National Armed Forces Association 2025 Plan Summary and Cost of Coverage

With the National Armed Forces Association 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 35% - 50%** on covered services when you use a participating dentist[3]

Eligibility

All National Armed Forces Association members[4] in good standing, their spouses/domestic partners, and dependent children[5] may apply.

Plan Benefits – High Plan

Network: PDP Plus[§]

Coverage Type	In-Network % of Negotiated Fee[*]	Out-of-Network % of MAC**
Type A: Preventive cleanings, exams, bitewing X-rays No waiting period	100%	100%
Type B: Basic Restorative sealants, amalgam fillings, resin composite fillings (excludes coverage for composite fillings on molars) No waiting period	80%	80%
Type C: Major Restorative root canal, periodontal surgery, scaling & root planning, recementations, dentures	60%	60%
Type D: Orthodontia orthodontic diagnostics and orthodontic treatment for a child under age 19	50%	50%
Deductible[†]		
Individual (per calendar year)	$50	$50
Family (per calendar year)	$150	$150
Annual Maximum Benefit		
Per Person	$1,250	$1,250
Orthodontia Lifetime Maximum		
Per Person (for children under age 19 only)	$1,500	$1,500

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

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

*Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, 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.

**Maximum Allowable Charge: The out-of-network Maximum Allowable Charge is equal to the in-network negotiated fee. Payment for out-of-network services is based on the lesser of the dentist's actual fee or the Maximum Allowable Charge (MAC). The out-of-network Maximum Allowable Charge is a scheduled amount determined by MetLife.

†Applies only to Type B and C Services.

Benefit Waiting Period

Dental coverage is subject to no waiting periods.

To find a PDP Plus Dentist go to:

https://www.metlife.com/insurance/dental-insurance/

Click on Find a Dentist, Choose PDP Plus, & enter your zip code.

Rates at a glance

Monthly Costs

The following monthly costs are effective through December 31, 2024. Monthly cost covers all eligible children.

PDP Plus High Plan

	Member Only	Member + Spouse/ Domestic Partner	Member + Child(ren)	Member + Family
Area 1	$31.21	$63.13	$75.50	$113.45
Area 2	$34.78	$73.31	$87.69	$135.07
Area 3	$42.27	$84.23	$100.74	$153.53
Area 4	$45.37	$90.42	$108.14	$168.11
Area 5	$47.80	$96.42	$115.32	$178.31
Area 6	$51.54	$104.97	$125.54	$192.64

Areas are determined based on zip code – see the area schedule below. Rates are guaranteed from January 1, 2024 – December 31, 2024.

Area Schedule

To determine the appropriate premium rates for a dental plan, look up your state of residence, and then look up your 3-digit zip code, if applicable. Use the Area number that applies to your state/zip to determine the premium rate from the table above.

State	Area	First 3 Digits of Zip Code (if applicable)	State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369	Montana	3	Not available
	2	355-361, 365-366	Nebraska	1	680-684, 689-690
Alaska	6	Not available		2	685-688, 691-693
Arizona	2	850-857	Nevada	2	889-891
	3	859-865		4	893-898
Arkansas	2		New Hampshire	4	Not available
California	2	923-925		5	Not available
	3	900, 905-922, 926-938, 952-953, 955-961	New Jersey	2	071-072
	4	901-904, 939, 945-946, 948, 950-951		3	070, 073, 077, 080-087
	5	940-944, 947, 949, 954		4	074-076, 078-079, 088-089
Colorado	3		New Mexico	3	Not available
Connecticut	4		New York	2	104, 124-129, 133-136, 142
Delaware	4	197, 199		3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	5	198		4	063, 105-108, 111-114, 116
D.C.	3			6	100-102
Florida	2	320-322, 325-329, 334-338, 342-349	North Carolina	3	270-281, 283-289
	3	323-324, 333, 339-341		4	282
	4	330-332	North Dakota	3	
Georgia	2	306-310, 312, 319	Ohio	2	430-435, 437-459
	3	300-305, 311, 313-318, 398		3	436
Hawaii	3		Oklahoma	2	731, 735-749
Idaho	2			3	730, 734
Illinois	1	624, 628-629	Oregon	3	
	2	609-623, 625-627	Pennsylvania	1	Not available
	3	600-608		2	Not available
Indiana	1	471, 475			
	2	460-462, 465-470, 472-474, 476-479		3	Not available
	3	463-464	Puerto Rico	1	
Iowa	1	508-510, 512-516	Rhode Island	3	
	2	500-507, 520-528	South Carolina	3	
	3	511	South Dakota	2	570, 572-577
Kansas	2			3	571
Kentucky	1	400-404, 406-409, 411-419, 425-427	Tennessee	2	
	2	405, 410, 420-424	Texas	1	782
Louisiana	2			2	754-759, 764-769, 773-774, 776-781, 783-785,
Maine	3	Not available			788-789, 794-799
	4	Not available		3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Maryland	1	215	Utah	1	Not available
	2	206, 210-214, 216-219	Vermont	4	Not available
	3	207-209	Virginia	2	230-246
Massachusetts	3	010, 012-013		3	201, 220-229
	4	011, 014-027	Virgin Islands	3	
Michigan	2	486	Washington	3	990-992, 994
	3	480-485, 487-499		4	985-989, 993
Minnesota	3			5	980-984
Mississippi	2		West Virginia	2	
Missouri	1	645	Wisconsin	3	
	2	630-644, 646-651, 653-659	Wyoming	2	
	3	652			

How do I pay for my coverage?

Please contact your administrator at 1-651-259-9001 for information about your payment options.

List of Primary Covered Services & Limitations

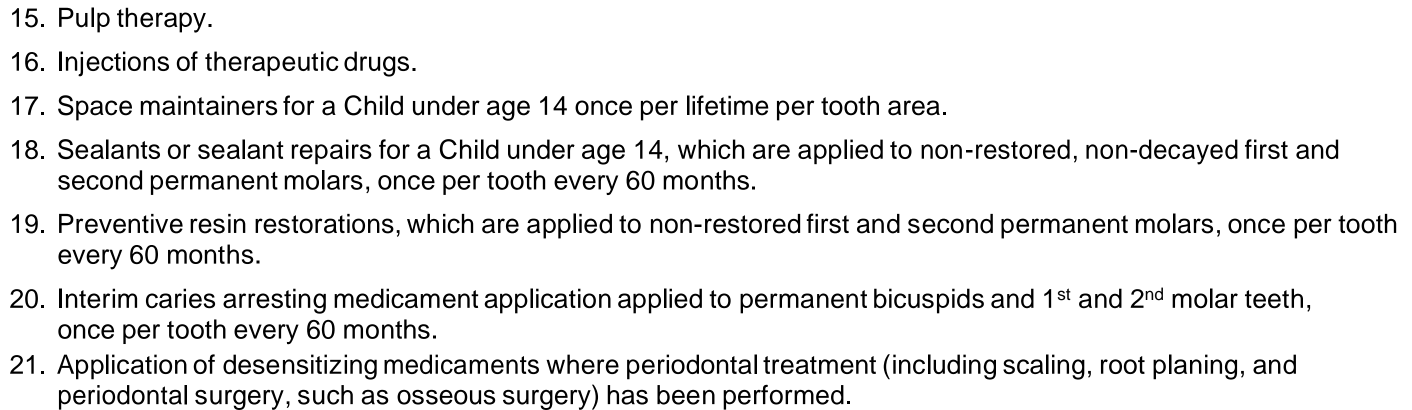
The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Type A: Preventive

1. Oral exams and problem-focused exams, but no more than one exam (whether the exam is an oral exam or problem-focused exam) every 6 months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than once every 6 months.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than once every 6 months.
4. Bitewing x-rays 1 set every 12 months.
5. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) once every 6 months.
6. Topical fluoride treatment for a Child under age 14 once in 12 months.

Type B:Basic Restorative

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
5. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
6. Diagnostic casts.
7. Emergency palliative treatment to relieve tooth pain.
8. Initial placement of amalgam fillings.
9. Replacement of an existing amalgam filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
10. Initial placement of resin-based composite fillings.
11. Replacement of an existing resin-based composite filling, but only if:
    - at least 24 months have passed since the existing filling was placed; or
    - a new surface of decay is identified on that tooth.
12. Protective (sedative) fillings.
13. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to once in 6 months, less the number of teeth cleanings received during such 6 month period.
14. Pulp capping (excluding final restoration).



15. Pulp therapy.
16. Injections of therapeutic drugs.
17. Space maintainers for a Child under age 14 once per lifetime per tooth area.
18. Sealants or sealant repairs for a Child under age 14, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 60 months.
19. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 60 months.
20. Interim caries arresting medicament application applied to permanent bicuspids and 1st and 2nd molar teeth, once per tooth every 60 months.
21. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

Type C: Major Restorative

1. Therapeutic pulpotomy (excluding final restoration).
2. Apexification/recalcification.
3. Pulpal regeneration, but not more than once per lifetime.
4. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia or intravenous sedation is necessary in accordance with generally accepted dental standards.
5. Local chemotherapeutic agents.
6. Initial installation of full or partial Dentures (other than implant supported prosthetics):
   - when needed to replace congenitally missing teeth; or
   - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
7. Addition of teeth to a partial removable Denture to replace teeth removed while this Dental Insurance was in effect for the person receiving such services.
8. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 10 Years prior to replacement.
9. Replacement of a non-serviceable removable Denture if such Denture was installed more than 10 Years prior to replacement.
10. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
11. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
12. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
13. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
14. Initial installation of Cast Restorations (except implant supported Cast Restorations).
15. Replacement of Cast Restorations (except an implant supported Cast Restoration) but only if at least 10 Years have passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or

- a Cast Restoration for the same tooth was replaced.

16. Prefabricated crown, but no more than one replacement for the same tooth within 10 Years.
17. Core buildup, but no more than once per tooth in a period of 10 Years.
18. Posts and cores, but no more than once per tooth in a period of 10 Years.
19. Labial veneers, but no more than once per tooth in a period of 10 Years.
20. Oral surgery, except as mentioned elsewhere in this certificate.
21. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than once in a 12 month period.
22. Other consultations, but not more than once in a 12 month period.
23. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
24. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
25. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.
26. Full mouth debridements, but not more than once per lifetime.
27. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
28. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
29. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
30. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 10 Year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
31. Repair of implants, but no more than once in a 12 month period.
32. Implant supported Cast Restorations, but no more than once for the same tooth position in a 10 Year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
33. Implant supported fixed Dentures, but no more than once for the same tooth position in a 10 Year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
34. Implant supported removable Dentures, but no more than once for the same tooth position in a 10 Year period:
    - when needed to replace congenitally missing teeth; or
    - when needed to replace teeth that are lost while the person receiving such benefits was insured for Dental Insurance.
35. Tissue conditioning, but not more than once in a 36 month period.
36. Simple repair of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
37. Occlusal adjustments, but not more than once in a 12 month period.

38. Cleaning and inspection of a removable appliance once every 6 months.

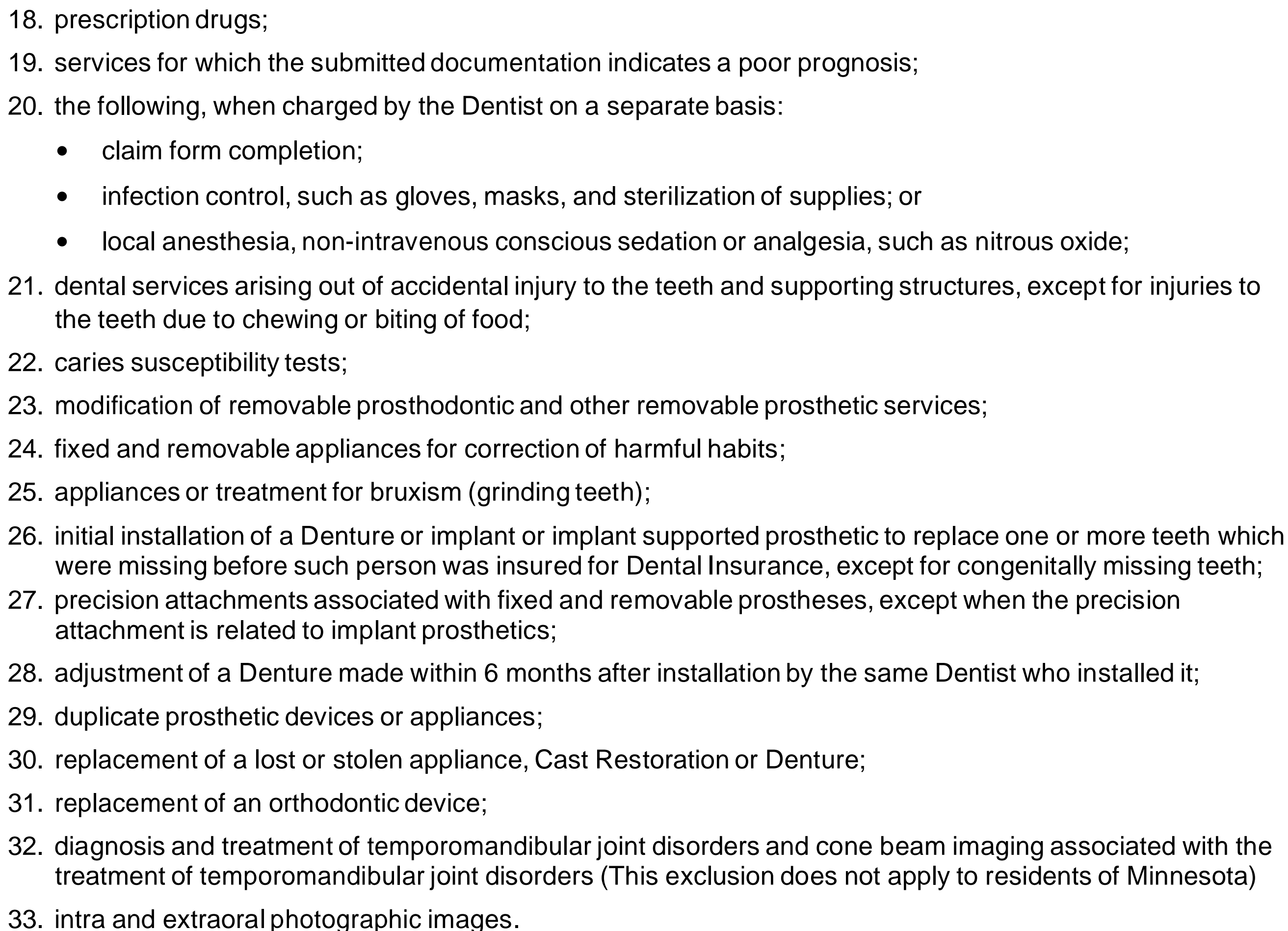
Type D: Orthodontia

- Your children, up to age 19, 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
- 20% of the Orthodontia Lifetime Maximum 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:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. 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;
5. services which are primarily cosmetic, (For residents of Texas, see notice page section);
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. 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 required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;



18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. 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;
21. 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;
22. caries susceptibility tests;
23. modification of removable prosthodontic and other removable prosthetic services;
24. fixed and removable appliances for correction of harmful habits;
25. appliances or treatment for bruxism (grinding teeth);
26. initial installation of a Denture or implant or implant supported prosthetic to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing teeth;
27. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
28. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
29. duplicate prosthetic devices or appliances;
30. replacement of a lost or stolen appliance, Cast Restoration or Denture;
31. replacement of an orthodontic device;
32. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders (This exclusion does not apply to residents of Minnesota)
33. 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. 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 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.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP15-2T / GCERT2000-DENTAL) issued by MetLife. Coverage terminates when your membership ceases, the last day of the calendar month insurance ceases for your class, 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 MetLife data. Negotiated fees refer to the fees that in-network dentists have agreed to accept as payment in full for certain services, subject to any co-payments, 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. Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit a dentist and the cost of services rendered.
4. You must be a member in good standing of the National Armed Forces Association to qualify for this insurance plan.
5. Refers to your unmarried, dependent children to age 26.

Coverage may not be available in all states. Please call your plan administrator at 1-651-259-9001 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/exhibits. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization.

The association and/or 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. 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. Please contact your plan administrator at 1-651-259-9001 for costs and complete details.

Policy form GPNP15-2T
Certificate form GCERT2000-DENTAL

Policy number 253905-1-G

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
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Navigating life together