing X-rays Prophylaxis (cleanings) Topical Fluoride Applications Sealants	<ul style="list-style-type: none"> • Oral exams but not more than once every 6 months. • Full mouth X-rays: once every 60 months. • Not more than 1 set every 12 months for all Covered Persons. • Cleaning of teeth (oral prophylaxis) but not more than once every 6 months. • Topical fluoride treatment for a Dependent child under 14 years of age but not more than once in 12 months. • Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 14, but not more than once per tooth every 60 months.
Type B - Basic Restorative	<u>How Many/How Often:</u>
Space Maintainers Fillings Periodontal Maintenance Emergency Palliative Treatment Injections of Antibiotic Drugs	<ul style="list-style-type: none"> • Space Maintainers for dependent children to 14 years of age. • Amalgam and Resin-based Fillings. • Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed two treatments in a calendar year.
Type C - Major Restorative	<u>How Many/How Often:</u>
Crowns/Inlays/Onlays Prefabricated Crowns Repairs of Dentures, Crowns, Inlays, and Onlays Endodontics Periodontal Surgery Periodontics Relining and Rebasing Simple Extractions Oral Surgery Bridges and Dentures General Anesthesia Consultations	<ul style="list-style-type: none"> • Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 10 Year period. • Prefabricated stainless steel crowns but not more than once in any 60 month period. • Simple Repairs of Cast Restorations. • Root canal treatment, but not more than once in any 24 month period for the same tooth. • Periodontal surgery but no more than one surgical procedure per quadrant in any 36 month period. • Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period. • Relining and Rebasing of existing removable dentures but not more than once in 36 months. • Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 10 Years prior to its replacement. • When dentally necessary in connection with oral surgery, extractions or other covered dental services. • Consultations, but not more than twice in a 12 month period.

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 plans 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 for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

The MetLife® Preferred Dentist Program (PDP) Exclusions

The following expenses are not Covered Dental Expenses

x Services or Supplies...

- related to teeth lost before dental benefits began or for congenitally missing natural teeth;
- 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;²
- for which a covered person is not required to pay;¹
- which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
- which do not meet generally accepted dental standards, including experimental treatment;
- 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 any other plan which the employer (or an affiliate) contributes to or sponsors.²
- x 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.
- x 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 that has resulted in a functional defect.
- x Replacement of a lost, missing or stolen crown, bridge or denture.
- x Repair or replacement of an orthodontic appliance.
- x Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.
- x Any duplicate appliance or prosthetic device.
- x Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.
- x Instruction for oral care such as hygiene or diet.
- x Periodontal splinting.
- x Charges by a dentist for completing dental forms.²
- x Charges for broken appointments.³
- x Temporary or provisional restorations.
- x Temporary or provisional appliances.
- x Sterilization supplies.³
- x Services or supplies furnished by a family member.³
- x Treatment of temporomandibular joint disorders.
- x Implant Services.
- x Orthodontia.
- x Myofunctional therapy or correction of harmful habits.
- x Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

In Maryland:

x 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:

- a. refers a covered person to; or
- b. directs an employee or a person under contract with the 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

¹ In policies situated in **MD**, these exclusions do not apply to Medicaid.

² Not applicable in **MD**.

³ Not applicable in **FL, MD, NJ** and **TN**.

Common Questions... Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP 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.

How do I find a participating PDP dentist? There are more than 150,000 participating PDP dentist locations nationwide, including over 37,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program (PDP) offer any discounts on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists 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 you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed 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 e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-275-4638.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends 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're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? If you have MyBenefits you can access the Dental Procedure Fee Tool provided by go2dental.com where you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fees* for dental services in your area.

* 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, we recommend that you obtain pre-treatment estimates through your dentist

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 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 dental benefits plan summary for your out-of-network dental coverage.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision 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're 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, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

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 MetLife or your plan administrator for costs and complete details. Metropolitan Life Insurance Company, New York, NY 10166

