Dental Insurance

Coverage that can help lower your dental costs.

Plan Year: 01/01/2027 to 12/31/2027

Network: PDP Plus

Active Employee Plan Options

	Plan Option 1 IBM Dental Basic		Plan Option 2 IBM Dental Plus	
	In-Network[1] % of Negotiated Fee[2]	Out-of-Network[1,3] % of R&C Fee[4]	In-Network[1] % of Negotiated Fee[2]	Out-of-Network[1,3] % of R&C Fee[4]
Coverage Type				
Type A: Preventive & Diagnostic (cleanings, exams, X-rays)	100%	100%	100%	100%
Type B: Basic Restorative (fillings)	80%	80%	80%	80%
Type C: Major Restorative (bridges, dentures, crowns)	Not Covered	Not Covered	65%	65%
Type D: Orthodontia	Not Covered	Not Covered	50%	50%
Deductible				
Individual	None	None	None	None
Family	None	None	None	None
Annual Maximum Benefit[5]				
Per Person	$500 (In- and Out-of-Network Combined)		$2,500 (In- and Out-of-Network Combined)	
Orthodontia Lifetime Maximum				
Per Person	Not Covered		$2,500 (In- and Out-of-Network Combined)	

Child(ren)'s eligibility for dental coverage is from birth up to age 26. See "Questions & Answers" for more details.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
[2] Negotiated fees 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. Negotiated fees are subject to change. Negotiated fees do not apply to non-covered services in states that prohibit limitations for services not covered under a plan. Participating providers in these states may charge their non-negotiated fees for non-covered services.
[3] Payment for out-of-network services is based on the lesser of the dentist's actual fee or Maximum Allowable Charge (MAC). The out-of-network MAC is a scheduled amount determined by MetLife
[4] 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.
[5] Preventive services not included in the Annual Maximum are – cleanings, topical fluoride, space maintainers, sealants or sealant repairs, resin restorations, interim caries applied to permanent bicuspids 1st and 2nd molar teeth.

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List of Primary Covered Services & Limitations

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

Plan Type	Plan Option 1: Active How Many/How Often	Plan Option 2: Active Plus How Many/How Often
Type A — Preventive & Diagnostic		
Prophylaxis (cleanings)	Two per calendar year	Two per calendar year
Oral Examinations	Two exams per calendar year	Two exams per calendar year
Topical Fluoride Applications	One fluoride treatment per calendar year	One fluoride treatment per calendar year
X-rays	• Full mouth X-rays; once every 60 months • Bitewings X-rays; one set per calendar year for adults; two sets per calendar year for children	• Full mouth X-rays; once every 60 months • Bitewings X-rays; one set per calendar year for adults; two sets per calendar year for children
Space Maintainers	Covered	Covered
Sealants	Covered	Covered
Type B — Basic Restorative		
Fillings	Covered	Covered
Type C — Major Restorative		
Simple Extractions	Not Covered	Covered
Crown, Denture and Bridge Repair/ Recementations	Not Covered	Covered
Oral Surgery	Not Covered	Covered
Implants	Not Covered	Replacement once every 7 years
Bridges and Dentures	Not Covered	• Initial placement to replace one or more natural teeth, which are lost while covered by the plan • Dentures and bridgework replacement; once every 7 calendar years • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays and Onlays	Not Covered	Replacement once every 7 calendar years
Endodontics	Not Covered	Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.

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General Anesthesia	Not Covered	When dentally necessary in connection with oral surgery, extractions or other covered dental services
Periodontics	Not Covered	• Periodontal scaling and root planing once per quadrant, once every 24 months • Periodontal surgery once per quadrant, once every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year
Type D — Orthodontia		
All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. This includes, but is not limited to: • Traditional braces • Invisalign • Retainers • Palate expanders	Not Covered	• You, your spouse and your children (up to age 26) are covered while Dental insurance is in effect • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 25% of the amount charged by the dentists will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the plan summary • Orthodontic benefits end at cancellation of coverage

Exclusions

This plan does not cover the following services, treatments and supplies:

- 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;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- 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;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- 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 not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;

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- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- 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.
- 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;
- Caries susceptibility tests (Basic Only);
- Other fixed Denture prosthetic services not described elsewhere in the certificate (Basic Only);
- Precision attachments, except when the precision attachment is related to implant prosthetics(Basic Only);
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal(Basic Only);
- Repair of implants (Basic Only);
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards (Basic Only);
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders (Basic Only);
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture;
- Intra and extraoral photographic images (Basic Only);
- Simple Extractions (Basic Only);
- Crown, Denture and Bridge Repair/ Recementations (Basic Only);
- Oral Surgery (Basic Only);
- Endodontics (Basic Only);
- General Anesthesia (Basic Only);
- Periodontics (Basic Only);
- Bridges and Dentures (Basic Only);
- Orthodontia (Basic Plan Only);
- Crowns, Inlays and Onlays (Basic Only)

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, payment 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 pre-treatment 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 plan's payment 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.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) issued by Metropolitan Life Insurance Company (MetLife). Coverage terminates when your participation ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy.

Group dental plans featuring the Preferred Dentist Program are provided by Metropolitan Life Insurance Company, New York, NY 10166.

Savings from enrolling in a dental benefits plan featuring the MetLife Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.

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Like most group benefits programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. You may be financially responsible for copayments, deductibles, or any other amounts in excess of those MetLife is required to pay for covered services as described in your dental certificate and/or policy. Ask your MetLife representative for costs and complete details.
The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

Questions & Answers

Q. When can I enroll in the Dental plan?

A. You can enroll during IBM's Annual Benefits Enrollment period or if you experience a Qualified Status Change. New hires can enroll within 60 days from their date of hire.

Q. How do I enroll in the Dental plan during Annual Enrollment or as a New Hire?

A. Please contact the IBM Benefits Center – Provided by Fidelity at www.NetBenefits.com/IBM or at 1-866-937-0720 Monday through Friday (excluding NYSE holidays, except Good Friday), 8:30 a.m. to 8:30 p.m. ET to enroll.

Q. Who is eligible to enroll in the Dental plans?

A. All active regular full-time, regular part-time and retiree supplemental employees of International Business Machines Corporation, or those subsidiaries of IBM authorized to participate in the plans, regularly assigned in the United States of America, its territories and possessions and the Commonwealth of Puerto Rico, and their dependents (spouse/domestic partner and children), are eligible for the Dental Insurance options for Active Employees. This includes Supplemental 2 employees.

Q. Can I change my Dental plan outside of Annual Enrollment?

A. You are eligible to enroll in, or change, dental insurance outside of Annual Enrollment, only if you have a Qualifying Life Event. A qualifying event includes:

- marriage or newly formed domestic partnership
- the birth, adoption or placement for adoption of a dependent child
- divorce, legal separation or annulment, dissolution of a domestic partnership
- the death of a dependent
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage; or
- If you previously did not enroll for Dental Insurance for You or Your dependent because You had other group coverage, but that coverage has ceased due to one or more of the following reasons:
    - loss of eligibility for the other group coverage
    - termination of employer contributions for the other group coverage
    - COBRA Continuation of the other group coverage was exhausted
    - Your or Your dependent's loss of coverage under any group health coverage sponsored by a governmental or educational institution.

Qualifying Life Events need to be reported to the IBM Benefits Center – Provided by Fidelity to make any enrollment changes.

Q. What is the definition of spouse/domestic partner?

A. Spouse and domestic partner are defined as follows:

- Your spouse (same or opposite sex) if the marriage met the laws of the jurisdiction in which it was entered into.
- Your domestic partner (same or opposite sex) if the marriage met the laws of the jurisdiction in which it was entered into.
- Your common-law spouse may be eligible in certain circumstances. To meet the eligibility criteria to add a common-law spouse to your health coverage, you must:
    - Reside in a state that recognizes common-law marriage
    - Openly represent yourselves as husband and wife to government and tax authorities as well as to your relatives, friends, neighbors, coworkers, and acquaintances with whom you associate. It is expected that you file your income taxes as “married”
    - Change your status to “married” at IBM and ensure that your IRS form W-4 reflects “married”
    - Not be legally married to another person

Q. What is the definition of a child?

A. A child can be covered only up until age 26. A child includes your biological children, stepchildren, adopted children, and any child who resides with and is fully supported by you. Children who are disabled and were enrolled in dental coverage under the

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IBM Medical and Dental Benefits Plan for Regular Full-time and Regular Part-time Employees prior to attaining age 26 are eligible to retain coverage after they attain age 26. Disabled means incapable of self-sustaining employment because of mental or physical handicap.

Insurance for a disabled child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap, as defined by applicable law, and can be continued as long as the child:

- Remains incapable of self-sustaining employment because of a mental or physical handicap; and
- Continues to qualify as a Child, except for the age limit.

The Application for Coverage of Disabled Dependent Child Under IBM Health Benefit Plans form must be completed and sent to the IBM Benefits Center – Provided by Fidelity 60 days before the date the child attains age 26. It is your responsibility to notify the IBM Benefits Center – Provided by Fidelity of any changes to the child's eligibility for coverage.

Q. Who is a participating dentist?

A. A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 30% – 45% below the average fees charged in a dentist's community for the same or substantially similar services.[5]

Q. How do I find a participating dentist?

A. There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/IBM or call 1-800-872-6963 to have a list faxed or mailed to you.

Q. What services are covered under this plan?

A. The Plan documents set forth the services covered by your plan. The List of Primary Covered Services & Limitations herein contains a summary of covered services. In the event of a conflict between the Plan documents and this summary, the terms of the Plan documents shall govern. Please review the enclosed plan benefits to learn more.

Q. May I choose a non-participating dentist?

A. Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist your out-of-pocket costs may be higher.

Q. Can my dentist apply for participation in the network?

A. Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[6] The website and phone number are for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your 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. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-872-6963.

Q. Can I get an estimate of what my out-of-pocket expenses will be before receiving a service?

A. Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend 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 are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Q. Can MetLife help me find a dentist outside of the U.S. if I am traveling?

A. Yes. Through international dental travel assistance services[8] 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.[9] Please remember to hold on to all receipts to submit a dental claim.

Q. How does MetLife coordinate benefits with other insurance plans?

A. Coordination of benefits provisions 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, subject to applicable law, but the two plans may work together to provide up to 100% coverage. For more information, contact MetLife's Dental Service Center.

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Q. Do I need an ID card?

A. No. You do not need an ID card to receive dental services. However, if you enroll in a dental option administered by MetLife, you will receive an ID card, which will remain good for as long as you are enrolled in any dental option administered by MetLife. New cards will not be sent each year. You should receive your ID Card within a month of enrollment in the dental plan as a New Hire, or approximately two weeks after requesting a replacement.

If your card is lost or damaged, call MetLife's Dental Service Center to request a replacement card or log onto www.metlife.com/mybenefits to print one.

You can download the MetLife App for iOS and Android to access your ID Card. The MetLife App is available on the Apple App Store and Google Play.[10]

Q. How does the Dental plan save me money?[5]

A. Think about this: Having a good dental plan in place can help you save money every year. You also get protection against costly emergency dental treatments that may run into the hundreds or even thousands of dollars. In-network dentists have agreed to accept negotiated fees as payment in full for covered services, subject to any deductibles, copayments, cost sharing and benefits maximums. Negotiated fees typically range from 30–45% below the average fees charged in a dentist's community for similar services. Non-participating dentists have not agreed to accept negotiated fees.

In particular, the cost of specialty care like implants, root canals and crowns can really add up. That's why it's good to know the network is there to help you manage your out-of-pocket costs. You can view potential savings on in-network vs. out-of-network fees by using the Dental Procedure Tool.[7]

Q. Are Wisdom Teeth extractions covered?

A. Wisdom Teeth extractions are covered under the IBM Dental Plus Plan, but not the IBM Dental Basic Plan.

Wisdom Teeth Extraction coverage will be unique to each participant. If a simple extraction is needed to remove the wisdom teeth, that claim can be directed to MetLife for consideration of dental benefits. Benefits for simple extractions under the IBM Dental Plus plan are considered at 65% of the covered expense, up to the annual maximum.

However, if the wisdom teeth are impacted or need oral surgery to remove, there are a few things that should be considered which include, but may not be limited to, coordination with Medical Insurance and Anesthesia.

- Anesthesia, full sedation, is only covered if 2 or more wisdom teeth are extracted during the same visit and it is deemed medically necessary.
- Oral surgery can be quite costly. As surgery may be covered as a medical procedure under a Medical Insurance plan, submitting the claim for benefits consideration to the Medical Insurer first (since it may have a higher annual maximum or no annual maximum), followed by MetLife for Dental Benefits, could significantly reduce your out-of-pocket cost. You are not required to submit the oral surgery claim to your medical insurance first, but if you do, please include the medical EOB when sending the claim to MetLife.

Dental benefits for oral surgery under the IBM Dental Plus plan are considered at 65% of the covered expense, up to the annual maximum and not to exceed 100% of the covered expense (if coordinating with medical insurance or if the patient is covered under more than one dental insurance plan).

Q. How do I contact MetLife directly?

A. To follow-up on previously reported claims or for questions on the IBM Dental Plan, including covered dental services and frequency limitations, please call 1-800-872-6963.

Monthly Cost

For information on cost of coverage, please contact the IBM Benefits Center – Provided by Fidelity at www.NetBenefits.com/IBM or at 1-866-937-0720 Monday through Friday (excluding NYSE holidays, except Good Friday), 8:30 a.m. to 8:30 p.m. ET.

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[5] "Savings from enrolling in a dental benefits plan featuring the MetLife Preferred Dentist Program will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.
[6] Due to contractual requirements, MetLife is prevented from soliciting certain providers.
[7] The Dental Procedure Fee Tool application is provided by an independent vendor. 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.
[8] 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 or services provided by MetLife. Referral services are not available in all locations.
[9] Refer to your dental benefits plan summary for your out-of-network dental coverage.
[10] 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.

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