

**Plan Design for: Indiana Hand to Shoulder Center****Original Plan Effective Date: January 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 % of Negotiated Fee ²	Out-of-Network ¹ % of R&C Fee ⁴
Type A - Preventive	100%	100%
Type B - Basic Restorative	80%	80%
Type C - Major Restorative	50%	50%
Type D - Orthodontia	50%	50%
Deductible ³		
Individual	\$50	\$50
Family	\$150	\$150
Annual Maximum Benefit:		
Per Individual	\$1250	\$1250
Orthodontia Lifetime Maximum - Ortho applies to Child Only		
	Child to age 19	
	\$1250 per Person	\$1250 per Person
Dependent Age:	Eligible for benefits until the day that he or she turns 26.	
1. "In-Network Benefits" means benefits provided under this plan for covered dental services that are provided by a MetLife PDP dentist. "Out-of-Network Benefits" means benefits provided under this plan for covered dental services that are not provided by a MetLife PDP dentist.		
2. PDP Fee refers to the fees that MetLife PDP dentists have agreed to accept as payment in full.		
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 the 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 the percentage of the Reasonable and Customary (R&C) charges. 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	2 in 12 months - Children to age 14
Sealants	1 in 36 months - Children to age 16
Emergency Palliative Treatment	

Type B - Basic Restorative

How Many/How Often:

Space Maintainers	1 per lifetime per tooth area - Children up to age 16
Amalgam and Composite Fillings	1 in 24 months.
Prefabricated Crowns	1 per tooth in 10 years
Repairs	1 in 24 months
Periodontal Scaling & Root Planing	1 in 24 months per quadrant
Periodontal Maintenance	2 in 1 year, includes 2 cleanings
Oral Surgery (Simple Extractions)	
General Anesthesia	
Harmful Habits Appliances	

Type C - Major Restorative

How Many/How Often:

Crowns/Inlays/Onlays	1 per tooth in 10 years
Endodontics Root Canal	1 per tooth per lifetime
Periodontal Surgery	1 in 36 months per quadrant
Oral Surgery (Surgical Extractions)	
Other Oral Surgery	
Bridges	1 in 10 years
Dentures	1 in 10 years
Consultations	1 in 12 months
Implant Services	1 service per tooth in 10 years - 1 repair per 84 months

Type D - Orthodontia

- Dependent children up to age 19. Age limitations may vary by state. Please see your Plan description for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.
- All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits and procedures performed in connection with the orthodontic treatment, are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage

***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 for complete details. In the event of a conflict with this summary, the terms of the certificate will govern.

Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

Common Questions ... Important Answers

Who is a participating dentist?

A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan 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.*

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

How do I find a participating PDP 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 PDP 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.

Does the Preferred Dentist Program offer any discounts on non-covered services?

Negotiated fees may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If permitted, you may only be responsible for the negotiated fee.

* Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

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 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 e-mail 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.

How can I learn about what dentists in my area charge for different procedures?

If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area.* You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

* The Dental Procedure Fee Tool application is provided by go2dental.com, Inc., an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a vendor. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.

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 provision 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 require 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 MetLife's 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.

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.



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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.

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.

	Frequency
Eye exam	Once every 12 months

- Eye health exam, dilation, prescription and refraction for glasses: Covered in full after \$20 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
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- Allowance: \$130 after \$20 eyewear copay.
- Costco: \$70 allowance after \$20 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
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- Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after \$20 eyewear copay

Standard lens enhancements¹	Once every 12 months
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- Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: Covered in full after \$20 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
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- 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/mybenefits for 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 $\pm .50$ 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

1 All 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.

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