METLIFE DENTAL INSURANCE

Network	PDP Plus			
	Base PPO Plan 1		Buy Up PPO Plan 2	
Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Maximum Per Member	$1,500		**$3,000**	
Calendar Year Deductible (CYD) Per Member	$50		$50	
Calendar Year Deductible (CYD) Per Family	$150		$150	
Waived for Class 1 Services?	Yes		Yes	
CLASS 1 SERVICES: DIAGNOSTIC & PREVENTIVE	**In Network**	**Out of Network***	**In Network**	**Out of Network***
Routine Oral Exam (2 Per Year)	Plan Pays: 80% Deductible Waived*		Plan Pays: 80% Deductible Waived*	
Routine Cleanings (2 Per Year)				
Bitewing X-rays (2 Per Year)				
Panoramic X-rays (1 Per 3 Years)				
Full Mouth X-Rays (1 Per 3 Years)				
Fluoride Treatments (Annually to Age 19)				
Sealants (Every 3 Years to Age 14)				
Space Maintainers (Non-Orthodontic Treatment)				
CLASS 2 SERVICES: BASIC RESTORATIVE				
Fillings (Amalgam & Composite)	Plan Pays: 80% After CYD*		Plan Pays: 80% After CYD*	
Routine Extractions				
Root Canal Therapy				
Periodontal Scaling (Entire Mouth)				
Oral Surgery				
General Anesthesia				
CLASS 3 SERVICES: MAJOR RESTORATIVE**				
Bridges	Plan Pays: 50% After CYD*		Plan Pays: 50% After CYD*	
Crowns				
Dentures				
CLASS 4 SERVICES: ORTHODONTIA**				
Lifetime Maximum	$1,500		$1,500	
Benefit	50% Coinsurance; No Deductible*		50% Coinsurance; No Deductible*	

Out of Network Balance Billing
For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Dental PPO - Participating and Non-Participating Providers section in your Summary Plan Description.
*Late entrant limitation will apply for 12 months on all services

How to Find a Provider
To search for a participating provider, contact MetLife's Customer Service or (941) 893-2556 or visit MetLife's website at www.metlife.com, click on Find a Dentist, then click on PDP Plus network.

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METLIFE VISION INSURANCE

The City offers vision insurance through MetLife. The employee costs and benefits are provided in the below tables. For detailed coverages, exclusions and stipulations, please refer to the carrier's benefit summary, contact MetLife at 855-638-3931 or visit MetLife's website at www.metlife.com.

Tier of Coverage	Employee Cost Bi Weekly
Employee Only	$2.26
Employee + One	$4.28
Employee + Family	$5.58

Network	MetLife Vision	
Services	**In Network**	**Out of Network**
Eye Exam	$10 Copay	Up to $45 Reimbursement After $10 Copay
Materials	$20 Copay	$20 Copay Applies. Plan Reimbursement Based on the Type of Service
Frequency of Services	**In Network**	**Out of Network**
Examination	12 Months	
Lenses	12 Months	
Frames	12 Months	
Contact Lenses	12 Months	
Lenses	**In Network**	**Out of Network**
Single	Paid in Full After Copay	Up to $30 Reimbursement After Copay
Bifocal		Up to $50 Reimbursement After Copay
Trifocal		Up to $65 Reimbursement After Copay
Frames	**In Network**	**Out of Network**
Basic, Preferred or Non-Preferred	$150 Retail Allowance: 20% discount on balance	Up to $70 Reimbursement After Copay
Contact Lenses*	**In Network**	**Out of Network**
Non-Elective (Medically Necessary)	Covered In full After Copay	Up to $210 Reimbursement After Copay
Elective Lenses	$150 Retail Allowance After Copay	Up to $105 Reimbursement After Copay
Standard Fitting	Covered in full with a maximum copay of $60	Applied to contact lens allowance
Specialty Fitting	Covered in full with a maximum copay of $60	Applied to contact lens allowance

**Contact Lenses are in lieu of spectacle lenses and a frame*

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