

# National Association of Personal Financial Advisors

## Plan Summary

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

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

### Eligibility

All Active Members

All Employees of Members who are Actively at Work (at least 20 hours per week)

### Plan Benefits — Choose a Plan

#### Plan Option 1

#### Dental High Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee**
<b>Type A: Preventive</b> (cleanings, exams, X-rays) No waiting period	<b>100%</b>	<b>100%</b>
<b>Type B: Basic Restorative</b> (fillings, extractions) No waiting period	<b>90%</b>	<b>90%</b>
<b>Type C: Major Restorative</b> (bridges, dentures) Benefit Waiting Period: 12 Months	<b>60%</b>	<b>60%</b>
<b>Type D: Orthodontia</b> (orthodontic diagnostics and orthodontic treatment) Benefit Waiting Period: 12 Months	<b>50%</b>	<b>50%</b>
<b>Deductible†</b>		
<b>Individual</b> (per calendar year)	<b>\$25</b>	<b>\$25</b>
<b>Family</b> (per calendar year)	\$75 for each family member	\$75 for each family member
<b>Annual Maximum Benefit</b>		
Per Person	<b>\$2,000</b>	<b>\$2,000</b>

Orthodontia Lifetime Maximum		
Per Person (for children up to age 19 only)	\$1,500	\$1,500

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

**Waiting period:** There is a 12-month waiting period for Type B and Type C services following date of enrollment.

\*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. / \*MAC refers to the Maximum Allowed Charge, which is based on the lesser of (1) the amount charged by the in-network dentist or (2) the maximum amount which the in-network dentist has agreed to accept as payment in full for the dental service.

\*\*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 charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. / \*\*MAC refers to the Maximum Allowed Charge, which is based on the lesser of (1) the amount charged by the out-of-network dentist or (3) the out-of-network scheduled amount for the state where the dental service is performed.

†Applies only to Type B and C Services.

## Plan Option 2

### Dental Low Plan

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee**
<b>Type A: Preventive</b> (cleanings, exams, X-rays) No waiting period	<b>100%</b>	<b>100%</b>
<b>Type B: Basic Restorative</b> (fillings, extractions) No waiting period	<b>70%</b>	<b>70%</b>
<b>Type C: Major Restorative</b> (bridges, dentures) Benefit Waiting Period: 12 Months	<b>40%</b>	<b>40%</b>
<b>Deductible†</b>		
<b>Individual</b> (per calendar year)	<b>\$50</b>	<b>\$50</b>
<b>Family</b> (per calendar year)	<b>\$150</b> for each family member	<b>\$150</b> for each family member
<b>Annual Maximum Benefit</b>		
Per Person	<b>\$1,500</b>	<b>\$1,500</b>

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

**Waiting period:** There is a 12-month waiting period for Type C services following date of enrollment.

\*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. / \*MAC refers to the Maximum Allowed Charge, which is based on the lesser of (1) the amount charged by the in-network dentist or (2) the maximum amount which the in-network dentist has agreed to accept as payment in full for the dental service.

\*\*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 charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. / \*\*MAC refers to the Maximum Allowed Charge, which is based on the lesser of (1) the amount charged by the out-of-network dentist or (3) the out-of-network scheduled amount for the state where the dental service is performed.

†Applies only to Type B and C Services.

## 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

Covered Services (for all plans)

- Prophylaxis (cleanings) - Once every six (6) months
- Oral Examinations - Once every six (6) months
- Topical Fluoride Applications - One fluoride treatment in a 12-month period for dependent children up to their 14<sup>th</sup> birthday
- X-rays –
- Bitewings X-rays; one set for adults and children under age 19 in a 12-month period

### Type B: Basic Restorative

Covered Services (for all plans)

- Fillings – one replacement per surface in 24 months
- Simple Extractions
- Periodontics –
  - Periodontal scaling and root planning once per quadrant, every 24 months
  - Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year.
- Space Maintainers - Space maintainers for dependent children up to their 14<sup>th</sup> birthday.
- Sealants - One application of sealant material every 5 years for each non-restored, non-decayed 1<sup>st</sup> and 2<sup>nd</sup> molar of a dependent child up to their 16<sup>th</sup> birthday

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable, except for sealants, amalgam fillings and resin composite fillings (excludes coverage for composite fillings on molars).

### Type C: Major Restorative



## Covered Services (for all plans)

- Crown, Denture, Implant and Bridge Repair/Re-cementations
- Oral Surgery
- Implants- Replacement once every 5 years
- 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 7 years
  - Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
- Crowns, Inlays and Onlays - Replacement once every 7 years
- Endodontics - Root canal treatment limited to once per tooth in your lifetime
- General Anesthesia - When dentally necessary in connection with oral surgery, extractions or other covered dental services
- Periodontics-
  - Periodontal surgery once per quadrant, every 36 months

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable.

## Type D: Orthodontia

### Covered Services (for **Plan Option 1: Dental High Plan only**)

- You, your spouse and 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

Certain benefit waiting periods may need to be satisfied before expenses for these services are payable.

## 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 participating association of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the participating association, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the participating association;
- 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;
- 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 supported prosthetics to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- 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;
- 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 GPNP15-2T / GCERT2015-DENTAL) issued by MetLife.

Coverage terminates when your membership ceases, the participating association ceases to participate in the trust, 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 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.
4. You must be an active member of the National Association of Personal Financial Advisors to qualify for this insurance plan.
5. Refers to your unmarried, dependent children through age 26.

Coverage may not be available in all states. Please contact the plan administrator for more information.

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. Please contact your plan administrator for costs and complete details.

Certificate form GCERT2015-DENTAL

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**Metropolitan Life Insurance Company** | 200 Park Avenue | New York, NY 10166  
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