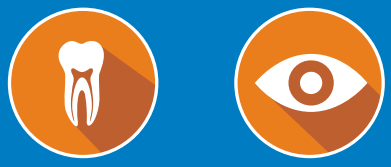
Pennsylvania Public School Employees' Retirement System (PSERS)

Health Options Program

The MetLife Dental and EyeMed Vision Option



The Health Options Program offers Medicare-eligible participants a choice of coverage options. In addition to medical and prescription drug coverage, participants can elect dental and vision coverage too. It's easy to do. You cannot enroll in vision and dental coverage separately.

The dental and vision option includes preventive care and offers discounts for certain services when you use an in-network provider.

Review the sections that follow for more details on how the benefits work, how to find network providers, and any limitations or restrictions.

You must be enrolled in the HOP Medical Plan or the Value Medical Plan to be eligible for the dental and vision option. It is not available on a stand-alone basis or if you are enrolled in a Medicare Advantage plan.

If you do not enroll in the dental and vision option for 2022, or enroll but drop your coverage at a later date, you will not be able to re-enroll unless there is an open enrollment or you experience a Qualifying Event.

What's Inside

MetLife

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MetLife Dental Coverage

Highlights

- You don't need to change dentists when you join. You can visit any dentist you want, but choosing one that's part of the MetLife network (an in-network dentist) saves you money.*
- If you use an in-network dentist, there's no annual deductible, which means you start saving on dental care the first time you visit a dentist in 2022.
- When you see an in-network dentist, you pay nothing for preventive care (exams and cleanings) and less than half the cost for all other services as compared to going out of network.
- Each year, you can receive up to $1,350 in basic and major restorative services. Preventive services do not count toward the maximum annual benefit.
- If you use an in-network dentist after you receive the maximum annual benefit, you'll continue to pay discounted rates.

Coverage at a glance

Here's how much you would pay for in-network and out-of-network dental care in 2022. See "Covered services and limitations" on page 4 for additional important information about benefits.

	IN-NETWORK	OUT-OF-NETWORK**
Preventive Services		
Deductible	$0	$0
Oral exams; cleanings; full mouth or panoramic X-rays; bitewing X-rays; intraoral, periapical, and extraoral X-rays; fluoride treatments (for dependent child(ren) up to age 14)	0%	20% of MetLife's discounted rate plus 100% of the difference between the actual and discounted rates
Basic and Major Restorative Services		
Deductible	$0	$100
Basic Services (pulp vitality tests, diagnostic casts, bacteriological studies, sealants, space maintainers, palliative care, sedative fillings, fillings, periodontal maintenance, pulp capping, therapeutic pulpotomy, periodontics—nonsurgical, simple extractions, surgical extractions/oral surgery)	30% of MetLife's discounted rate	50% of MetLife's discounted rate plus 100% of the difference between the actual and discounted rates
Major Services (recementations and repairs, rebases/relines, general anesthesia, consultations, inlays/onlays, crowns, crown build-ups, dentures, bridges, endodontics/root canal, periodontics—surgical, placement of implants)	40% of MetLife's discounted rate	50% of MetLife's discounted rate plus 100% of the difference between the actual and discounted rates

* Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the costs for services rendered.

** These out-of-network reimbursement levels do not apply in Texas, Mississippi, Louisiana, Montana, Massachusetts, or Alaska. If you live in one of these states, call the HOP Administration Unit (1-800-773-7725) for reimbursement levels.

Understanding in-network and out-of-network dental benefits

Each time you need dental care, you decide whether to use an in-network dentist or one that is not part of the MetLife network. While you are free to go out of network whenever and as often as you like, using a MetLife dental provider is your lower-cost option.

Here's why:

- With in-network providers, **you never pay a deductible.** If you use out-of-network dentists, you must satisfy a $100 deductible before the Plan pays any benefits for basic or major restorative services.
- Your **percentage of the cost is always lower** with an in-network provider.
- MetLife negotiates **discounted rates*** with in-network dentists. This means they are under contract to accept a specific amount for each service. Out-of-network dentists can charge any amount, but MetLife will pay benefits based only on the amount it has established for in-network providers. This means that if you use an out-of-network dentist, you pay 100% of the difference between what the dentist charges and MetLife's discounted rate.

Example. You need a periodontal scaling and root planing (a basic restorative service), which has a discounted rate of $119. You have a choice of two equally qualified dentists. One dentist belongs to the MetLife network and charges the discounted rate of $119. You pay $35.70 (30% of $119), and MetLife pays $83.30.

The other dentist is not in the MetLife network and charges $216 for the service. Assuming that you have already met the $100 annual deductible for out-of-network restorative services, your cost consists of two charges:

- $59.50 (50% of the $119 discounted rate), plus
- $97 (100% of the difference between the dentist's actual charge of $216 and the discounted rate of $119)

So you pay $156.50 ($59.50 + $97) and MetLife pays $59.50. In this example, **you would save $120.80** ($156.50 - $35.70) by using an in-network dentist.

To find a MetLife dentist

There are thousands of general dentists and specialists to choose from nationwide, so you are sure to find one who meets your needs. A complete list of in-network MetLife dentists is online at **metlife.com/dental**. Click on the **Find a participating dentist** tool on the home page, enter your ZIP code, and choose **PDP Plus** as your network in the drop-down list. You can also call MetLife toll-free at 1-855-700-7997 and request that a list of dentists be mailed to you.

If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit **metdental.com** or call 1-866-PDP-NTWK (737-6895) for an application. (This website and phone number are for use by dental professionals only.)

When you go to the dentist

You are not required to show an ID card to your dentist as proof of coverage. Just tell your dentist's office that MetLife is your dental carrier when you schedule an appointment. Dentists may submit claims for you, which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed.

Pre-treatment estimates

You can get an estimate of what your out-of-pocket expenses will be before receiving a service by asking for a pre-treatment estimate. It is recommended that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at **metdental.com** or call 1-877-MET-DDS9 (638-3379). (This website and phone number are for use by dental professionals only.) You and your dentist will receive a benefit 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.

* Discounted rates refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing, and benefits maximums. Discounted rates are subject to change.

Maximum benefits

Once you receive $1,350 in dental benefits (in-network and out-of-network combined; this doesn't include preventive and diagnostic care), you pay 100% for any additional care you receive for the rest of the calendar year. However, **in-network dentists accept MetLife's negotiated rates even after the maximum has been reached**—which means you continue to receive discounts on covered dental services.

Covered services and limitations

Preventive Services	
Oral exams	One oral exam every six consecutive months
Cleanings (prophylaxis)	One cleaning every six consecutive months
X-rays	One full-mouth X-ray and panoramic X-ray per 60 consecutive months
	Bitewing X-rays: one set per calendar year for adults; one set per six consecutive months for children
Topical fluoride treatments	One fluoride treatment in 12 months for dependent children up to age 14
Basic and Major Restorative Services	
Basic Services	
Sealants	Limitation of one application of sealant material for each nonrestored permanent first and second molar tooth of a dependent child to age 19, once every 60 consecutive months
Space maintainers	Space maintainers for dependent children up to age 14
Fillings	One per tooth surface per 24 consecutive months
Periodontics—nonsurgical	Periodontal scaling and root planing once per quadrant, every 12 months
	Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Major Services	
Crown, denture, and bridge repair/ recementations	Replacement: once every 84 consecutive months
General anesthesia	When dentally necessary in connection with oral surgery, extractions, or other covered dental services
Inlays/onlays, crowns	Replacement: once every 84 consecutive months
Bridges and dentures	Initial placement to replace one or more natural teeth, which are lost while covered by the Plan
	Dentures and bridgework replacement: once every 84 consecutive months
	Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 consecutive months after the temporary denture was installed
Endodontics	Root canal treatment not more than once in any 24-consecutive-month period for the same tooth
Periodontics—surgery	Periodontal surgery once per quadrant, every 36 months
	Tissue conditioning, but not more than once in a 36-month period
Implants	Once in 84 consecutive months

Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Ask MetLife or the HOP Administration Unit for costs and complete details.

What is not covered

The MetLife Dental Plan does not cover the following services, treatments, and supplies:

- Services that are not dentally necessary, that do not meet generally accepted standards of care for treating the particular dental condition, or that MetLife deems experimental in nature
- Services that are neither performed nor prescribed by a dentist, except for those services of a licensed dental hygienist that are supervised and billed by a dentist and are for scaling and polishing of teeth or are fluoride treatments
- Services for which you would not be required to pay in the absence of dental coverage
- Services or supplies received by you or your dependent before the MetLife Dental Plan starts for that person
- Services that are primarily cosmetic
- Services or appliances that restore or alter occlusion or vertical dimension
- Restoration of tooth structure damaged by attrition, abrasion, or erosion unless caused by disease
- Restorations or appliances used for the purpose of periodontal splinting
- Counseling or instruction about oral hygiene, plaque control, nutrition, and tobacco
- Personal supplies or devices including, but not limited to, water flossers, toothbrushes, or dental floss
- Decoration or inscription of any tooth, device, appliance, crown, or other dental work
- Missed appointments
- Temporary or provisional restorations
- Temporary or provisional appliances
- Prescription drugs
- Services for which the submitted documentation indicates a poor prognosis
- Services to the extent that such services, or benefits for such services, are available under a government plan
- The following when charged by the dentist on a separate basis: claim form completion; infection control such as gloves, mask, and sterilization or supplies; or local anesthesia, non-intravenous conscious sedation, or analgesia such as nitrous oxide
- Dental service arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Caries-susceptibility tests
- Appliances or treatment for bruxism including, but not limited to, occlusal guards and night guards
- Orthodontic services or appliances
- Repair or replacement of an orthodontic device
- Intra- and extraoral photographic images
- Initial installation of a denture to replace one or more natural teeth that were missing before such person was insured under the MetLife Dental Plan, except for congenitally missing natural teeth
- Precision attachments associated with fixed and removable prostheses
- Adjustment of a denture made within six months after installation by the same dentist who installed it
- Duplicate prosthetic devices or appliances
- Replacement of a lost or stolen appliance or crown, inlay/onlay, or denture
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders (this exclusion does not apply to residents of Minnesota)
- Implant-supported prosthetics to replace one or more natural teeth that were missing before such person was insured under the MetLife Dental Plan, except for congenitally missing natural teeth

Other important information

If you are traveling outside the U.S.

The MetLife Dental Plan includes international dental travel services. If you are traveling abroad and need a dentist, you can obtain a local referral by calling +1 312-356-5970 (collect). This service is available 24/7 and gives you access to international dental providers in more than 200 countries. With just one phone call, you will reach a multilingual assistance coordinator who will help you get the care you need. If you submit all receipts and a claim form to MetLife, coverage will be considered under your out-of-network benefits.

International travel assistance is provided by AXA Assistance USA, Inc. AXA Assistance 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.

Submitting claims

In most cases, your dentist will submit claims for you. However, if you need to submit a claim yourself (for example, for out-of-network services) you can request a claim form by calling 1-855-700-7997. All claim forms should be mailed to MetLife Dental Claims, P.O. Box 981282, El Paso, TX 79998-1282.

Additional resources

- Visit the dental education website at **oralfitnesslibrary.com** for important tools and resources to help you become more informed about dental care. You can also put your oral health to the test by taking an online risk assessment.
- **Coordination of benefits.** A coordination of benefits provision is a set of rules that is followed when a patient is covered by more than one benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife Dental Plan is primary, MetLife will pay the full amount of benefits that would normally be available under the Plan. If the MetLife Dental 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.
- **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 costs above the benefit amount. To avoid any misunderstandings, you should discuss treatment options with your dentist before services are rendered and obtain a pre-treatment estimate of benefits (see page 3) prior to receiving certain high-cost services such as crowns, bridges, or dentures.
- **Cancellation/termination of benefits.** Coverage is provided under a group insurance policy (policy form GPNP99) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease, or upon termination of the plan by PSERS or MetLife. 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.
- Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Ask MetLife or the HOP Administration Unit for costs and complete details.

* Discounted rates refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing, and benefits maximums. Discounted rates are subject to change.

EyeMed Vision Coverage

Highlights

- Eye examinations, frames, and prescription lenses or medically necessary contact lenses are covered once every other calendar year.
- You have the option to see a provider in the EyeMed Insight network or an out-of-network provider; however, you'll always pay less for in-network services.
- When you visit a PLUS Provider (e.g., LensCrafters and Target Optical), you are eligible for an additional $50 frame allowance.
- Out-of-network care will be reimbursed up to the Plan limits (noted below) after you submit a claim for the full amount of the service.
- The HealthyEyes wellness program keeps the focus on your eye health with online tools, articles, and videos.

Coverage at a glance

Here's how much you would pay for in-network and out-of-network vision care in 2022. See "Additional covered services, discounts, and limitations" on page 8 for additional important information about benefits.

COVERED SERVICES (ONCE EVERY OTHER CALENDAR YEAR)	YOUR COST IN-NETWORK	YOUR REIMBURSEMENT OUT-OF-NETWORK
Vision Exam	$0	Up to $30
Frame	20% off balance over $100 allowance	Up to $45
Frame From a PLUS Provider	20% off balance over $150 allowance	Up to $45
Standard Plastic Lenses (in lieu of medically necessary contacts)		
Single-vision	$0	Up to $25
Bifocal	$0	Up to $36
Trifocal	$0	Up to $46
Lenticular	$0	Up to $46
Progressive—standard	$55	Up to $36
Medically Necessary Contact Lenses (in lieu of lenses)	$0	Up to $210

Understanding in-network and out-of-network vision benefits

Each time you need vision care, you decide whether to use an in-network provider or one that is not part of the EyeMed Insight network. While you are free to go out of network whenever and as often as you like, using an EyeMed provider is your lower-cost option.

Here's why:

- For most in-network services, including eye exams, most lenses and frames, you'll pay nothing—a $0 copay—when you need care.
- When you purchase frames from a PLUS Provider (e.g., LensCrafters and Target Optical), you'll receive an additional $50 frame allowance.

- If you visit an out-of-network provider, you'll pay the full amount of the service up front and submit a claim for reimbursement, along with an itemized invoice.
- EyeMed **negotiates discounted rates*** with in-network providers. This means they are under contract to accept a specific amount for each service. Out-of-network providers can charge any amount, but EyeMed will only pay up to the maximum reimbursement level. This means, if you use an out-of-network provider, you pay 100% of the difference between what the provider charges and EyeMed's maximum reimbursement level.

* Discounted rates refer to the fees that in-network providers have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing, and benefits maximums. Discounted rates are subject to change.

To find an EyeMed vision provider

EyeMed's Enhanced Provider Search has more than 100,000 Insight network providers nationally. You can filter your search to find ones near you that have the frame brands, hours, and services you want most. To use the search tool, visit **eyedoclocator.eyemedvisioncare.com**, and select the Insight network. You may also download the EyeMed Members app through the Apple App Store or Google Play.

When you go to the vision provider

EyeMed will send you two ID cards when you join, but you don't have to show the card when you visit your eye doctor.

If you lose your card or need extras for your family, you can print a replacement by logging in to **member.eyemedvisioncare.com**, or, to pull up a digital version anytime or anywhere, download the EyeMed Members app through the Apple App Store or Google Play.

Additional covered services, discounts, and limitations

ADDITIONAL COVERED SERVICES*	YOUR COST IN-NETWORK	YOUR REIMBURSEMENT OUT-OF-NETWORK
Additional Standard Plastic Lenses (once every other plan year; in lieu of medically necessary contacts)		
Progressive—Premium Tier 1	$85	Up to $36
Progressive—Premium Tier 2	$95	Up to $36
Progressive—Premium Tier 3	$110	Up to $36
Progressive—Premium Tier 4	$175	Up to $36
Additional Lens Options		
Anti-reflective coating—Standard	$45	Up to $5
Anti-reflective coating—Premium Tier 1	$57	Up to $5
Anti-reflective coating—Premium Tier 2	$68	Up to $5
Anti-reflective coating—Premium Tier 3	$85	Up to $5

* The service categories and plan limitations shown above represent an overview of the Vision Plan benefits. This document presents the majority of services within each category but is not a complete description of the Plan.

Discounts

DISCOUNTS	YOUR COST IN-NETWORK*
Discounted Exam Services	
Retinal imaging	Up to max. of $39
Contact Lens Fit and Follow-Up (following a comprehensive eye exam)	
Fit and follow-up—Standard	Up to max. of $40
Fit and follow-up—Premium	10% off retail price
Discounted Lens Options	
Photochromic—non-glass	$75
Polycarbonate—standard	$40
Scratch coating—standard plastic	$15
Tint—solid or gradient	$15
UV treatment	$15
Other Add-On Services and Materials	20% off retail price

* Discounts are available in-network only.

Discount details

- Member receives a 20% discount on items not covered by the Plan at in-network locations. Discount does not apply to EyeMed provider's professional services or contact lenses.
- Plan discounts cannot be combined with any other discounts or promotional offers.
- In certain states, members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
- Discounts on vision materials may not be applicable to certain manufacturers' products.
- EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level.
- All providers are not required to carry all brands at all levels.
- Service and amounts listed above are subject to change at any time.

What is not covered

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services, or supplies for the treatment of the eye, eyes, or supporting structures; refraction, when not provided as part of a comprehensive eye examination; services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof; orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; aniseikonic lenses; any vision examination or any corrective vision materials required by a policyholder as a condition of employment; safety eyewear; solutions, cleaning products, or frame cases; nonprescription sunglasses; plano (nonprescription) lenses; plano (nonprescription) contact lenses; two pairs of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order; or lost or broken lenses, frames,

glasses, or contact lenses that are replaced before the next benefit frequency when vision materials would next become available. Fees charged by a provider for services other than a covered benefit and any local, state, or federal taxes must be paid in full by the insured person to the provider. Such fees, taxes, or materials are not covered under the policy. Allowances provide no remaining balance for future use within the same benefit frequency. Some provisions, benefits, exclusions, or limitations listed herein may vary by state.

Other important information

If you are traveling outside the U.S.

EyeMed offers an International Travel Solution if you have a vision emergency abroad and need to find a trusted provider.

Submitting claims

When you visit an in-network provider, you won't have to submit a claim; EyeMed will take care of all the paperwork.

If you go out of network for care, you'll need to pay during the visit and then submit a claim form and itemized invoice for reimbursement. To access the out-of-network form or to check the status of a claim, log in to Member Web (**member.eyemedvisioncare.com**) and navigate to the **Claims** tab. Remember to upload an itemized paid receipt with your name included.

Additional resources

- **Savings for members.** If you enroll in the Plan, you have access to additional savings through EyeMed, including:
  - 40% off additional pairs of glasses
  - 15% discount on conventional lenses
  - 20% off any item not covered by the Plan, including nonprescription sunglasses
- **Using benefits online.** You can use your EyeMed benefits online at many popular eyewear stores, with free shipping, free returns, and no paperwork. Online stores connected to your vision benefits include:
  - LensCrafters: **lenscrafters.com**
  - Target Optical: **targetoptical.com**
  - **Glasses.com**
  - ContactsDirect: **contactsdirect.com**
  - Ray-Ban: **ray-ban.com**

Required notices and information

- **Coordination of benefits.** All claims will be processed as primary through EyeMed.
- **Cancellation/termination of benefits.** Coverage is provided under a group insurance policy issued by EyeMed. Coverage terminates when your membership ceases, when your contributions cease, or upon termination of the group policy by PSERS or EyeMed. The group policy terminates for nonpayment of premium and may terminate if participation requirements are not met or if PSERS fails to perform any obligations under the policy.

Like most group benefit programs, benefit programs offered by EyeMed contain certain exclusions, exceptions, waiting periods, reductions, limitations, and terms for keeping them in force. Ask EyeMed or the HOP Administration Unit for costs and complete details.