ALPA DENTAL INSURANCE PLAN

Frequently Asked Questions

Updated January 2024

Table of Contents

BENEFIT INFORMATION QUESTIONS

I am considering the ALPA Dental Plan in lieu of my employer-sponsored dental plan. What should I consider in evaluating which plan will be better for me?
After you've compared the benefits and premiums under both dental plans, if you are considering the ALPA Dental Plan instead of your employer-sponsored plan, you should take into consideration that your contribution for the employer-sponsored plan is made on a pretax basis, but your premium payments for the ALPA Dental Plan will be made on a post-tax basis. If both plans provide the same benefits levels and have exactly the same premiums, the ALPA Dental Plan will actually be more expensive due to the loss of the tax savings.

What coverage is available under ALPA's Dental Plan?
There are two coverage options available under the ALPA Dental Plan: Basic and Comprehensive. Both options offer coverage for preventive, diagnostic, and restorative services, and the Comprehensive option also includes coverage for orthodontic services. Insured through MetLife, the Dental Plan includes access to MetLife's extensive PDP Plus network of participating providers to maximize plan value, but you can visit any licensed dentist. For details regarding the benefits available under each option and the associated costs, please visit memberinsurance.alpa.org and click on Dental Insurance Plans under the ALPA Insurance Products tab.

How has my coverage changed under ALPA's Dental Plan with the move to MetLife dental?
Members that are enrolled under the MetLife plan as of 12/31/2023 will be switched to the MetLife Dental plan effective 1/1/2024. Members should not see any change or disruption in the current coverage they have in place. However, there is a slight possibility that a provider under MetLife Dental could be considered out-of-network under the MetLife plan which could have an impact on services provided. We are encouraging all members to visit **MetLife at www.metlife.com** and click **Find a Dentist/PDP Plus** to make sure their provider is still in the network before seeking services.

Is there a deductible my family must meet before I receive benefits?
Yes, under the Basic Plan, for all services including preventive, you must meet a $50 deductible per person, with a maximum family deductible of $150. Under the Comprehensive Plan, this deductible is waived for Diagnostic or Preventive services, but would need to be met for all other services.

How does the Calendar Year Maximum work?
A calendar year refers to the period of January 1 - December 31. Your annual maximum will start fresh each January 1.

Do I or my children have orthodontic coverage?
Under the Comprehensive Plan only, your dependent children through the age of 26, to the end of the calendar year, will be covered for braces at 50% to a lifetime maximum of $1,000 per child.

Are there any waiting periods?
Yes, if you or your dependents enroll in coverage after this initial enrollment period, there is a 12-month waiting period for Major Services and Prosthetics. These include crowns, bridges, dentures, and implants. There are no additional waiting periods to receive benefits.

What happens if I am currently in treatment?
Many members need continued dental care during times of change, and MetLife wants to help ease the transition. For dental treatment in progress, MetLife will generally credit each participant the annual or lifetime maximum usage, deductibles, and other plan limits used under the prior carrier. That means members don't have to start over or pay excessive out-of-pocket expenses. And any remaining benefits will be paid according to the MetLife plan. And if you choose, you have the flexibility to tailor the standard MetLife guidelines to meet your needs. Please refer to the **Transition of Care Guidelines** at https://www.alpa.org/resources/alpa-insurance/dental

COORDINATION OF BENEFITS BETWEEN DENTAL PLANS QUESTIONS

I have dental coverage through my employer. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the dental plan that covers you as an active employee—your employer-sponsored plan in this case—is primary, and the ALPA Dental Plan is secondary.

I have dental coverage through my spouse's employer. Which dental plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the plan that covers you other than as a dependent, for example as an employee or policyholder, is primary to a plan that covers you as a dependent. If you elect coverage under the ALPA Dental Plan and are also covered as a dependent under your spouse's employer-sponsored plan, the ALPA Dental Plan, under which you are the policyholder, will be primary, and your spouse's plan will be secondary for your dental coverage. However, if you also cover your spouse under the ALPA Dental Plan, your spouse's employer-sponsored plan will be primary for your spouse's dental benefits and the ALPA Dental Plan will be secondary. For children who are covered under both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is generally the primary plan with regard to the children (unless a court order specifies otherwise if you are divorced or separated).

I am retired and have retiree dental coverage under my previous employer's dental plan. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Under the generally applicable coordination of benefits principles, if you are covered by one dental plan as a retiree and another as the policyholder, either plan could be primary. In such situations, the plan that has covered you for the longer period— your employer-sponsored retiree dental plan in this case—is usually considered primary.

I am retired and have dental coverage under an individual plan. Which plan will be primary if I also have coverage under the ALPA Dental Plan?
Based on generally applicable coordination of benefits principles, the plan that has covered you the longest would be primary, but you should confirm the coordination rules under your other dental plan before electing coverage under the ALPA Dental Plan.

How does the ALPA Dental Plan coordinate benefits if I have other primary coverage and the ALPA Dental Plan is secondary?

If you have other dental coverage and the ALPA Dental Plan is secondary, it doesn't mean that your benefits are doubled. What it means is that you may enjoy lower out-of-pocket costs for your dental care. MetLife Dental works with the other dental carrier and your dental office to coordinate your benefits and ensure that the combined amount paid by both plans does not exceed the total amount the dentist has agreed to accept from MetLife.

Suppose, for example, that both your employer-sponsored plan and the ALPA Dental Plan provide two cleanings a year, each with 80% coverage. You would not be entitled to four cleanings per year, but you may have some cost savings. Assuming a charge of $100 for a cleaning is allowable under both plans, the employer-sponsored primary plan would pay $80, and then the ALPA Dental Plan, as secondary, would cover the remaining $20 that you would have had to pay out-of-pocket if you were only covered by the primary plan.

Note that in any case where a plan other than the ALPA Dental Plan would be secondary, you should determine how the other plan coordinates when secondary. Many plans, when secondary, will not pay additional benefits if the primary plan already paid as much as the secondary plan would have paid if primary. In other words, under this method, if the primary plan in the example above pays $80 for the cleaning (80% of a $100 covered expense), and the secondary plan would also have paid $80 for the same cleaning (80% of a $100 covered expense), no additional benefits would be payable by the secondary plan. The ALPA Dental Plan, as secondary payer, coordinates to 100% of a "covered expense", as determined by MetLife Dental, so the $20 out-of-pocket expense in this example would be covered.

How does orthodontia coverage or coverage for dental work in progress under the ALPA Dental Plan (Comprehensive option) coordinate with my employer-sponsored plan's orthodontia coverage?

As with all other benefits under the plan, the primary plan—your employer-sponsored plan in this case—will pay first, and then the ALPA Dental Plan, as secondary, will determine its liability and pay the amount not paid by the primary plan, subject to the applicable coinsurance and maximum lifetime benefit under the ALPA Dental Plan. Please refer to the **MetLife Transition of Care Guidelines** at

https://www.alpa.org/resources/alpa-insurance/dental

I have supplemental dental insurance or dental HMO insurance through a Medicare supplemental plan. How does the ALPA Dental Plan coordinate benefits with my plan?

The ALPA Dental Plan will be considered primary over supplemental plans, including a supplemental Medicare plan.

ELIGIBILITY QUESTIONS

Who is eligible to enroll in ALPA's Dental Plan?
ALPA members in the following membership classes are eligible to enroll in the Dental Plan:

AC	Active Member
AP	Apprentice Member
AR	Reactivated Member
EA	Executive Active Member
EI	Executive Inactive Member
IP	Inactive Participant Member
RT	Retired Member
SI	Sick Inactive Member
F1	Furloughed Member
ML	Military Leave Member
PL	Personal Leave Member
GP	Grievance Pending Member

A member who enrolls in ALPA's Dental Plan may also enroll his/her spouse, domestic or civil union partner and any of the member's and spouse's or partner's children who will be under age 26 on the January 1 of the plan year of enrollment. For purposes of this FAQ, spouse means domestic or civil union partner of the same or opposite sex.

Can I enroll or re-enroll at any time during the policy year?
Yes. Coverage may be selected anytime throughout the year. However, rates are subject to an annual renewal date of Jan 1st. There is also a 12-month waiting period on all major services for all new enrollments.

I have applied for coverage by the open enrollment deadline. When will my coverage be effective?
There is no annual open enrollment. All enrollments or changes will be effective on the first of the month following the date of approval and processing of the change in your billing statement.

What happens to spouse and dependent coverage upon termination of a member's coverage?
In most cases, if a member's coverage terminates, spouse and dependent coverage will also terminate at the end of the month following the termination date. However, a surviving spouse and any other covered dependents of a deceased member may continue participation by electing to participate in COBRA. Members and their families (qualified beneficiaries) are offered the opportunity for a temporary extension of coverage at group rates where coverage under the plan would otherwise end. Members,

spouse, and dependents have a right to choose COBRA (within 60 days of the event) if they lose their group dental coverage. The COBRA Administrator will provide for direct billing and annual open enrollment for the COBRA plans.

When does coverage end for a covered child?
Coverage for children ends at the end of the calendar year in which they turn age 26. At the end of the child coverage, the covered child can elect to continue coverage under COBRA.

How does the Dental Plan apply to members on military leave?
Eligible members on military leave can enroll and participate in the Dental Plan or make changes according to the qualifying life event change rules. Members on military leave also may suspend coverage in the Dental Plan upon commencement of military leave and reinstate coverage as of the first of the month following return from military leave.

Can my dependent(s) enroll without me?
No. Members must enroll for dependents to have coverage, and all covered family members must be enrolled in the same Dental Plan option.

If I enroll in the Dental Plan, can I cover only certain dependents? For example, if my spouse has coverage through his or her employer, can I just enroll myself and my child(ren)?
Yes. Any eligible dependent(s) can be covered upon your initial eligibility or added anytime throughout the year. A 12-month waiting period on major services will apply.

What happens if my ALPA membership classification changes from an eligible to an ineligible membership class?
When a member moves into an ineligible class, coverage for the member (including the member's spouse and any covered dependents) will terminate at the end of the month following the change in membership status. Members and their families (qualified beneficiaries) are offered the opportunity for a temporary extension of coverage at group rates where coverage under the plan would otherwise end. Members, spouse, and dependents have a right to choose COBRA (within 60 days of the event) if they lose their group dental coverage. The COBRA Administrator will provide for direct billing and annual open enrollment for the COBRA plans.

How can my cancelled ALPA dental coverage be reinstated?
Coverage cancelled due to premium delinquency can be reinstated no later than 90 days from the due date, provided all delinquent premiums are paid in full. If the member decides not to reinstate and re-enroll later, member may re-enroll subject to any waiting periods for major services.

DENTAL NETWORK QUESTIONS

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 who meets your needs. Look for a list of participating dentists online at **www.metlife.com**. Enter your ZIP code and select the **PDP Plus** network.

Step 1: Go to www.metlife.com
Step 2: Select "Find a Dentist" next to the "How can we help you?"
Step 3: Select "PDP Plus" next to "Choose your network." Enter your zip code, City or State and select the "Find a Dentist" button.

May I choose a non-participating dentist?

You are always free to select any general dentist or specialist. However, you usually save more when you visit a participating dentist. Participating dentists have agreed to accept negotiated fees as payment in full for covered services. Negotiated fees typically range from 30–45% below the average fees charged in a dentist's community for similar services.[5] Non-participating dentists have not agreed to accept negotiated fees. So, you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

What happens if I use an out of network provider?

Your out of network reimbursement is at the 90th percentile. For example, the 90th percentile means that 90% of providers in each zip code area charge at or below the fee that will be used by MetLife for reimbursement.

If the dentist charges at or lower than the percentile used, your benefits (coinsurance, maximum and deductibles) are based on the dentist's billed charge for the service.

If the dentist charges higher than this allowable fee, you will be responsible for any amount above this allowable fee and the allowable amount determined by MetLife.

Can I get an estimate of my out-of-pocket expenses?

Yes. We recommend that you request a pre-treatment estimate for services totaling more than $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 an 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 the time of payment.

How are claims processed?

Dentists may submit claims for you, which means you have little or no paperwork. If you need a claim form, visit the Forms Library on **www.metlife.com** or call **1-888-817-0845**.

What if I need dental care if I'm traveling outside the United States?

Our International Dental Travel Assistance program provides international assistance tied to your out-of-network benefits, including:

- 24/7 help in multiple languages
- Access to dental providers (based on strict credentialing criteria) in approximately 200 countries.
- Toll-free calling within the U.S., or collect calling outside the U.S.

MISCELLANEOUS QUESTIONS

How can I obtain a dental identification card?
Once you are enrolled, a set of two ID cards will automatically be sent to you. You may request a replacement or additional ID cards through the MetLife Dental member portal or mobile app.

How do I log in to the Dental Member Services portal?

Go to metlife.com/mybenefits or download the MetLife Mobile App[12] on the App Store and Google Play. You can find a dentist, view your claims, access your ID card, and more.

Digital servicing capabilities make dental care easy.

MetLife's mobile app[12] puts your ID card, plan details, and claim information at your fingertips. For added convenience, it also includes features like:

- A Find a Dentist tool with easy access to provider ratings.
- Online appointment scheduling for select dentists.
- Convenient claim status notifications via text messaging
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Our digital tools available on MyBenefits also include:

- Access a Dental Cost Estimator[10] so you can view personalized, plan-specific, and ZIP code-based cost estimates for most common procedures – as well as the deductibles, plan maximums, and frequency limitations that apply.

A digital virtual assistant that's available 24/7 to help you with common tasks like accessing coverage information, getting personalized estimates, or viewing claims.

What can I do on the Dental Member Services portal?

MetLife benefits information right from your desktop

The MyBenefits web site is a quick and easy way for you to get the information you need about your MetLife benefits — all in one place. Log in at **metlife.com/mybenefits** to see how we've taken personalization and integration to a new level.

Personalized homepage to all your MetLife benefits

Get more information on your MetLife benefits, where you can link to detailed coverage information and can perform tasks, such as:

Additional MyBenefits features include:

Planning tools that you can use to help you make informed decisions regarding your retirement, benefits coverage as well as other useful information for a variety of everyday topics.

Forms and documents that you may need are in the "Tools & Resources" area at the bottom of the MyBenefits home page for you to download.

Online claims tracking and email notifications called eAlerts, which will provide information regarding status changes to your claims for certain benefits.[1]

MetLife Virtual Assistant available on MyBenefits for Dental PPO members – a new click-to-chat feature offers quick help for dental related inquiries and other common tasks such as viewing claims, personal coverage and obtaining personalized estimates.

Dental Plans — Easily find a participating dentist or view your benefits, copay or coinsurance amount, and claims[1] online. Plus, you will have access to our extensive Oral Health Library[3] to research important dental topics.

Dental ID cards are available online for you to download and print at your convenience.[1] Cards contain your name, employer/association name and group number. Also included are MetLife's claims submission address,[1] website address, customer service telephone number and a service number for International Dental Travel Assistance.[4]

Who do I call if I have questions?
Call the MetLife customer service number on the back of your ID card or 1-888-817-0845. Enroll or make changes at memberinsurance.alpa.org or contact ALPA Member Insurance at 1-888-FLY-ALPA option 3, option 4 to learn more.

1. This feature is not available for members with a MetLife Dental HMO/Managed care plan.
2. To use the MetLife mobile app, employees can choose to register at metlife.com/mybenefits from a computer or directly through the app. Certain features of the MetLife Mobile App are not available for all MetLife Dental Plans.
3. All information provided on this website ("Website") is intended for your general knowledge only and is not a substitute for obtaining

medical or dental advice for specific medical or dental conditions or other advice from your dentists or doctors. By making the Website available to you, Metropolitan Life Insurance Company and its affiliates (collectively, "MetLife") is not engaged in rendering any such advice. Use of the Website is subject to all the terms stated therein. The Website is developed, provided and maintained by Verifpoint, an independent vendor. Insofar as the information provided on the Website is from third parties or links to third party websites, it has no association whatsoever with MetLife, unless expressly stated.

4. AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.
5. Based on internal MetLife analysis. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-pays, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
10. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.
12. To use the MetLife mobile app, employees can choose to register at metlife.com/mybenefits from a computer or directly through the app. Certain features of MetLife Mobile App are not available for MetLife Dental Plans.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions of benefits, limitations and terms for keeping them in force. Please contact MetLife for complete details.

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