Cornell University Student Dental Plan Summary and Cost of Coverage

With a MetLife Dental Insurance plan, your acceptance is guaranteed.

- **100% coverage** for preventive care for in-network exams, cleanings and X-rays[1]
- **Freedom to visit any dentist** you want whether they are in the MetLife network or not[2]
- **Typical savings of 30% - 45%** on covered services when you use a participating dentist[3]

Eligibility

All active full-time students and dependents

Plan Benefits

Cornell Student Dental

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of Max Allowed Charge**
Type A: Preventive (cleanings, exams, X-rays) No waiting period	100%	100%
Type B: Basic Restorative (fillings, extractions) No waiting period	80%	80%
Type C: Major Restorative (bridges, dentures) No waiting period	50%	50%
Deductible† Applies only to type B & C services		
Individual (per calendar year)	$50	$50
Family (per calendar year)	$150	$150
Annual Maximum Benefit		
Per Person	$750	$750

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*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.

**Maximum Allowed Charge (MAC), which is based on the lesser of (1) the amount charged by the out-of-network dentist or (2) the out-of-network scheduled amount for the state where the dental service is performed.

†Applies only to Type B and C Services.

Rates at a glance

The following monthly costs are effective through **July 31, 2022**.

Monthly Rates

Student Only	$23.25
Student + One	$47.90
Student + Family	$60.61

Fall Annual Rates (11 Months)

Student Only	$255.75
Student + One	$526.90
Student + Family	$666.71

Spring Annual Rates (6 Months)

Student Only	$139.50
Student + One	$287.40
Student + Family	$363.66

List of Primary Covered Services & Limitations

The services 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.

Type A: Preventive

- Prophylaxis (cleanings) - Two per calendar year, in a twelve-month period
- Oral Examinations - Two exams per calendar year in a twelve-month period
- Topical Fluoride Applications - One fluoride treatment per calendar year for dependent children up to their 19th birthday
- X-rays –
  - Full mouth X-rays; one per 60 months
  - Bitewings X-rays; one set per calendar year for adults; one set per calendar year for children
- Sealants - One application of sealant material every 5 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to their 17th birthday

Type B: Basic Restorative

- Amalgam Fillings – 1 replacement per surface in 24 months
- Resin Composite Filings (excludes coverage for composite filings on molars) – 1 replacement per surface in 24 months
- Simple Extractions
- Crown – prefabricated – 1 per tooth in 24 months
- Crown build ups/post core – 1 per tooth in 10 calendar years
- Crown repairs – 1 in 12 months
- Recementations – 1 in 12 months
- Oral Surgery
- Endodontics - Root canal treatment limited to once per tooth per 12 months
- General Anesthesia - When dentally necessary in connection with oral surgery, extractions or other covered dental services
- Periodontics –
    - Periodontal scaling and root planing once per quadrant, every 24 months
    - Periodontal surgery once per quadrant, every 36 months
    - Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in twelve (12) months, includes two cleanings.

Type C: Major Restorative

- Denture Repair/Recementations – once in a 12-month period
- Dentures – Rebases/Relines – one in a 36-month period
- Oral Surgery – surgical extractions
- General Anesthesia - When dentally necessary in connection with oral surgery, extractions or other covered dental services

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 covered person would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by a covered person 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 unless caused by a 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: waterpicks, 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 policyholder of the person receiving such services is required to pay; or
  - 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
- Biopsies of hard or soft oral tissue;
- Temporary or provisional restorations;
- 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;
- Interim caries arresting medicament application;
- Modification of removal prosthodontic and other removable prosthetic services;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Implants including, but not limited to any related surgery, placement, restorations, maintenance, and removal;
- Repair of implants;
- 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;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of New Mexico. This exclusion does not apply to residents of Minnesota;
- Repair or replacement of an orthodontic device;
- 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.
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.

Limitations

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 additional payment responsibility. 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 reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by dialing [1-800-942-0854] and using the MetLife

Dental Automated Information Service. 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 GBLKT21-DENTAL) issued by MetLife. Coverage terminates 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. 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.

1. Preventive services (Type A) are 100% covered when you visit an in-network participating dentist. Subject to frequency limitations.
2. Your out-of-pocket costs may be greater when you visit a dentist who does not participate in the MetLife network.
3. Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

Coverage may not be available in all states. Please contact the Third-Party Administrator, Member Benefits at 1-800-282-8626 for more information.

Rates may be changed on the entire group plan or on a class basis and on any premium due date on which benefits are changed. A class is a group of people defined in the group policy. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization.

The plan administrator incurs costs in connection with providing oversight and administrative support for this sponsored plan. To provide and maintain this valuable membership benefit, MetLife may compensate the association and/or the plan administrator for these and/or other costs.

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 your plan administrator Member Benefits at 1-800-282-8626 for costs and complete details.

Policy form GPNP15-2T
Certificate form GBLKT21-DENTAL

Policy number 234782-1-G

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Navigating life together