# 2018 Insurance Rates
# (Per Pay Period)

| Medical (Aetna) | Plan Rate | Employee Pays |
|---|---|---|
| **Employee Only** | $230.50 | $ 0.00 (Company Paid) |
| **Employee/Spouse** | $507.00 | $276.50 |
| **Employee/Children** | $438.00 | $207.50 |
| **Employee/Family** | $714.50 | $484.00 |

www.aetna.com Plan Code 14026300

| Dental (MetLife) | Plan Rate | Employee Pays |
|---|---|---|
| **Employee Only** | $16.65 | $ 0.00 (Company Paid) |
| **Employee/Spouse** | $35.58 | $18.93 |
| **Employee/Children** | $37.74 | $21.09 |
| **Employee/Family** | $60.60 | $43.95 |

www.metlife.com/mybenefits Group number 5936332

| Vision (MetLife) | Plan Rate | Employee Pays |
|---|---|---|
| **Employee Only** | $3.37 | $ 0.00 (Company Paid) |
| **Employee/Spouse** | $6.76 | $ 3.39 |
| **Employee/Children** | $5.72 | $ 2.35 |
| **Employee/Family** | $9.44 | $ 6.07 |

www.metlife.com/mybenefits Group number 59363332

| | Plan Rate | Employee Pays |
|---|---|---|
| **$25,000 Basic Life Insurance** | $ ---- | $ 0.00 (Company Paid) |
| **$25,000 AD&D** | $ ---- | $ 0.00 (Company Paid) |

www.unum.com

| AllState Basic/Premium Cancer | Plan Rate | Employee Pays |
|---|---|---|
| **Employee Only** | $11.67/19.10 | $11.67/19.10 |
| **Employee/Spouse** | $18.08/29.50 | $18.08/29.50 |
| **Employee/Children** | $16.26/27.08 | $16.26/27.08 |
| **Employee/Family** | $22.66/37.47 | $22.66/37.47 |

www.allstatebenefits.com/mybenefits

Voluntary Term Life Insurance
Rates are located in enrollment package
www.allstatebenefits.com/mybenefits

made available through aetna®

TELADOC™

# Talk to a  anytime

**Teladoc® gives you 24/7/365 access to U.S. board-certified doctors** through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

## WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

## GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

## MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

## Talk to a doctor anytime for $40 or less!

**Teladoc.com/Aetna**

**1-855-Teladoc (835-2362)**

**Facebook.com/Teladoc**

**Teladoc.com/mobile**


Teladoc is being provided as a pilot program to fully-insured Aetna members and members of plans administered by Aetna. It is not available in all States. It is also provided to self-insured Aetna members and members of plans administered by Aetna whose employer has elected to offer the program to their employees. Teladoc and Teladoc physicians are independent contractors and are neither agents nor employees of Aetna or plans administered by Aetna. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

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Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna℠

# Aetna Navigator® Member Website

## The edge you need to make the most of your plan

**www.aetna.com**

11.03.312.1 M (8/13)

When you're an Aetna member, you get tools and resources to help you easily manage your health and your benefits. All of your health benefits and health insurance plan information and cost-savings tools are in one place — your Aetna Navigator member website.

When you sign up and use it, you're not just a member, you're ***a navigator***.

## Navigators have know-how

Navigators are smart about their health care. Once you're a navigator, you can easily:

- **Find the right doctor — and save money.** Locate in-network doctors who accept your plan.
- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs *before* you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.
- **Check your health accounts.** Easily look up your health savings account* or health fund balances.

## Easy-to-use tools help you make smart choices about your health.

## Peace of mind is a password away

It's easy to be a navigator. (You don't need any special technical skills, we promise.) Just sign up at **www.aetna.com** once you are an Aetna member. Then you can start using Aetna Navigator's valuable features and tools.

## Meet Ann, your virtual assistant

She can help you sign up for Aetna Navigator. She can even help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. Ann never sleeps, so chat with her anytime.

## Go to **www.aetnatools.com** to see a preview of what Aetna Navigator has to offer once you are an Aetna member.

## Find what you need — wherever, whenever


The Aetna Mobile app puts our most popular online features at your fingertips. It's available for iPhone® and Android™ mobile devices.

Scan this code now to download.
Or visit **www.aetna.com/mobile**.

*Health savings accounts are currently not available to health maintenance organization (HMO) members in Illinois and California.

**Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health of California Inc., Aetna Health Insurance Company of New York, Aetna Health Insurance Company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.**

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. The availability of Aetna Navigator's key features may vary by plan. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. The health assessment is used in a variety of ways to support Aetna products and services that help you manage your health. Aetna will use your health assessment information in compliance with all applicable state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. For more information, view Aetna's Notice of Privacy Practices, located at the bottom of Aetna's website, or call the number on the back of your ID card. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

**Policy forms issued in Oklahoma include:** HMO OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POS RIDER 08/07, GR-23 and/or GR-29/GR-29N.

**www.aetna.com**


11.03.312.1 M (8/13)

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

# Aetna Mobile

## You never know when you'll need it ... but you'll always know where to find it

**www.aetna.com**

## Find what you need — wherever, whenever — with Aetna Mobile

That's why it's great to know you can use your cell phone with web access to view your health plan information — whenever you want, wherever you are. The Aetna Mobile app works with iPhone® mobile digital devices and Android™-powered phones.

**Use a different smartphone or mobile device?** Instead of loading an app, just visit **www.aetna.com** and use the mobile web version of the site.

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You're in your car, at the doctor's office ... anywhere. You need that ID number or claims record now. With Aetna Mobile, you'll get all the answers you need, instantly.

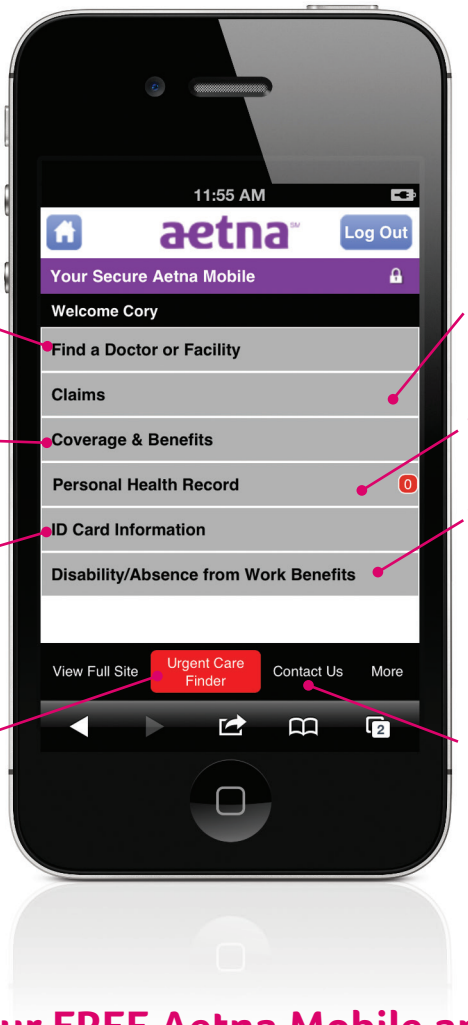
## Features of Aetna Mobile

**Find a doctor** — it's easy to search for doctors, dentists and specialists in your area.

**Check benefits and coverage information** — just clear, accurate details when you click.

**Pull up your medical and/or dental ID card information** — if you left your ID card at home, it's no problem.

**Use the Urgent Care Finder** — it's for immediate help in an emergency. Because every minute counts.




**Search claims** — no more guesswork when you don't have the paperwork with you.

**Track your health and claims** — with your Personal Health Record.

**View your disability or leave information** — reference your existing claims, leaves and payments while you're on the go.

**Contact Us** — for fast answers to your plan questions.

## Two ways to download your FREE Aetna Mobile app:

- Text **Apps** to **44040** to download now*
- Scan the code with your mobile device

Learn more, visit us at **www.aetna.com/mobile**

*Standard text messaging rates may apply.



**www.aetna.com**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**PLAN DESIGN AND BENEFITS - NC PPO 2000 80/50 (2018)**

**NC Group Business 51-100 Employees**

| PLAN FEATURES | NETWORK CARE | OUT-OF-NETWORK CARE |
|---|---|---|
| **Primary Care Physician Selection** | Not applicable | Not applicable |
| **Deductible** (per plan year) | $2,000 Individual<br>$4,000 Family | $4,000 Individual<br>$8,000 Family |
| Unless otherwise indicated, the deductible must be met before benefits can be paid. | | |
| Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the deductible. | | |
| As indicated in the plan, member cost sharing for certain services are excluded from the charges to meet the deductible. | | |
| No one family member may contribute more than the individual deductible amount to the family deductible. | | |
| **Member Coinsurance**<br>(applies to all expenses unless otherwise stated) | 20% | 50% |
| **Out-of-Pocket (OOP) Maximum**<br>(per plan year, includes deductible) | $5,000 Individual<br>$10,000 Family | $10,000 Individual<br>$20,000 Family |
| Claims from in-network and out-of-network providers do not cross-accumulate to satisfy the out-of-pocket maximums. | | |
| Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and copays may be used to satisfy the out of pocket maximum. | | |
| No one family member may contribute more than the individual out-of-pocket maximum amount to the family out-of-pocket maximum. | | |
| **Payment for Out-of-Network Care*** | Not applicable | Professional: 90% of Medicare<br>Facility: 90% of Medicare |
| **Certification Requirements** | | |
| Certification for certain types of out-of-network care must be obtained to avoid a reduction in benefits paid for that care. Certification for hospital admissions, treatment facility admissions, skilled nursing facility admissions, home health care, and hospice care is required. If the necessary certification is not received, payment for services will be reduced by $400 per occurrence | | |
| **Referral Requirement** | Not applicable | Not applicable |
| **Benefit Limitations --** For any service or supply that is subject to a maximum visit, day, or dollar limitation, such services or supplies accumulate toward both the participating provider and non-participating provider benefit limits under this plan. | | |
| PHYSICIAN SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Office Visits to Non-Specialist** | $30 copay deductible waived | 50% after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician for diagnosis and treatment of an illness or injury. | | |
| **Specialist Office Visits** | $60 copay deductible waived | 50% after deductible |
| **Walk-in Clinics** | $30 copay deductible waived | Not covered |
| Walk-in clinics are network, free-standing health care facilities. They are an alternative to a doctor's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, is considered a walk-in clinic. | | |
| **Maternity - Delivery and Post-Partum Care** | 20% after deductible | 50% after deductible |
| **Allergy Testing** (given by a physician) | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible |
| **Allergy Injections** (not given by a physician) | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible |
| PREVENTIVE CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| Preventive care services are covered in accordance with Health Care Reform. | | |
| **Routine Adult Physical Exams and Immunizations**<br>Coverage is limited to 1 exam every 12 months. | Covered in full | 30% after deductible |
| **Well Child Exams and Immunizations**<br>Coverage is limited 7 exams in the first 12 months of life; 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam every 12 months thereafter to age 22. | Covered in full | 30% after deductible |

| | | |
|---|---|---|
| **Routine Gynecological Exams**<br>Includes Pap smear, HPV screening and related lab fees. Coverage is limited to 1 exam every 12 months. | Covered in full | 30% after deductible |
| **Routine Mammograms**<br>For covered females age 40 and over. Frequency schedule applies. | Covered in full | 30% after deductible |
| **Women's Health**<br>Includes: Screening for gestational diabetes; HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections; counseling and screening for human immunodeficiency virus; screening and counseling for interpersonal and domestic violence; breastfeeding support, supplies and counseling; Limitations may apply. | Covered in full | Member cost sharing is based on the type of service performed and the place of service where it is rendered. |
| **Prenatal Maternity** | Covered in full | 30% after deductible |
| **Routine Digital Rectal Exam / Prostate-Specific Antigen Test**<br>For covered males age 40 and over. Frequency schedule applies. | Covered in full | 30% after deductible |
| **Colorectal Cancer Screening**<br>Sigmoidoscopy and Double Contrast Barium Enema - 1 every 5 years for all members age 50 and over. Preventive Colonoscopy - 1 every 10 years for all members age 50 and over. Fecal Occult Blood Testing - 1 every year for all members age 50 and over. | Covered in full | 30% after deductible |
| **Routine Eye and Hearing Screenings** | Paid as part of routine physical exam. | Paid as part of routine physical exam. |
| HEARING SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Hearing Exam** (by Specialist) | Not covered | Not covered |
| **Hearing Aid**<br>Coverage is limited to 1 per ear every 36 months. | 20% after deductible | 50% after deductible |
| VISION SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Adult Routine Eye Exams (Refraction)** | Not covered | Not covered |
| **Pediatric Routine Eye Exams (Refraction)**<br>Standard Vision Benefit: Coverage is limited to one exam 12 months. | Not covered | Not covered |
| **Adult Vision Hardware** | Not covered | Not covered |
| **Pediatric Vision Hardware** | Not covered | Not covered |
| DIAGNOSTIC PROCEDURES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Outpatient Diagnostic Laboratory** | 20% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray (except for Complex Imaging Services)** | 20% after deductible | 50% after deductible |
| **Outpatient Diagnostic X-ray for Complex Imaging Services**<br>Including, but not limited to, MRI, MRA, PET and CT scans. Precertification required. | 20% after deductible | 50% after deductible |
| EMERGENCY MEDICAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Urgent Care Provider**<br>(Benefit Availability may vary by location.) | $75 copay deductible waived | 50% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not covered | Not covered |
| **Emergency Room**<br>Copay waived if admitted. | $300 copay deductible waived | Paid as in-network |

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|---|---|---|
| **Non-Emergency care in an Emergency Room** | Not covered | Not covered |
| **Emergency Ambulance** | 20% after deductible | Paid as in-network |
| **Non-Emergency Ambulance** | 20% after deductible | Paid as in-network |
| HOSPITAL CARE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Coverage**<br>Including maternity (prenatal, delivery and postpartum) and transplants. | 20% after deductible | 50% after deductible |
| **Outpatient Surgery**<br>Provided in an outpatient hospital department or freestanding surgical facility. | 20% after deductible | 50% after deductible |
| **Colonoscopy**<br>(non-preventive) | Member cost sharing is based on the type of service performed and the place rendered. | Member cost sharing is based on the type of service performed and the place rendered. |
| **Transplants**<br>Coverage is limited to IOE facilities only. | 20% after deductible | Not covered |
| MENTAL HEALTH and SUBSTANCE USE SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Inpatient Mental Health & Substance Use Services** | 20% after deductible | 50% after deductible |
| **Outpatient Office Visit Mental Health & Substance Use Services** | $60 copay deductible waived | 50% after deductible |
| **Outpatient Other Mental Health & Substance Use Services**<br>(e.g,:partial hospitalization programs, intensive outpatient programs, applied behavior analysis) | 20% after deductible | 50% after deductible |
| OTHER SERVICES AND PLAN DETAILS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Skilled Nursing Facility**<br>Coverage is limited to 90 days per plan year. | 20% after deductible | 50% after deductible |
| **Home Health Care**<br>Coverage is limited to 120 visits per plan year.<br>1 visit equals a period of 4 hours or less. | 20% after deductible | 50% after deductible |
| **Infusion Therapy**<br>Provided in the home or physician's office. | 20% after deductible | 50% after deductible |
| **Infusion Therapy**<br>Provided in the outpatient hospital department of freestanding facility. | 20% after deductible | 50% after deductible |
| **Inpatient Hospice Care** | 20% after deductible | 50% after deductible |
| **Outpatient Hospice Care** | 20% after deductible | 50% after deductible |
| **Private Duty Nursing -**Outpatient | Not covered | Not covered |
| **Outpatient Short-Term Rehabilitation - Physical Therapy**<br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Coverage is limited to 60 visits per plan year, PT/OT/ST combined, rehabilitation and habilitation combined. | 20% after deductible | 50% after deductible |
| **Outpatient Short-Term Rehabilitation - Occupational Therapy**<br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Coverage is limited to 60 visits per plan year, PT/OT/ST combined, rehabilitation and habilitation combined. | 20% after deductible | 50% after deductible |

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|---|---|---|
| **Outpatient Short-Term Rehabilitation - Speech Therapy**<br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Coverage is limited to 60 visits per plan year, PT/OT/ST combined, rehabilitation and habilitation combined. | 20% after deductible | 50% after deductible |
| **Outpatient Chiropractic**<br>If provided in the outpatient hospital department, paid under outpatient hospital benefit.<br><br>Coverage is limited to 20 visits per plan year. | $60 copay deductible waived | 50% after deductible |
| **Acupuncture** | Not covered | Not covered |
| **Durable Medical Equipment** | 20% after deductible | 50% after deductible |
| **Diabetic Supplies not obtainable at a pharmacy** | Covered same as any other medical expense. | Covered same as any other medical expense. |
| FAMILY PLANNING | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Infertility Treatment - Diagnostic only**<br>Covered only for the diagnosis and treatment of the underlying medical condition. | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible |
| **Infertility Treatment - Artificial Insemination or Ovulation Induction** | Not covered | Not covered |
| **Advanced Reproductive Technology.** Including, but not limited to, GIFT, ZIFT, IVF, ICSI, ovum microsurgery and cryopreserved embryo transfers. | Not covered | Not covered |
| **Voluntary Sterilization - Vasectomy** | Member cost sharing is based on the type of service performed and the place rendered. | 50% after deductible |
| **Voluntary Sterilization - Tubal Ligation** | Covered in full | 50% after deductible |
| PEDIATRIC DENTAL SERVICES | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Preventive & Diagnostic** (includes exams, cleanings, x-rays, fluoride, sealants) | Not covered | Not covered |
| **Basic** (includes space maintainers, fillings, anesthesia, denture adjustments) | Not covered | Not covered |
| **Major** (includes crowns, endodontics, periodontics, oral surgery, dentures, bridges) | Not covered | Not covered |
| **Orthodontia** (limited to medically necessary orthodontia) | Not covered | Not covered |
| PHARMACY DEDUCTIBLE | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Prescription drug plan year deductible** | Not applicable | Not applicable |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | NETWORK CARE | OUT-OF-NETWORK CARE |
| **Retail**<br>Up to a 90 day supply | | |
| **Generic Drugs** | $15 copayment | 30% |
| **Preferred Brand Drugs** | $65 copayment | 30% |
| **Non-Preferred Drugs** | Generic & Brand: 50% up to $500 | Generic & Brand: 30% |
| **Specialty Drugs**<br>**Includes self-injectable, infused and oral specialty drugs** (retail and mail order up to a 30-day supply, excludes insulin). | 30% up to $300 | 30% |
| **Mail Order Delivery** | When you fill your prescription by mail order, you may save money 31-90 days – excludes specialty drugs when compared to the cost to purchase your prescriptions at your local retail pharmacy. | |

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|---|---|---|
| **Generic Drugs** | $30 copayment | Not covered |
| **Preferred Brand Drugs** | $130 copayment | Not covered |
| **Non-Preferred Drugs** | Generic & Brand: 50 % up to $1,000 | Not covered |
| **Specialty Drugs**<br>**Includes self-injectable, infused and oral specialty drugs** | Not covered | Not covered |
| **Specialty CareRx**[SM] -<br>For more information, please go to **www.aetnaspecialtycarerx.com** | | |

**Choose Generic -** Included. See Aetna Formulary for details.
Member pays the difference in cost between a brand and generic drug plus the applicable cost share if a generic drug is available and a brand-name drug is dispensed unless the physician indicated "Dispense as Written" on the prescription. The cost difference between the generic and brand does not count toward the Out of Pocket Maximum.

**Precertification -** Included. See Aetna Formulary for details.

**Step Therapy -** Included. See Aetna Formulary for details.

**Pharmacy Plan includes:**

Diabetic supplies obtainable from a pharmacy (Including: needles, syringes, test strips, lancets and alcohol swabs - available at retail or mail order).

Coverage is excluded for lifestyle/performance drugs.

Formulary generic FDA-approved Womens Contraceptives covered 100% in network.

**In-Network and Out-of-Network Providers**

We cover the cost of services based on whether doctors are "in-network" or "out-of-network". We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a provider who is out-of-network, your Aetna health plan may pay some of that provider 's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

Your doctor sets his or her own rate to charge you. It may be higher - sometimes much higher - than what your Aetna plan "recognizes". Your non-network doctor may bill you for the dollar amount that Aetna doesn't "recognize". You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This applies when you choose to get care out-of-network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in the network. You pay cost sharing and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

**What's Not Covered**

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design purchased.

- All medical or hospital services not specifically covered in or which are limited or excluded in the plan documents
- Charges related to any eye surgery mainly to correct refractive errors
- Cosmetic surgery, including breast reduction
- Custodial care
- Adult dental care and x-rays
- Donor egg retrieval
- Experimental and investigational procedures
- Immunizations for travel or work
- Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-medically necessary services or supplies
- Orthotics except as specified in the plan

- Over-the-counter medications and supplies
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs
- Special duty nursing
- Weight reduction programs, or dietary supplements

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan includes a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step therapy, please refer to our website at **www.aetna.com**, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan uses copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Benefits are provided by Aetna Life Insurance Company (ALIC).

For more information about Aetna plans, refer to **www.aetna.com**.

FORM #: 14.35.305.1A (9/17)  Print Date:11-10-2017 TPID: 14041482

aetna® : NC PPO 2000 80/50

**Coverage for:** Employee + Family | **Plan Type:** PPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=081700-120120-121736 or by calling 1-888-802-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-802-3862 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For each Plan Year, In-network: Individual $2,000 / Family $4,000. Out-of-network: Individual $4,000 / Family $8,000. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Certain office visits, preventive care, emergency care, urgent care and prescription drugs in-network. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-network: Individual $5,000 / Family $10,000. Out-of-network: Individual $10,000 / Family $20,000. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.aetna.com/docfind or call 1-888-802-3862 for a list of in-network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out–of–Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay/visit, deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $60 copay/visit, deductible does not apply | 50% coinsurance | None |
| | Preventive care /screening /immunization | No charge | 30% coinsurance | You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | Out-of-network precertification required or $400 penalty applies per occurrence. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.aetna.com/individuals-families/find-a-medication.html | Preferred generic drugs | $15 copay for up to a 30 day supply, $30 copay for up to a 90 day supply, deductible does not apply | 30% coinsurance for up to a 30 day supply, deductible does not apply | Covers up to a 30 day supply (retail prescription), 31-90 day supply (retail & mail order prescription). Applicable cost share plus difference (brand minus generic cost) applies for brand when generic available unless Dispense as Written. No charge for preferred generic FDA-approved women's contraceptives in-network. Precertification and step therapy may be required. No coverage for mail order prescriptions out-of-network. |
| | Preferred brand drugs | $65 copay for up to a 30 day supply, $130 copay for up to a 90 day supply, deductible does not apply | 30% coinsurance for up to a 30 day supply, deductible does not apply | |
| | Non-preferred generic/brand drugs | 50% coinsurance up to a $500 maximum for up to a 30 day supply, 50% coinsurance up to a $1,000 maximum for up to a 90 day supply, deductible does not apply | 30% coinsurance for up to a 30 day supply, deductible does not apply | |
| | Preferred/non-preferred specialty drugs | 30% coinsurance up to a $300 maximum for up to a 30 day supply, deductible does not apply | 30% coinsurance for up to a 30 day supply, deductible does not apply | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out–of–Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit, deductible does not apply | $300 copay/visit, deductible does not apply | Copay waived if admitted. Out-of-network emergency room care cost-share same as in-network. No coverage for non-emergency care. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Out-of-network cost-share same as in-network. |
| | Urgent care | $75 copay/visit, deductible does not apply | 50% coinsurance | No coverage for non-urgent use. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Out-of-network precertification required or $400 penalty applies per occurrence. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Outpatient office visits: $60 copay/visit, deductible does not apply; All other outpatient services: 20% coinsurance | Office visits and all other outpatient services: 50% coinsurance | None |
| | Inpatient services | 20% coinsurance | 50% coinsurance | Out-of-network precertification required or $400 penalty applies per occurrence. |
| **If you are pregnant** | Office visits | No charge | 30% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | Out-of-network precertification required or $400 penalty applies per occurrence. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-Network Provider (You will pay the least) | Out–of–Network Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | Coverage is limited to 120 visits. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy & Speech Therapy combined. |
| | Habilitation services | 20% coinsurance | 50% coinsurance | Coverage is limited to 60 visits for Physical Therapy, Occupational Therapy & Speech Therapy combined, rehabilitation and habilitation combined. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Coverage is limited to 90 days. Out-of-network precertification required or $400 penalty applies per occurrence. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Coverage is limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
| | Hospice services | 20% coinsurance | 50% coinsurance | Out-of-network precertification required or $400 penalty applies per occurrence. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered. |
| | Children's glasses | Not covered | Not covered | Not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine Eye Care (Adult & Child)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care - Coverage is limited to 20 visits.
- Hearing aids - Coverage is limited to 1 per ear every 36 months.

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: North Carolina Department of Insurance, Health Insurance Smart NC, 1201 Mail Service Center, Raleigh, NC 27699-1201, (855) 408-1212, http://www.ncdoi.com/Smart.

- For more information on your rights to continue coverage, contact the plan at 1-888-802-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-802-3862.
- North Carolina Department of Insurance, Health Insurance Smart NC, 1201 Mail Service Center, Raleigh, NC 27699-1201, (855) 408-1212, http://www.ncdoi.com/Smart.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Health Insurance Smart NC, NC Department of Insurance, 430 N. Salisbury Street, Suite 1018, Raleigh, NC 27603, (855) 408-1212, http://www.ncdoi.com/Smart/

## Does this plan Provide Minimum Essential Coverage? **Yes.**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## Does this plan Meet Minimum Value Standard? **Yes.**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

*----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $100 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,260** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $2,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,200** |

Note: If your plan has a wellness program and you choose to participate, you may be able to reduce your costs.

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-802-3862.

## Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

## Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-802-3862.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462 Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

## Language Assistance:

For language assistance in your language call 1-888-802-3862 at no cost.

| | |
|---|---|
| Arabic - | للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-802-3862 |
| Chinese - | 欲取得繁體中文語言協助，請撥打 1-888-802-3862，無需付費。 |
| French - | Pour une assistance linguistique en français appeler le 1-888-802-3862 sans frais. |
| German - | Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-802-3862 an. |
| Gujarati - | ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-802-3862 પર કૉલ કરો. |
| Hindi - | हिन्दी में भाषा सहायता के लिए, 1-888-802-3862 पर मुफ्त कॉल करें। |
| Hmong - | Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-802-3862. |
| Japanese - | 日本語で援助をご希望の方は、1-888-802-3862 まで無料でお電話ください。 |
| Korean - | 한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-802-3862 번으로 전화해 주십시오. |
| Laotian - | ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ **1-888-802-3862** ໂດຍບໍ່ເສຍຄ່າໂທ. |
| Mon-Khmer, Cambodian - | សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-802-3862 ដោយឥតគិតថ្លៃ។ |
| Navajo - | T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-802-3862 |
| Russian - | Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-802-3862. |
| Spanish - | Para obtener asistencia lingüística en español, llame sin cargo al 1-888-802-3862. |
| Tagalog - | Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-802-3862 nang walang bayad. |
| Vietnamese - | Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-802-3862. |

# Dental

MetLife

## Plan Design for: Exclusive Jets
## Original Plan Effective Date: April 1, 2016

**Network: PDP Plus**

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you.

| **Coverage Type:** | **In-Network[1]**<br>% of Negotiated Fee[2] | **Out-of-Network[1]**<br>% of R&C Fee[4] |
|---|---|---|
| **Type A** - Preventive | 100% | 100% |
| **Type B** - Basic Restorative | 80% | 80% |
| **Type C** - Major Restorative | 50% | 50% |
| | | |
| **Deductible[3]** | | |
| Individual | $50 | $50 |
| Family | $150 | $150 |
| | | |
| **Annual Maximum Benefit:** | | |
| Per Individual | $1250 | $1250 |
| **Dependent Age:** | Eligible for benefits until the day that he or she turns 26. | |

1. "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.
2. Negotiated fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
3. Applies to Type B and C services only.
4. Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of:
   - the dentist's actual charge (the 'Actual Charge'),
   - the dentist's usual charge for the same or similar services (the 'Usual Charge') or
   - the usual charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 90th percentile. Services must be necessary in terms of generally accepted dental standards.

## Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice – in or out of the network. .

If you receive in-network services, you will be responsible for any applicable cost sharing, negotiated charges after benefit maximums are met, and costs for non-covered services. If you receive out-of-network services, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the negotiated fee schedule amount, and charges for non-covered services.

- Plan benefits for in-network services are based on a percentage of the Negotiated fee – the Fee that participating dentists have agreed to accept as payment in full.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) Fee. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service

**Take advantage of online self-service capabilities with MyBenefits.**

- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits** and follow the easy registration instructions.

## Selected Covered Services and Frequency Limitations*

| Type A - Preventive | How Many/How Often: |
|---|---|
| Oral Examinations | 1 in 6 months |
| Full Mouth X-rays | 1 in 60 months |
| Bitewing X-rays (Adult/Child) | 1 in 12 months |
| Prophylaxis - Cleanings | 1 in 6 months |
| Topical Fluoride Applications | 1 in 12 months - Children to age 14 |
| Sealants | 1 in 60 months - Children to age 14 |
| Space Maintainers | No limit - Children up to age 14 |

| Type B - Basic Restorative | How Many/How Often: |
|---|---|
| Amalgam and Composite Fillings | 1 in 24 months. |
| Endodontics Root Canal | 1 per tooth in 24 months |
| Periodontal Surgery | 1 in 36 months per quadrant |
| Periodontal Scaling & Root Planing | 1 in 24 months per quadrant |
| Periodontal Maintenance | 4 in 1 year, includes 2 cleanings |
| Oral Surgery (Simple Extractions) | |
| Oral Surgery (Surgical Extractions) | |
| Other Oral Surgery | |
| Emergency Palliative Treatment | |
| General Anesthesia | |

| Type C - Major Restorative | How Many/How Often: |
|---|---|
| Crowns/Inlays/Onlays | 1 per tooth in 10 years |
| Prefabricated Crowns | 1 per tooth in 10 years |
| Repairs | 1 in 12 months |
| Bridges | 1 in 10 years |
| Dentures | 1 in 10 years |
| Consultations | 1 in 12 months |
| Implant Services | 1 service per tooth in 60 months - 1 repair per 12 months |

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you receive a more costly treatment alternative, your dentist may charge you or your dependent for the difference between the cost of the service that was performed and the least costly treatment alternative.

The service categories and plan limitations shown above represent an overview of your Plan of Benefits. This document presents many services within each category, but is not a complete description of the Plan. Please see your Plan description/Insurance certificate for complete details. In the event of a conflict with this summary, the terms of your insurance certificate will govern.

## We will not pay Dental Insurance benefits for charges incurred for:

1. 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;
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 primarily cosmetic (For residents of Texas, see notice page section in your certificate).
5. 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.

   **For NY Sitused Groups, this exclusion does not apply.**
6. Services or appliances which restore or alter occlusion or vertical dimension.
7. Restoration of tooth structure damaged by attrition, abrasion or erosion.
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, personalization 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 not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    **For North Carolina and Virginia Sitused Groups, this exclusion does not apply.**
14. Services paid under any worker's compensation, occupational disease or employer liability law as follows:
    - for persons who are covered in North Carolina for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' compensation Act;
    - or for persons who are not covered in North Carolina, services paid or payable under any workers compensation or occupational disease law.

    **This exclusion only applies for North Carolina Sitused Groups.**
15. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.

    **This exclusion only applies for North Carolina Sitused Groups.**
16. Services covered under any workers' compensation, occupational disease or employer liability law for which the employee/or Dependent received benefits under that law.

    **This exclusion only applies for Virginia Sitused Groups.**
17. Services:
    - for which the employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the policyholder, labor union, mutual benefit association, or VA hospital.

    **This exclusion only applies for Virginia Sitused Groups.**
18. Services covered under other coverage provided by the Employer.
19. Temporary or provisional restorations.
20. Temporary or provisional appliances.
21. Prescription drugs.
22. Services for which the submitted documentation indicates a poor prognosis.
23. 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.
24. 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.

    **For NY Sitused Groups, this exclusion does not apply.**
25. Caries susceptibility tests.
26. 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.
27. Other fixed Denture prosthetic services not described elsewhere in this certificate.
28. Precision attachments, except when the precision attachment is related to implant prosthetics.
29. Initial installation or replacement of a full or 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.
30. 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.
31. Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it.

32. Implants to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth.
33. 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.
34. Fixed and removable appliances for correction of harmful habits.[1]
35. Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.[1]
36. Diagnosis and treatment of temporomandibular joint (TMJ) disorders. This exclusion does not apply to residents of Minnesota.[1]
37. Orthodontic services or appliances. [1]
38. Repair or replacement of an orthodontic device.[1]
39. Duplicate prosthetic devices or appliances.
40. Replacement of a lost or stolen appliance, Cast Restoration, or Denture.
41. Intra and extraoral photographic images.
42. Services or supplies furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article. A prohibited referral is one in which a Health Care Practitioner refers You to a Health Care Entity in which the Health Care Practitioner or Health Care Practitioner's immediate family or both own a Beneficial Interest or have a Compensation Agreement. For the purposes of this exclusion, the terms "Referral", "Health Care Practitioner" , "Health Care Entity", "Beneficial Interest" and Compensation Agreement have the same meaning as provided in Section 1-301 of the Maryland Health Occupations Article.
    **This exclusion only applies <u>for Maryland Sitused Groups</u>**

[1]Some of these exclusions may not apply. Please see your plan design and certificate for details.

## Common Questions … Important Answers

### Who is a participating dentist?

A participating, or network, dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

In addition to the standard MetLife network, your employer may provide you with access to a select network of dental providers that may be unique to your employer's dental program. When visiting these providers, you may receive a better benefit, have lower out-of-pocket costs and/or have access to care at facilities at your worksite. Please sign into MyBenefits for more details.

* Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change.

### How do I find a participating dentist?

There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/dental or call 1-800-275-4638 to have a list faxed or mailed to you.

### What services are covered by my plan?

All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

### May I choose a non-participating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating (out-of-network) dentist, your out-of-pocket costs may be higher. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

### Can my dentist apply for participation in the network?

Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.* The website and phone number are for use by dental professionals only.

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

### How are claims processed?

Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/dental or request one by calling 1-800-275-4638.

### Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

### Can MetLife help me find a dentist outside of the U.S. if I am traveling?

Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

**International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife.
** Refer to your dental benefits plan summary for your out-of-network dental coverage.

### How does MetLife coordinate benefits with other insurance plans?

Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions requires MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

### Do I need an ID card?

No, You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

**Do my dependents have to visit the same dentist that I select?**
No. You and your dependents each have the freedom to choose any dentist.

**If I do not enroll during my initial enrollment period can I still purchase Dental Insurance at a later date?**
Yes, employees who do not elect coverage during their 31-day application period may still elect coverage later. Dental coverage would be subject to the following waiting periods.

- No waiting period on Preventive Services
- 6 months on Basic Restorative (Fillings)
- 12 months on all other Basic Services
- 24 months on Major Services
- 24 months on Orthodontia Services (if applicable)

## CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
## NOTICE TO INSUREDS

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card, if any, or 1-800-942-0854. For more help call the CA Dept. of Insurance at 1-800-927-4357.
To receive a copy of the attached MetLife document translated into Spanish or Chinese, please mark the box by the requested language statement below, and mail the document with this form to:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Please indicate to whom and where the translated document is to be sent.

☐ **Servicio de Idiomas Sin Costo.** Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llámenos al número que aparece en su tarjeta de identificación, si tiene una, o al 1-800-942-0854. Para recibir ayuda adicional llame al Departamento de Seguros de California al 1-800-927-4357.
Para recibir una copia del documento adjunto de MetLife traducido al español, marque la casilla correspondiente a esta oración, y envíe por correo el documento junto con este formulario a:
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
Por favor, indique a quién y a dónde debe enviarse el documento traducido.
NOMBRE_____

DIRECCIÓN_____

☐ **免費語言服務。**您可獲得免費口譯服務。您可要求翻譯員向你口譯文件，或可要求向你發回文件的中文譯本。如需協助，請致電您的ID卡上所示號碼（如有），或 1-800-942-0854。如需更多協助，請致電加州保險部熱線1-800-927-4357。
爲收取隨附MetLife文件的中文譯本，請勾選此陳述前的方框，並將文件連同此表一併郵寄至：
Metropolitan Life Insurance Company
PO Box 14587
Lexington, KY 40512
請指明經翻譯文件收件人的姓名及地址。
姓名_____

地址_____

**Անվճար թարգմանչական ծառայություններ:** Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք մեզ Ձեր ID քարտի վրա նշված հեռախոսահամարով կամ 1-800-942-0854: Առավել մանրամասն տեղեկատվության համար զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով:

** សេវាបកប្រែជាឥតគិតថ្លៃ ។** អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើង តាមលេខដែលមានចុះនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នកប្រសិនបើមាន ឬ តាមលេខ 1-800-942-0854 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងនៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។

**Kev pab txhais lus tsis kom them nqi.** Koj thov tau kom nrhiav neeg txhais lus thiab nyeem ntaub ntaww hais ua lus Hmoob rau koj mloog. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj sau hauv koj daim npav ID, yog muaj, lossis 1-800-942-0854. Yog xav kom pab lwm yam hu rau lub CA Hauv Paus lv-saws-las ntawm 1-800-927-4357.

**無料の通訳サービス。**通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、お手持ちの ID カードに記載されている番号、または 1-800-942-0854 へお電話ください。さらなる支援が必要な場合は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。

**무료 통역 서비스.** 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 귀하의 ID 카드에 있는 번호나 1-800-942-0854 로 전화하십시오. 다른 도움이 필요하시면, 전화번호 1-800-927-4357 로 캘리포니아 보험국에 연락하여 주십시오.

**Бесплатные услуги устного перевода.** Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните нам по номеру, указанному на вашей идентификационной карточке, если у вас она есть, либо по номеру 1-800-942-0854. Если вам нужна помощь в других вопросах, позвоните в горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357.

**Libreng serbisyo sa pagsasalin.** Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa numerong nakalista sa iyong ID card, kung mayroon man, o sa numerong 1-800-942-0854. Para sa karagdagang tulong tawagan ang CA Dept. of Insurance sa numerong 1-800-927-4357.

**Dịch vụ thông dịch miễn phí.** Quý vị có thể tìm một thông dịch viên và nhờ đọc các tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho chúng tôi tại số nêu trên thẻ ID của quý vị, nếu có, hoặc 1-800-942-0854. Để được giúp đỡ thêm gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357.

**لا تتوفر خدمات ترجمة بتكلفة.** يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. للمساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك، أو اتصل بالرقم 1-800-942-0854. ولمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357.

**سرویس های ترجمه رایگان.** شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی،از طریق شماره درج شده در کارت شناسایی خود (در صورت وجود) با شماره 1-800-942-0854 با ما تماس بگیرید. برای راهنمایی بیشتر با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید.

**بلا معاوضہ مترجم دی خدمات مل سکدی اے۔** تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے۔ مدد واسطے اپڑیں آئی ڈی کارڈ، گرہوتو دے وچ نمبر یا 1-800-942-0854 پہ کال کرو۔ آگے مزید مدد واسطے اے نمبر 1-800-927-4357 پہ سی اے ڈیپارٹمنٹ برائے انشورنس نال گال کرو۔

# Group Vision Benefits Overview

This plan overview will outline your in-network and out-of-network vision benefits, help you find a vision specialist and share MetLife contact information.

MetLife

## With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical and Vision works.
- Take advantage of our service agreement with Walmart and Sam's Club—they check your eligibility and process claims even though they are out of network.

### In-network value added features:

Additional lens enhancements:[1] Average 20-25% savings on all other lens enhancements.

Savings on glasses and sunglasses: Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.

Laser vision correction: [2] Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

## In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

| | Frequency |
|---|---|
| **Eye exam** | Once every 12 months |
| • Eye health exam, dilation, prescription and refraction for glasses: Covered in full after **$10** copay. | |
| • Retinal imaging:[1] Up to a **$39** copay on routine retinal screening when performed by a private practice provider. | |
| **Frame** | Once every 24 months |
| • Allowance: **$130** after **$25** eyewear copay. | |
| • Costco: **$70** allowance after **$25** eyewear copay. You will receive an additional **20%** savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco.[1] | |
| **Standard corrective lenses** | Once every 12 months |
| • Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **$25** eyewear copay | |
| **Standard lens enhancements[1]** | Once every 12 months |
| • Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after **$25** eyewear copay. | |
| • Progressive, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits. | |
| **Contact lenses instead of eye glasses** | Once every 12 months |
| • Contact fitting and evaluation:[1] Covered in full with a maximum copay of **$60**. | |
| • Elective lenses: **$130** allowance. | |
| • Necessary lenses: Covered in full after eyewear copay. | |

## We're here to help

Find a participating vision specialist:

www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

Get a claim form:
www.metlife.com/mybenefits

General questions:
www.metlife.com/mybenefits or call [1-855-MET-EYE1 (1-855-638-3931)]

## Out-of-network reimbursement

You pay for services and then submit a claim for reimbursement. The same benefit frequencies for **In-network benefits** apply. Once you enroll, visit www.metlife.com/mybenefitsfor detailed out-of-network benefits information.

| | | |
|---|---|---|
| • Eye exam: up to **$45** | • Single vision lenses: up to **$30** | • Lined trifocal lenses: up to **$65** |
| • Frames: up to **$70** | • Lined bifocal lenses: up to **$50** | • Progressive lenses: up to **$50** |
| • Contact lenses: | • Lenticular lenses: up to **$100** | |
| - Elective up to **$105** | | |
| - Necessary up to **$210** | | |

# Exclusions and Limitations of Benefits

This plan does not cover the following services, materials and treatments.

### Services and Eyewear

- Services and/or materials not specifically included in the Vision Plan Benefits Overview (Schedule of Benefits).
- Any portion of a charge above the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
- Any eye examination or corrective eyewear required as a condition of employment.
- Services and supplies received by you or your Dependent before the Vision Insurance starts.
- Missed appointments.
- Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
- Services and materials obtained while outside the United States, except for emergency vision care.
- Services, procedures, or materials for which a charge would not have been made in the absence of insurance.
- Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.
- 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 Vision Insurance under the Group Policy be paid first. Government Plan means any plan, program, or coverage which is established under the laws or regulations of any government. The term does not include any plan, program, or coverage provided by a government as an employer or Medicare.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pairs of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen, or damaged (within the 12 month benefit period from date of purchase.)
- Contact lens insurance policies and service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing, and cleaning.

### Treatments

- Orthoptics or vision training and any associated supplemental testing.
- Medical and surgical treatment of the eye(s).

### Medications

- Prescription and non-prescription medication

*1All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.*

*2 Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.*

**Important:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

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Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY.

Certain claims and network administration services are provided through Vision Service Plan. In certain states, availability of MetLife's group vision benefits is subject to regulatory approval. 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 MetLife or your plan administrator for costs and complete details.

Metropolitan Life Insurance Company, New York, NY 10166