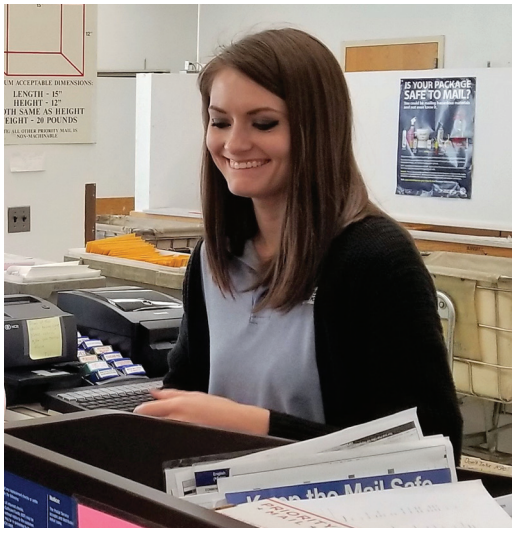
Dental Insurance Plan

for APWU Members Only

The benefits in this brochure are not part of the FEHB contract or premium, and you cannot file a FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow the Plan's guidelines. For additional information contact the Plan at 800-222-2798 or visit their website at www.apwuhp.com.



This plan is only open for enrollment during the APWU Health Plan Open Seasons.
June 1, 2019 – July 15, 2019 and November 11, 2019 – December 9, 2019

The Dental Plan is an indemnity plan. Under this program, after the deductible has been satisfied, covered services are reimbursed as a percentage of the "Reasonable and Customary" charges for that service in the same geographical area where the charge is incurred.

Obtain services from any dentist

Under this program, insured members may use any dentist they choose. If you were previously a member of a dental plan requiring the use of a specific dentist, you may continue to use that dentist if you so choose, but it is not a requirement of the Group Dental Plan.

Eligibility

All members in good standing, including Active / PSE (working at least 20 hours a week) and Retiree / Associate dues-paying APWU members are eligible to enroll. An eligible dependent is your lawful spouse or domestic partner and any unmarried dependent children whom you support up to age 26. (Subject to state variations).

Deductible amount

The Deductible is the expense that each insured person must incur each calendar year before any benefits are paid. There is no deductible for Type I benefits. A $50 deductible per person applies to the Type II and Type III Benefits combined.

If during a calendar year, insured persons of a family incur Covered Charges which are used to reduce the cash deductible and equal at least 3 times the individual deductible, no individual deductible will be required for any other insured person of that family during that calendar year. The charges that each family member may use to reduce the family deductible may not exceed that individual deductible for each person.

Calendar year maximum

The maximum amount payable for all Eligible Dental Expenses in any calendar year is $20,000 per person for all covered services. "Calendar year" is generally understood to mean January 1 through December 31. If someone's effective date of coverage is not January 1, the 12 month period beginning on their effective date of coverage would not be a "Calendar year".

Reasonable & customary

R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of 1) the dentist's actual charge, 2) the dentist's usual charge for the same or similar services or 3) the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

Waiting period

The period of time the insured person must be continuously covered under the group policy before the insured is entitled to be reimbursed for covered dental charges. There is no waiting period for Type 1 or Type 2 benefits.

Eligible expenses

Expenses must be incurred while the group policy is in force and the person is covered by the Policy. To be an Eligible Expense, the dental service must be performed by: (1) a licensed Dentist acting within the scope of his/her license; (2) a licensed dental hygienist acting under the supervision and direction of a Dentist. Any amount of eligible expense incurred which exceeds the "Reasonable and Customary" amount will not be covered.

Coverage will become effective on the first day of the period your first premium is received following the date of approval. Active / PSE members: You must be actively at work on the date the insurance is to take effect. If you are not, the insurance will take effect on the day you return to work. Dependent spouses/domestic partners and children, if enrolling, must not be hospitalized on the date the insurance is to take effect. If they are, the insurance will take effect on the day after they have been discharged.

Date insurance ends

This coverage will end on the earliest following date: when the group policy ends or when the premium is not paid when due. Coverage for dependents will end at the earliest of: the date the member's insurance ends, the date the insurance ends under the group policy; the date the person ceases to be a dependent; or if premium is not paid for the dependent when due.

APWU HEALTH PLAN

VOLUNTARY BENEFITS PLAN ★ BENEFITS FOR MEMBERS ONLY ★

PLEASE CALL 1-800-307-8615 FOR MORE INFORMATION

MetLife

Coverage schedule

Calendar Year Deductible	• Type I benefits: None • $50 per person – Type II & Type III benefits combined • Family Deductible $150 • No deductible for Type IV Benefits Orthodontic Coverage (if selected)
Calendar Year Maximum	• $20,000 per person for all covered services
Lifetime Maximum	• 2,500 per person per year, Max. of $5,000 for Orthodontic services (if selected)

Benefits schedule

After the annual deductible this plan will pay:

Type I Benefits	Type II Benefits	Type III Benefits	Type IV Benefits
Preventive Services • Exams • X-Rays • Cleanings	Basic Services • Fillings • Oral Surgery • Extractions	Major Services • Crowns • Bridges • Dentures • Periodontics	(Optional Coverage) Orthodontic Services
100% of the Reasonable and Customary charges	80% of the Reasonable and Customary charges	50% of the Reasonable and Customary charges (12 month waiting period)	50% of the Reasonable and Customary charges

Exclusions

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 Dental Insurance starts for that person.
4. Services which are primarily cosmetic (for residents of Texas, see notice page section in 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.
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 required to pay; or
    - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
14. Services covered under other coverage provided by the Employer.
15. Temporary or provisional restorations.
16. Temporary or provisional appliances.
17. Prescription drugs.
18. Services for which the submitted documentation indicates a poor prognosis.
19. 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.
20. 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.
21. Caries susceptibility tests
22. Replacement of an orthodontic device.
23. Duplicate prosthetic devices or appliances.
24. Replacement of a lost or stolen appliance Cast Restoration, or Denture.
25. Intra and extraoral photographic images.

On the list below, locate the state you live in	Active/PSE Members							
	Bi-weekly premium without orthodontic coverage				**Bi-weekly premium** with orthodontic coverage			
	Member Only	Member & Spouse/Domestic Partner	Member & Child	Member & Family	Member Only	Member & Spouse/Domestic Partner	Member & Child	Member & Family
ND, SC	$15.39	$29.41	$24.62	$43.76	$16.74	$31.98	$26.78	$47.58
AL, AR, GA, IA, ID, KY, MS, NC, NE, WI, WV, WY	$17.29	$33.04	$27.64	$49.16	$18.80	$35.92	$30.06	$53.46
HI, IN, KS, LA, ME, MN, MO, NM, OH, OK, TN, UT, VT	$18.99	$36.30	$30.38	$54.02	$20.66	$39.47	$33.04	$58.74
AZ, CO, DE, IL, MD, NV, PA, RI	$20.71	$39.56	$33.13	$58.88	$22.52	$43.02	$36.03	$64.03
DC, FL, MA, MI, NJ, TX, VA	$22.60	$43.19	$36.15	$64.29	$24.57	$46.97	$39.31	$69.91
CA, CT, WA	$24.31	$46.47	$38.89	$69.15	$26.44	$50.53	$42.29	$75.19
NY	$26.58	$50.81	$42.54	$75.64	$28.91	$55.25	$46.26	$82.25

On the list below, locate the state you live in	Retiree/Associate Members							
	Monthly premium without orthodontic coverage				**Monthly premium** with orthodontic coverage			
	Member Only	Member & Spouse/Domestic Partner	Member & Child	Member & Family	Member Only	Member & Spouse/Domestic Partner	Member & Child	Member & Family
ND, SC	$33.36	$63.72	$53.33	$94.81	$36.27	$69.29	$57.99	$103.10
AL, AR, GA, IA, ID, KY, MS, NC, NE, WI, WV, WY	$37.45	$71.59	$59.92	$106.51	$40.73	$77.85	$65.16	$115.82
HI, IN, KS, LA, ME, MN, MO, NM, OH, OK, TN, UT, VT	$41.15	$78.64	$65.84	$117.04	$44.75	$85.52	$71.59	$127.28
AZ, CO, DE, IL, MD, NV, PA, RI	$44.87	$85.73	$71.76	$127.59	$48.80	$93.23	$78.03	$138.74
DC, FL, MA, MI, NJ, TX, VA	$48.99	$93.60	$78.34	$139.29	$53.27	$101.79	$85.19	$151.47
CA, CT, WA	$52.67	$100.67	$84.27	$149.83	$57.27	$109.47	$91.64	$162.92
NY	$57.62	$110.10	$92.18	$163.88	$62.66	$119.73	$100.24	$178.20

Administered by:
Voluntary Benefits Plan® for the
APWU HEALTH PLAN
P.O. Box 12009 • Cheshire, CT 06410

VOLUNTARY BENEFITS PLAN • BENEFITS FOR MEMBERS ONLY •

PLEASE CALL 1-800-307-8615 FOR MORE INFORMATION

Underwritten by:
MetLife
Metropolitan Life Insurance Company
New York, New York

ACTIVATION FORM FOR THE DENTAL INSURANCE PLAN

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410

APWU HEALTH PLAN

Underwritten by:
MetLife
Metropolitan Life Insurance Company
New York, New York

MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Member's Name: _____ (Last Name) _____ (First) _____ (Middle Initial) Social Security Number: _____

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Phone: (____) _____ E-mail Address: _____ Local: _____

Date of Birth: ____ /___ /_____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Employment Status: ☐ Active ☐ PSE ☐ Retired ☐ Associate

COVERAGE

(Refer to the brochure or your certificate for eligibility, options and coverage descriptions.)

I HEREBY ENROLL IN THE FOLLOWING GROUP DENTAL INSURANCE PLAN: *(Choose one)*

PLAN: ☐ WITHOUT ORTHODONTIC COVERAGE ☐ WITH ORTHODONTIC COVERAGE

INDICATE COVERAGE DESIRED: *(Choose one)*

☐ Member Only ☐ Member & Spouse/Domestic Partner ☐ Member & Child ☐ Member & Spouse/Domestic Partner & Child(ren)

If **DEPENDENT** coverage is requested, list eligible dependents
(Lawful spouse and unmarried dependent children under age 19, 25 if a full-time student.) (Subject to state variations.)

SPOUSE'S/DOMESTIC PARTNER'S FULL NAME (Last, First, Mid. Init.)			Social Security Number	Date of Birth / /	☐ Male ☐ Female
1. (Child Name)	Date of Birth / /	☐ Male ☐ Female	4. (Child Name)	Date of Birth / /	☐ Male ☐ Female
2. (Child Name)	Date of Birth / /	☐ Male ☐ Female	5. (Child Name)	Date of Birth / /	☐ Male ☐ Female
3. (Child Name)	Date of Birth / /	☐ Male ☐ Female	6. (Child Name)	Date of Birth / /	☐ Male ☐ Female

NOTE: *If both parents are members, child(ren) can only be covered by one parent.*

I hereby enroll for and authorize the necessary salary deductions (for Active & PSE members) or Quarterly Direct Bill (For Retiree & Associate members) for the premium to pay for insurance in the APWU Health Plan's Dental Plan underwritten by MetLife Insurance Company. I further agree to participate in the Dental Plan for a minimum of one year. I understand that coverage applied for shall become effective on the first day of the period my first premium is received following the date of approval.

I have read and understand the conditions and exclusions of the program.

Important Notice – Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false Information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

_____ ____ /___ /_____
Member Signature X *(Sign in ink)* *Date*

NOTE: *If you have made corrections or strikeouts on this enrollment form, the Member MUST initial them.*

Group Policy # 122705