C.A.R. INSURANCE PRODUCTS

MetLife

# CALIFORNIA ASSOCIATION OF REALTORS®

Summary of Benefits

## MetLife Dental Insurance

*Plan benefits effective 1/1/25*

| BENEFITS<br>*Plans at a glance* | VALUE PLAN | | SELECT PLAN | | CHOICE PLAN | |
|---|---|---|---|---|---|---|
| **Reimbursement** | **In-Network** | **Out-of-Network[1]** | **In-Network** | **Out-of-Network[1]** | **In-Network** | **Out-of-Network[1]** |
| | Negotiated Fee[2] Schedule | Negotiated Fee[2] Schedule | Negotiated Fee[2] Schedule | R&C[3] 51st Percentile | Negotiated Fee[2] Schedule | R&C[3] 70th Percentile |
| **Type A – Preventive** | 70% | 70% | 100% | 80% | 100% | 90% |
| **Type B – Basic** | 70% | 70% | 80% | 60% | 80% | 70% |
| **Type C – Major** | 70% | 70% | 50% | 40% | 50% | 50% |
| **Calendar Year Deductible applies to:**<br>▪ **Individual**<br>▪ **Family** | Type B & C Services<br>$100<br>$300 Aggregate | Type B & C Services<br>$100<br>$300 Aggregate | Type B & C Services<br>$50<br>$150 Aggregate | Type B & C Services<br>$100<br>$300 Aggregate | Type B & C Services<br>$50<br>$150 Aggregate | Type B & C Services<br>$50<br>$150 Aggregate |
| **Calendar Year Maximum***<br>***(applies to B & C services)*** | $1,000 | $750 | $1,750 | $1,000 | $2,000 | $1,500 |
| **Orthodontia** | Not Covered | Not Covered | 50% | 50% | 50% | 50% |
| **Orthodontia Annual Maximum** | Not Covered | Not Covered | $1,000 | $1,000 | $1,000 | $1,000 |

***MetLife Dental Incentive Provision**

Effective 1/1/25, your plan includes a Dental Incentive Provision. For additional information, please click the link below:

MetLife Dental Incentive Provision Flyer

**MetLife Preferred Dentist Program**

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 the dentist and the cost of services rendered.

[1] Utilizing an out-of-network dentist for care may cost you more than using an in-network dentist.

[2] Negotiated Fee refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Non-participating dentists have not agreed to accept negotiated fees. When using a non-participating dentist you will be responsible for any difference in cost between the dentist's fee and your plan's benefit payment. Negotiated fees are subject to change.

[3] 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.

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# Frequency & Allocations / Exclusions – CHOICE PLAN

| Class Description: Choice plan | |
|---|---|
| **TYPE A**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Examinations | ▪ 2 times in 1 calendar year |
| ▪ Prophylaxis: Cleanings | ▪ 2 times in 1 calendar year |
| ▪ Fluoride | ▪ 1 time in 12 months for a dependent child under age 19 |
| ▪ Full Mouth or panoramic X-Rays | ▪ Once in 5 calendar years |
| ▪ Bitewing X-Rays | ▪ For a child under 19: 1 time in 6 months<br>▪ Adult: 1 time in 6 months |
| ▪ Periapical X-Rays | ▪ No frequency limitation |
| ▪ Other X-Rays | ▪ No frequency limitation |
| **TYPE B**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Sealants | ▪ 1 per molar in 2 years for a child under age 19 |
| ▪ Examinations – Problem Focused | ▪ 1 time in 1 calendar year |
| ▪ Space Maintainers | ▪ No Limit for a child under age 17 |
| ▪ Consultations | ▪ 2 in 12 months |
| ▪ Amalgam Fillings | ▪ 1 replacement per surface in 12 Months |
| ▪ Root Canal | ▪ 1 per tooth in 12 months |
| ▪ Periodontal Maintenance | ▪ 2 Perio. Treatments in a calendar year, includes 2 cleanings (total comb: 2) |
| ▪ Periodontal Surgery | ▪ 1 per quadrant in any 36 month period |
| ▪ Scaling & Root Planing | ▪ 1 per quadrant in any 24 month period |
| ▪ Prefabricated Crowns | ▪ 1 in 12 months |
| ▪ Repairs | ▪ No frequency limitation |
| ▪ Recementations | ▪ No frequency limitation |
| ▪ Labs & Other Tests | ▪ No frequency limitation |
| ▪ Emergency Palliative Treatment | ▪ No frequency limitation |
| ▪ General Anesthesia | ▪ No frequency limitation |
| ▪ Resin Composite Fillings(excludes coverage for composite fillings on molars) | ▪ No frequency limitation |
| ▪ Pulpotomy | ▪ No frequency limitation |
| ▪ Pulp Capping | ▪ No frequency limitation |
| ▪ Pulp Therapy | ▪ No frequency limitation |
| ▪ Apexification & Recalcification | ▪ No frequency limitation |
| ▪ Periodontal Surgery – Soft & Connective Tissue Grafts | ▪ No frequency limitation |
| ▪ Periodontics – Non-Surgical | ▪ No frequency limitation |
| ▪ Oral Surgery: Simple Extractions | ▪ No frequency limitation |
| ▪ Oral Surgery: Surgical Extractions | ▪ No frequency limitation |
| ▪ Other Oral Surgery | ▪ No frequency limitation |
| ▪ General Services | ▪ No frequency limitation |
| **TYPE C**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Crown Buildups / Post Core | ▪ 1 per tooth in 84 months |
| ▪ Dentures | ▪ 1 in 84 months |
| ▪ Dentures – Rebases / Relines | ▪ No frequency limitation |
| ▪ Denture Adjustments | ▪ No frequency limitation |
| ▪ Fixed Bridges | ▪ 1 in 84 months |
| ▪ Inlays / Onlays /Crowns | ▪ 1 replacement per tooth in 84 months |
| ▪ Implant Services | ▪ 1 per tooth position in 60 months |

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|---|---|
| ▪ Implant Repairs | ▪ 1 per tooth in 12 months |

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|---|---|
| ▪ Implant Supported Prosthetic | ▪ 1 per tooth in 84 Months |
| ▪ Tissue Conditioning | ▪ No frequency limitation |
| ▪ Occlusal Adjustments | ▪ No frequency limitation |
| **Orthodontics**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Orthodontic Diagnostics | ▪ No frequency limitation |
| ▪ Orthodontic Treatment | ▪ No frequency limitation |

**Exclusions**

**Choice plan**

- 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 a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- 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 or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which 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 piks, toothbrushes, or dental floss.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- 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 and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

# Frequency & Allocations / Exclusions – SELECT PLAN

| Class Description: Select plan | |
|---|---|
| **TYPE A**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Examinations | ▪ 2 times in 1 calendar year |
| ▪ Prophylaxis: Cleanings | ▪ 2 times in 1 calendar year |
| ▪ Fluoride | ▪ 1 time in 12 months for a dependent child under age 19 |
| ▪ Full Mouth or panoramic X-Rays | ▪ Once in 5 calendar years |
| ▪ Bitewing X-Rays | ▪ For a child under 19: 1 time in 6 months<br>▪ Adult: 1 time in 6 months |
| ▪ Periapical X-Rays | ▪ No frequency limitation |
| ▪ Other X-Rays | ▪ No frequency limitation |
| **TYPE B**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Sealants | ▪ 1 per molar in 2 years for a child under age 19 |
| ▪ Examinations – Problem Focused | ▪ 1 time in 1 calendar year |
| ▪ Space Maintainers | ▪ No Limit for a child under age 17 |
| ▪ Consultations | ▪ 2 in 12 months |
| ▪ Amalgam Fillings | ▪ 1 replacement per surface in 12 Months |
| ▪ Root Canal | ▪ 1 per tooth in 12 months |
| ▪ Periodontal Maintenance | ▪ 2 Perio. treatments in a calendar year, includes 2 cleanings |
| ▪ Periodontal Surgery | ▪ 1 per quadrant in any 36 month period |
| ▪ Scaling & Root Planing | ▪ 1 per quadrant in any 24 month period |
| ▪ Prefabricated Crowns | ▪ 1 in 12 months |
| ▪ Repairs | ▪ No frequency limitation |
| ▪ Recementations | ▪ No frequency limitation |
| ▪ Labs & Other Tests | ▪ No frequency limitation |
| ▪ Emergency Palliative Treatment | ▪ No frequency limitation |
| ▪ General Anesthesia | ▪ No frequency limitation |
| ▪ Resin Composite Fillings(excludes coverage for composite fillings on molars) | ▪ No frequency limitation |
| ▪ Pulpotomy | ▪ No frequency limitation |
| ▪ Pulp Capping | ▪ No frequency limitation |
| ▪ Pulp Therapy | ▪ No frequency limitation |
| ▪ Apexification & Recalcification | ▪ No frequency limitation |
| ▪ Periodontal Surgery – Soft & Connective Tissue Grafts | ▪ No frequency limitation |
| ▪ Periodontics – Non-Surgical | ▪ No frequency limitation |
| ▪ Oral Surgery: Simple Extractions | ▪ No frequency limitation |
| ▪ Oral Surgery: Surgical Extractions | ▪ No frequency limitation |
| ▪ Other Oral Surgery | ▪ No frequency limitation |
| ▪ General Services | ▪ No frequency limitation |
| **TYPE C**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Crown Buildups / Post Core | ▪ 1 per tooth in 84 months |
| ▪ Dentures | ▪ 1 in 84 months |
| ▪ Dentures – Rebases / Relines | ▪ No frequency limitation |
| ▪ Denture Adjustments | ▪ No frequency limitation |
| ▪ Fixed Bridges | ▪ 1 in 84 months |

| | |
|---|---|
| ▪ Inlays / Onlays /Crowns | ▪ 1 replacement per tooth in 84 months |
| ▪ Implant Services | ▪ 1 per tooth position in 60 months |
| ▪ Implant Repairs | ▪ 1 per tooth in 12 months |
| ▪ Implant Supported Prosthetic | ▪ 1 per tooth in 84 Months |
| ▪ Tissue Conditioning | ▪ No frequency limitation |
| ▪ Occlusal Adjustments | ▪ No frequency limitation |
| **Orthodontics**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Orthodontic Diagnostics | ▪ No frequency limitation |
| ▪ Orthodontic Treatment | ▪ No frequency limitation |

**Exclusions**

**Select plan**

- 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 a covered person would not be required to pay in the absence of dental insurance.
- Services or supplies received by a covered person before the insurance starts for that person.
- 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 or polishing of teeth or fluoride treatment.
- Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which 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 piks, toothbrushes, or dental floss.
- Decoration or inscription of any tooth, device, appliance, crown or other dental work.
- Missed appointments.
- Services covered under any workers' compensation or occupational disease law.
- Services covered under any employer liability law.
- Services for which the employer of the person receiving such services is not required to pay.
- Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.
- Services covered under other coverage provided by the Policyholder.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.
- 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 and biting of food.
- Caries susceptibility tests.
- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

# Frequency & Allocations / Exclusions – VALUE PLAN

| Class Description: Value plan | |
|---|---|
| **TYPE A**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Examinations | ▪ 2 times in 1 calendar year |
| ▪ Prophylaxis: Cleanings | ▪ 2 times in 1 calendar year |
| ▪ Fluoride | ▪ 1 time in 12 months for a dependent child under age 19 |
| ▪ Full Mouth or panoramic X-Rays | ▪ Once in 5 calendar years |
| ▪ Bitewing X-Rays | ▪ For a child under 19: 1 time in 6 months<br>▪ Adult: 1 time in 6 months |
| ▪ Emergency Palliative Treatment | ▪ No frequency limitation |
| ▪ Periapical X-Rays | ▪ No frequency limitation |
| ▪ Other X-Rays | ▪ No frequency limitation |
| **TYPE B**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Sealants | ▪ 1 per molar in 2 years for a child under age 19 |
| ▪ Examinations – Problem Focused | ▪ 1 time in 1 calendar year |
| ▪ Space Maintainers | ▪ No Limit for a child under age 17 |
| ▪ Consultations | ▪ 2 in 12 months |
| ▪ Amalgam Fillings | ▪ 1 replacement per surface in 12 Months |
| ▪ Root Canal | ▪ 1 per tooth in 12 months |
| ▪ Periodontal Maintenance | ▪ 2 Perio. Treatments in a calendar year, includes 2 cleanings (total comb: 2) |
| ▪ Periodontal Surgery | ▪ 1 per quadrant in any 36 month period |
| ▪ Scaling & Root Planing | ▪ 1 per quadrant in any 24 month period |
| ▪ Prefabricated Crowns | ▪ 1 in 12 months |
| ▪ Repairs | ▪ No frequency limitation |
| ▪ Recementations | ▪ No frequency limitation |
| ▪ Labs & Other Tests | ▪ No frequency limitation |
| ▪ General Anesthesia | ▪ No frequency limitation |
| ▪ Resin Composite Fillings(excludes coverage for composite fillings on molars) | ▪ No frequency limitation |
| ▪ Pulpotomy | ▪ No frequency limitation |
| ▪ Pulp Capping | ▪ No frequency limitation |
| ▪ Pulp Therapy | ▪ No frequency limitation |
| ▪ Apexification & Recalcification | ▪ No frequency limitation |
| ▪ Periodontal Surgery – Soft & Connective Tissue Grafts | ▪ No frequency limitation |
| ▪ Periodontics – Non-Surgical | ▪ No frequency limitation |
| ▪ Oral Surgery: Simple Extractions | ▪ No frequency limitation |
| ▪ Oral Surgery: Surgical Extractions | ▪ No frequency limitation |
| ▪ Other Oral Surgery | ▪ No frequency limitation |
| ▪ General Services | ▪ No frequency limitation |
| **TYPE C**<br>***Benefits are payable immediately from the start date of an individual's benefits*** | |
| ▪ Crown Buildups / Post Core | ▪ 1 per tooth in 60 months |
| ▪ Dentures | ▪ 1 in 60 months |
| ▪ Dentures – Rebases / Relines | ▪ No frequency limitation |
| ▪ Denture Adjustments | ▪ No frequency limitation |
| ▪ Fixed Bridges | ▪ 1 in 60 months |

| | |
|---|---|
| ▪ Inlays / Onlays /Crowns | ▪ 1 replacement per tooth in 60 months |
| ▪ Implant Services | ▪ 1 per tooth position 60 months |
| ▪ Implant Repairs | ▪ 1 per tooth in 12 months |
| ▪ Implant Supported Prosthetic | ▪ 1 per tooth in 60 months |
| ▪ Tissue Conditioning | ▪ No frequency limitation |
| ▪ Occlusal Adjustments | ▪ No frequency limitation |

| Exclusions |
|---|
| **Value plan** |
| ▪ 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.<br>▪ Services for which a covered person would not be required to pay in the absence of dental insurance.<br>▪ Services or supplies received by a covered person before the insurance starts for that person.<br>▪ 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 or polishing of teeth or fluoride treatment.<br>▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).<br>▪ Services or appliances which restore or alter occlusion or vertical dimension.<br>▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.<br>▪ Restorations or appliances used for the purpose of periodontal splinting.<br>▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.<br>▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.<br>▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work.<br>▪ Missed appointments.<br>▪ Services covered under any workers' compensation or occupational disease law.<br>▪ Services covered under any employer liability law.<br>▪ Services for which the employer of the person receiving such services is not required to pay.<br>▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital.<br>▪ Services covered under other coverage provided by the Policyholder.<br>▪ Temporary or provisional restorations.<br>▪ Temporary or provisional appliances.<br>▪ Prescription drugs.<br>▪ Services for which the submitted documentation indicates a poor prognosis.<br>▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first.<br>▪ 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.<br>▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food.<br>▪ Caries susceptibility tests.<br>▪ Precision attachments associated with fixed and removable prostheses.<br>▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it.<br>▪ Duplicate prosthetic devices or appliances.<br>▪ Replacement of a lost or stolen appliance, cast restoration or denture.<br>▪ Intra and extraoral photographic images.<br>▪ Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.<br>▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.<br>▪ Orthodontia services or appliances.<br>▪ Repair or a replacement of an orthodontic appliance. |

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.