Dental

Metropolitan Life Insurance Company

Plan Design for: Case Western Reserve Univesity
Date: 1/1/2027

Network:
The Preferred Dentist Program was designed to help you get the dental care you need and lower your costs. You get benefits for a wide range of covered services both in and out of the network. The goal is to deliver cost-effective protection for a healthier smile and a healthier you.

Coverage Type:	**In-Network**[1] % of Negotiated Fee[2]	**Out-of-Network**[1] %of R&C Fee[4]
Type A - Preventive	100%	70%
Type B - Basic Restorative	80%	60%
Type C - Major Restorative	60%	40%
Type D - Orthodontia	50%	50%
Deductible[3]		
Individual	$50	$50
Family	$150	$150
Annual Maximum Benefit:		
Per Person	$1250	$750
Orthodontia Lifetime Max – Child only	$1250 per Person	

1. "In-Network Benefits" refer to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refer to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fee refers to the fees that participating 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. Reimbursement for out-of-network services is based on 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.

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List of Covered Services & Limitations*

Type A - Preventive	How Many/How Often:
Oral Examinations	• Oral exams but not more than once every 6 months.
X-rays	• Full mouth X-rays: once every 60 months.
Bitewing X-rays	• Not more than 1 set every 6 months for Dependent Children under 19 years of age, no more than 1 set every 12 months for all other Covered Persons.
Prophylaxis (cleanings)	• Cleaning of teeth (oral prophylaxis) but not more than once every 6 months.
Topical Fluoride Applications	• Topical fluoride treatment for a Dependent child under 14 years of age but not more than once in 12 months.
Sealants	• Sealants which are applied to non-restored, non-decayed, first and second permanent molars only, for dependents up to the age of 14, but not more than once per tooth in a lifetime.
Space Maintainers	• Space Maintainers for dependent children to 19 years of age.

Type B - Basic Restorative	How Many/How Often:
Fillings	• Amalgam and Resin-based Fillings.
Repairs of Dentures, Crowns, Inlays, and Onlays	• Simple Repairs of Cast Restorations.
Endodontics	• Root canal treatment, but not more than once in any 24 month period for the same tooth.
Periodontal Surgery	• Periodontal surgery but no more than one surgical procedure per quadrant in any 36 month period.
Periodontics	• Periodontal scaling and root planing, but not more than once per quadrant in any 24 month period.
Periodontal Maintenance	• Periodontal maintenance where periodontal treatment has been previously performed, but the total of covered periodontal maintenance treatments and the number of covered oral prophylaxes will not exceed four treatments in a calendar year.
Relining and Rebasing	• Relining and Rebasing of existing removable dentures but not more than once in 36 months.
Simple Extractions Oral Surgery Emergency Palliative Treatment General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Consultations	• Consultations, but not more than twice in a 12 month period.
Injections of Antibiotic Drugs	

Type C - Major Restorative	How Many/How Often:
Crowns/Inlays/Onlays	• Replacement of crowns, inlays or onlays but not more than once for the same tooth in a 60 month period.
Prefabricated Crowns	• Prefabricated stainless steel crowns but not more than once in any 60 month period.
Bridges and Dentures	• Replacing an existing removable denture or fixed bridgework if: it is needed because of the loss of one or more natural teeth after the existing denture or bridgework was installed and the denture or bridgework cannot be made serviceable; or it is needed because the existing denture or bridgework can no longer be used and was installed more than 60 months prior to its replacement.

Type D – Orthodontia

- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- Benefit for initial placement of the appliance will be made representing 20% of the total benefit.
- Orthodontic benefits end at cancellation of coverage

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 additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment 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 plans reimbursement 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.

* The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group benefits programs, benefit programs offered by MetLife 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.

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Exclusions

The following expenses are not Covered Dental Expenses

x Services or Supplies…

— related to teeth lost before dental benefits began or for congenitally missing natural teeth;
— received by a covered person before the dental expense benefits start for that person;
— which are covered by any worker's compensation laws or occupational disease laws;
— which are covered by any employer's liability laws;
— which an employer is required by law to furnish in whole or in part;
— received through the medical department or similar facility which is maintained by the covered person's employer;
— received by a covered person for which no charge would have been made in the absence of dental expense benefits for that covered person;[2]
— for which a covered person is not required to pay;[1]
— which are not necessary, according to generally accepted dental standards, or which are not recommended or approved by a dentist;
— which do not meet generally accepted dental standards, including experimental treatment;
— received as a result of dental disease, defect, or injury due to an act of war, or warlike act in time of peace, which occurs while the dental expense benefits for the covered person are in effect;
— which are provided by any other plan which the employer (or an affiliate) contributes to or sponsors.[2]

x Services not performed by a dentist except for those of a licensed dental hygienist which are supervised and billed by a dentist and which are for cleaning and scaling of teeth or fluoride treatments.
x Cosmetic surgery or supplies. However, any such surgery or supply will be covered if it otherwise is a covered dental expense; it is required for reconstructive surgery that is incidental to or follows surgery that results from a trauma, an infection or other disease of the involved part; or is required for re-constructive surgery because of a congenital disease or anomaly of a dependent child that has resulted in a functional defect.
x Replacement of a lost, missing or stolen crown, bridge or denture.
x Repair or replacement of an orthodontic appliance.
x Adjustment of a denture or a bridgework which is made within six months after it is installed by the same dentist who installed it.
x Any duplicate appliance or prosthetic device.
x Use of materials or home health aids, to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluorides.
x Instruction for oral care such as hygiene or diet.
x Periodontal splinting.
x Charges by a dentist for completing dental forms.[2]
x Charges for broken appointments.[3]
x Temporary or provisional restorations.
x Temporary or provisional appliances.
x Sterilization supplies.[3]
x Services or supplies furnished by a family member.[3]
x Treatment of temporomandibular joint disorders.
x Implant Services.
x Myofunctional therapy or correction of harmful habits.
x Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.

In Maryland:

x Services or supplies furnished as a result of a Referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited Referral is one in which a Health Care Practitioner:

a. refers a covered person to; or
b. directs an employee or a person under contract with the Health Care Practitioner to refer a covered person to a Health Care Entity in which:
    a. the Health Care Practitioner; or
    b. the Health Care Practitioner's immediate family; or
    c. both own a Beneficial Interest or have a Compensation Agreement.

For the purposes of this provision, the terms "Referral," "Health Care Practitioner," "Health Care Entity," "Beneficial Interest," and "Compensation Agreement" have the same meaning as provided in Section 1-301 of the Maryland Health Occupations

[1] In policies sitused in **MD,** these exclusions do not apply to Medicaid.
[2] Not applicable in **MD**.
[3] Not applicable in **FL, MD, NJ** and **TN**.

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Frequently Asked Questions

Average fees charged in a dentist's community for the same or substantially similar services.

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. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

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

Can my dentist apply for participation in the network?
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.[2] The website and phone number are for use by dental professionals only.

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-275-4638.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends 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're still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* 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.** Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision 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.

Do I need an ID card? No, you do not need to present an ID card to confirm that you're eligible. You should notify your dentist that you participate in MetLife's PDP. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

Do my dependents have to visit the same dentist that I select? No, you and your dependents each have the freedom to choose any dentist.

If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?
Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

Group dental insurance policies featuring the Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, New York, NY 10166.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods, and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details. Metropolitan Life Insurance Company, New York, NY 10166

1. In-Network Benefits" refer to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refer to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Due to contractual requirements, MetLife is prevented from soliciting certain providers.

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[3.] 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.

[4.] Refer to your dental benefits plan summary for your out-of-network dental coverage.

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CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
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爲收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____

地址_____

Անվճար թարգմանչական ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

សេវាបកប្រែភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

Kev pab txhais lus tsis kom them nqi. Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntawv hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus lv-saws-las ntawm 1-800-927-4357.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

Libreng serbisyo sa pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) با شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

بلا معاوضہ مترجم دی خدمات مل سکدی اے۔ تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گرہوتو دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔