



AFA Veteran Benefits Association
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AFAVBA Dental Plan Benefits

Get the benefits with savings[#] you need, the flexibility you want and service you can

trust. PDP Plus Network - Benefit Summary

Plan Option 1 Benefit Highlights:			Plan Option 2 Benefit Highlights:		
Comprehensive Plan Description			Basic Plan Description		
Your AFAVBA Plan Pays			Your AFAVBA Plan Pays		
Coverage Type	In-Network:	Out-of-Network: Type	Coverage Type	In-Network:	Out-of-Network:
A – cleanings, oral examinations	100% of MAC*	100% of MAC*	Type A – cleanings, oral examinations	100% of MAC*	100% of MAC*
Type B – fillings	80% of MAC*	80% of MAC*	Type B – fillings	60% of MAC*	60% of MAC*
Type C – bridges and dentures	50% of MAC*	50% of MAC*			
Type D – orthodontia	50% of MAC*	50% of MAC*			
Deductible**	In-Network	Out-of-Network	Deductible***	In-Network	Out-of-Network
Individual	\$50	\$50	Individual	\$75	\$75
Family	\$150	\$150	Family	\$225	\$225
Annual Maximum Benefit:	In-Network	Out-of-Network	Annual Maximum Benefit:	In-Network	Out-of-Network
Per Person	\$2,000	\$2,000	Per Person	\$750	\$750
Orthodontia Lifetime Maximum:	In-Network***	Out-of-Network***	ORTHODONTIA NOT AVAILABLE		
Per Person	\$1,000	\$1,000			
Waiting Period: 6 month Waiting Period for all Type C Services.					
*MAC means the lesser of: the amount charged by the Dentist; or the maximum amount which the In-Network Dentist has agreed to accept as payment in full for the dental service., subject to any co-payments, deductibles, cost sharing and benefit maximums.			*MAC means the lesser of: the amount charged by the Dentist; or the maximum amount which the In-Network Dentist has agreed to accept as payment in full for the dental service., subject to any co-payments, deductibles, cost sharing and benefits maximums.		
Applies only to Type B & C Services			*Applies only to Type B Services		
***For a Child under 19 or 23 if a full time student, if the orthodontic appliance is initially installed while Dental Insurance is in effect for such Child.					
Dependent ages for WA & TX may vary, please refer to Certificate of Insurance			Dependent ages for WA & TX may vary, please refer to Certificate of Insurance		

The service categories shown above represent an overview of your Plan of Benefits but are not a complete description of the Plan. An insurance certificate describing all benefits and limitations will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the certificate of insurance and group insurance policy.

[#] Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the costs for services received.

Monthly Rates: The following monthly rates are effective through June 30, 2019, since the renewal occurs annually. Please refer to the enclosed Region Locator to determine your monthly premium.

Plan 1 – Comprehensive Plan

Eligibility Options	Region 1	Region 2	Region 3	Region 4
Member Only	\$ 57.68	\$ 63.37	\$72.57	\$ 80.02
Member + One	\$113.82	\$125.28	\$143.85	\$158.86
Member + Family	\$165.06	\$181.80	\$208.89	\$230.83

Plan 2 – Basic Plan

Eligibility Options	Region 1	Region 2	Region 3	Region 4
Member Only	\$25.92	\$28.35	\$32.25	\$35.41
Member + One	\$50.00	\$54.88	\$62.81	\$69.20
Member + Family	\$73.44	\$80.76	\$92.57	\$102.15

An example of savings[#] when you visit a participating dentist:

This hypothetical example[@] shows how receiving services from a participating dentist can save[#] you money.

Comprehensive Plan		Basic Plan	
<p>Your Dentist says you need a Crown, a Type C* service:</p> <p>Negotiated Fee: \$375.00</p> <p>Dentist's Usual Fee: \$600.00</p> <p>[@]Please note: This example assumes that your annual deductible has been met and annual maximum benefit has not been reached.</p>		<p>Your Dentist says you need a Filling , a Type B service:</p> <p>Negotiated Fee: \$42.00</p> <p>Dentist's Usual Fee: \$113.00</p> <p>[@] Please note: This example assumes that your annual deductible has been met and annual maximum benefit has not been reached.</p>	
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
When you receive care from a participating dentist:	When you receive care from a non-participating dentist:	When you receive care from a participating dentist:	When you receive care from a non-participating dentist:
Dentist's Usual Fee is: \$600.00	Dentist's Usual Fee is: \$600.00	Dentist's Usual Fee is: \$113.00	Dentist's Usual Fee is: \$113.00
The MAC Fee is: \$375.00	Your Plan Pays:	The MAC Fee is: \$42.00	Your Plan Pays:
Your Plan Pays:	50% X \$375 Fee -\$187.50	Your Plan Pays:	60% X \$42.00 Fee -\$25.20
50% X \$375 Fee -\$187.50	Your Out-of-Pocket Cost: \$412.50	60% X \$42 Fee -\$25.20	Your Out-of-Pocket Cost: \$87.80
Your Out-of-Pocket Cost: \$187.50		Your Out-of-Pocket Cost: \$16.80	

In this example, you save[#] \$225.00 (\$412.50 minus \$187.50)... by using a participating dentist.

In this example, you save[#] \$71.00 (\$87.80 minus \$16.80)... by using a participating dentist.

[#] Savings from enrolling in the MetLife Preferred Dentists Program will depend on various factors, including how often participants visit the dentist and the costs for services received.

[@]Please note: This example assumes that your annual deductible has been met and annual maximum benefit has not been reached.

* There is a 6 month waiting period for Type C Services.

List of Primary Covered Services & Limitations

Primary Covered Services Plan Option 1: Comprehensive Plan		Primary Covered Services Plan Option 2: Basic Plan	
Type A - Preventive	<u>How Many/How Often:</u>	Type A - Preventive	<u>How Many/How Often:</u>
Prophylaxis (cleanings)	• Once every 6 months.	Prophylaxis (cleanings)	• Once every 6 months.
Oral Examinations	• Once every 6 months.	Oral Examinations	• Once every 6 months.
Topical Fluoride Applications	• 1 fluoride treatment in 12 months for dependent children up to 19th birthday.	Topical Fluoride Applications	• 1 fluoride treatment in 12 months for dependent children up to 19 th birthday.
X-rays	• Bitewing X-rays: one set per calendar year for adults & children.	X-rays	• Bitewing X-rays: one set per calendar year for adults & children.
Sealants	• One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday.	Sealants	• One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday.
Type B - Basic Restorative	<u>How Many/How Often:</u>	Type B - Basic Restorative	<u>How Many/How Often:</u>
Fillings		Fillings	
Pulp Capping		Pulp Capping	
Palliative Care		Palliative Care	
Periodontics	• Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in any calendar year less the number of teeth cleanings received during such 12-month period.	Periodontics	• Periodontal maintenance where periodontal treatment (including scaling, root planning, and periodontal surgery such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to 4 times in any calendar year less the number of teeth cleanings received during such 12-month period.
Space Maintainers	• Limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19.	Space Maintainers	• Limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19.
X-rays Periapicals and other x-rays	• Full mouth and panorex X-rays: once per 60 consecutive months.	X-rays Periapicals and other x-rays	• Full mouth and panorex x-rays: once per 60 consecutive months.
Type C - Major Restorative*	<u>How Many/How Often:</u>	Type C - Major Restorative	<u>NOT COVERED</u>
Simple Extractions			
Pulpal Therapy			
Crown, Denture and Bridge Repair	• Initial installation of fixed bridgework		
	• Initial installation of partial or full removable dentures		
	• Adjustment of dentures (minimum is 6 months after initial installation)		
	• Initial installation of crowns, inlays and onlays (cast restorations): once in 60 consecutive months.		
Implants	• Initial installation of implants: once in 60 consecutive months.		
	• Maintenance or repair of implant services: once in 12 consecutive months.		
Bridges and Dentures	• Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.		
	• Dentures and bridgework replacement: one every 10 years.		
	• Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed (minimum is 12 months after initial installation).		
Crowns/Inlays/Onlays	• Replacement: once every 60 months.		
Endodontics	• Root canal treatment limited to once per tooth per 24 months.		
General Anesthesia & IV Sedation	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.		
Oral Surgery & Surgical Extractions			
Periodontics	• Periodontal scaling and root planning once per quadrant, every 24 months.		
	• Periodontal surgery including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft and guided tissue regeneration once per quadrant every 36 months.		
Consultations	• Limited to twice in 12 consecutive months.		
Rebases/Relines	• Relines and rebases to dentures are limited to one per 36 months		
Harmful Habit Appliance	(minimum is 6 months after initial installation)		
Type D - Orthodontia	<u>How Many/How Often:</u>	Type D - Orthodontia	<u>NOT COVERED</u>
	• All dental procedures performed in connection with Orthodontic treatment are payable as Orthodontia for a child under 19 or 23 if a full time student, if the orthodontic appliance is initially installed while Dental Insurance is in effect for such child.		
	• Initial payment due upon installation of the Orthodontic appliance; repetitive payments for the Orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum.		
Orthodontic Diagnostics	• Orthodontic benefits end at cancellation of coverage.		

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan. A group insurance policy including a certificate of insurance will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the actual group insurance policy. If non-insured, the summary plan description will be made available following your plan's effective date and will govern if any discrepancies exist between this overview and the actual group insurance policy.

*There is a 6 months waiting period for Type C services.

Common Questions...Important Answers

Q. What 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 services provided to plan participants. Negotiated fees typically range from 15-45%[‡] below the average fees charged by dentists in your area for the same or substantially similar services.

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 who meets your needs. You can get a list of these participating dentists online at www.metlife.com/dental or call 1-800-291-8480 to have a list faxed or mailed to you.

Q. What services are covered by the plan?

A. The services covered by the plan are those defined under your group dental benefits plan. 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 dentist who does not participate in the MetLife PDP Plus Network, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment. If you receive services from a participating dentist, you are only responsible for the difference between the negotiated in-network fee and your plan's payment. Please note: plan designs may vary, so you should always refer to your specific plan to help determine actual out-of-network benefits. As always, plan deductibles must be met.

Q. Can my dentist apply for participation?

A. Yes. If your current dentist does not participate in the PDP Plus Network and you'd like to encourage him or her to apply for membership, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS[®] for an application. Website and phone number are designed for use by dental professionals only.

Q. How are claims processed?

A. Dentists may submit your claims for you which helps to reduce your paperwork. If you need a claim form, you can find one online at www.metlife.com/dental.

Q. When will my coverage be effective?

A. The coverage will be effective on the first day of the month following receipt of your completed application and premium payment.

[‡] Based on internal analysis by MetLife

* Due to contractual requirements, MetLife is prohibited from soliciting certain providers

Savings from enrolling in a dental benefits plan will depend on various factors, including how often participants visit the dentist and the cost of services covered.

® Negotiated fees for non-covered services may not apply in all states.

Exclusions – Plan 1 (Comprehensive Plan)

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

- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- 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 not performed 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 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 picks, 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 member or 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 or appliances
- Prescription drugs
- The following when charged by the Dentist on a separate basis: claim form completion; infection control such as gloves, mask, and sterilization or supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental service arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Services for which the submitted documentation indicates a poor prognosis
- Caries susceptibility tests
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders
- Initial installation of a 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
- 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 or crown, inlay/onlay, or Denture

Exclusions – Plan 2 (Basic Plan)

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

- Type C (Major) & Type D (Orthodontia)
- Harmful habits appliance
- 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 not performed 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 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 member or 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 or appliances
- Prescription drugs
- The following when charged by the Dentist on a separate basis: claim form completion; infection control such as gloves, mask, and sterilization or supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental service arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food
- Services for which the submitted documentation indicates a poor prognosis
- Caries susceptibility tests
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, 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. 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 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 GPNP99 ASSN) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease, upon termination of the group policy by the Policyholder or MetLife, or insurance ends for your class. The group policy terminates for non-payment of premium or if the Policyholder fails to perform any obligations under the policy. Coverage for dependents ends if your insurance ends, on the date you die, the group policy ends, when your membership ends, the date dependents' insurance ends under the group policy, or insurance ends for your class, the person ceases to be a dependent or premium is not paid for the dependent when due. 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.

Like most group benefit programs, benefit programs offered by MetLife contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your MetLife group representative for costs and complete details.

Insurance coverage is issued by Metropolitan Life Insurance Company, New York, NY 10166.

Policy form GPNP99 ASSN
Policy number: 74570-2-G



**Air Force Association
Veteran Benefits Association
Region Locator**

How to Use This Chart:

To determine the appropriate premium rate, locate your state of residence on this chart, then the first three digits of your zip code and notate the corresponding Region number. Use this Region to determine your premiums from the Dental Plan Summary.

The MetLife Dental Plan is subject to state approval and is currently not available to Members residing in Maine or Puerto Rico.

State	Region	3 Digit Zip Codes
Alabama (AL)	1	350 - 352, 354 – 369
Alaska (AK)	4	995 – 999
Arkansas (AR)	1	716 - 720, 722 – 726, 728, 729
	2	721,727
Arizona (AZ)	1	857
	2	850, 852, 853, 855, 856, 859, 860, 863 – 865
California (CA)	2	917 - 925, 936 - 938, 953
	3	900 - 908, 912 - 916, 926 - 928, 930, 932 - 934, 952, 955 – 961
	4	910, 911, 931, 935, 939 - 951, 954
Colorado (CO)	2	800 - 802, 804 - 807, 809 – 815
	3	803, 808
	4	816
Connecticut (CT)	3	060, 063, 064, 066, 067
	4	061, 062, 065, 068, 069
Delaware(DE)	4	197 – 199
District of Columbia (DC)	2	200, 202 – 205
Florida (FL)	1	320 - 329, 333 - 339, 342, 344, 346, 347, 349
	2	330 - 332, 341
Georgia (GA)	1	304, 307 - 310, 312
	2	300 -303, 305, 306, 311, 313 - 319, 398
Hawaii (HI)	2	967, 968
Illinois (IL)	1	604, 605, 609 - 620, 622 – 629 600 - 603, 606 - 608
Indiana (IN)	1	460 - 465, 469, 471 – 478
	2	466 – 468, 470, 479
Iowa (IA)	1	500 - 502, 504 - 510, 512 - 516, 520 – 528
	2	503
	3	511
Idaho (ID)	1	832, 833, 834, 835, 838
Kansas (KS)	1	661, 667, 668, 669, 671, 673 – 679
	2	660, 662, 664 - 666, 670, 672
Kentucky (KY)	1	400 - 418, 421 – 427
	2	420
Louisiana (LA)	1	700, 701, 703, 704 - 708, 710 – 714
Maryland (MD)	1	206, 210 - 212, 214 – 219
	2	207 – 209
Massachusetts (MA)	2	010, 012, 013
	3	011, 014 – 027

Michigan (MI)	1	486, 487
	2	484, 485, 488- 499
	3	480 – 483
Minnesota (MN)	1	561, 562, 564 – 567
	2	550, 551, 553 - 556, 559 - 560, 563
	3	557, 558
Missouri (MO)	1	630 - 633, 635 - 641, 644 – 657
	2	634, 658
Mississippi (MS)	1	386 – 395
	2	396, 397
Montana (MT)	2	590 - 597, 599
	3	598
Nebraska (NE)	1	680, 681, 683 – 693
New Hampshire (NH)	4	030 – 038
North Carolina (NC)	2	270, 278, 279, 283 -286
	3	271 – 277, 280 - 282, 287 – 289
North Dakota (ND)	2	580 – 588
New Jersey (NJ)	2	070 - 073, 077, 080 - 084, 086, 087
	3	074 - 076, 078, 079, 085, 088, 089
Nevada (NV)	2	889 – 891
	3	893, 898
	4	894, 895, 897
New Mexico (NM)	2	870 - 875, 877 - 884
New York (NY)	1	120 - 126, 140 - 143, 147 – 149
	2	103, 104, 109 - 119, 127 - 139, 144 – 146
	3	100 - 102, 105 – 108
Ohio (OH)	1	430 - 450, 452 - 456, 458, 459
	2	451
	3	457
Oklahoma (OK)	1	730, 731, 733, 734, 736 - 741, 743 – 749
	2	735
Oregon (OR)	3	970 - 979
Pennsylvania (PA)	1	150 - 168, 170 - 174, 180, 182 - 188, 190 – 192
	2	169, 175 - 179, 181, 189, 193 – 196
Rhode Island (RI)	3	028, 029
South Carolina (SC)	2	290 – 299
South Dakota (SD)	2	570 – 577
Tennessee (TN)	1	370 - 372, 374 -375, 377 - 379, 380 – 385
	2	373, 376
Texas (TX)	1	750 – 753, 755-764, 766-777, 779-799
	2	754, 765, 778, 885
Utah (UT)	1	840 - 847
Virginia (VA)	1	224, 225, 227, 228, 230 - 233, 236, 238 - 244, 246
	2	201 220 – 223, 226, 229, 234, 235, 237, 245
Vermont (VT)	2	008
	3	050 - 054, 056 – 59
Washington (WA)	3	990-992,994
	4	980-989, 993
Wisconsin (WI)	1	530 - 532, 534, 535, 538 -549
	2	537

West Virginia (WV)	1	247, 248, 250 - 253, 255 - 258, 260, 262 - 268
	2	249, 259, 261
	3	254
Wyoming (WY)	1	820 -831