Summary of Benefits
Dental Insurance - Vol Dental Option 4

Voluntary Dental		
Class Description	All Active Full Time Employees (30 Hours)	
	In-Network	**Out-of-Network***
Reimbursement	Negotiated Fee Schedule	R&C 90th Percentile
Type A – Preventive	100%	100%
Type B – Basic	100%	80%
Type C – Major	60%	50%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $0 $0 Aggregate	B & C $50 $150 Aggregate
Calendar Year Maximum ***(applies to A,B,C services)***	$1,250	$1,250
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000

* 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 (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

Voluntary Dental	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
▪ Employee Only	$32.71	23	$1,284	$15,413
▪ Employee + Spouse	$69.96	3		
▪ Employee + Child(ren)	$77.09	1		
▪ Employee + Family	$122.56	2		
▪ Total		29		
Rates are guaranteed from December 1, 2016 - November 30, 2017 (12 months)				
2nd year Rate Cap: The first year's renewal rates will not be increased by more than 6.0% above the current rates.				

Frequency & Allocations / Exclusions

(Custom Primary (Flex) - Custom Lower Cost (Flex))

Class Description: All Active Full Time Employees	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 1 time in 6 months
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 1 time in 6 months
▪ Sealants	▪ 1 per molar in 60 months for a child under age 14
▪ Space Maintainers	▪ No Limit for a child under age 14
▪ Fluoride	▪ 1 time in 12 months for a dependent child under age 14
▪ Full Mouth X-Rays	▪ Once in 60 months
▪ Bitewing X-Rays	▪ For a child under 14: 1 time in 12 months ▪ Adult: 1 time in 12 months
▪ Emergency Palliative Treatment	
▪ Periapical X-Rays	
▪ Other X-Rays	
▪ Harmful Habit Appliances	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Amalgam Fillings	▪ 1 replacement per surface in 24 Months
▪ Root Canal	▪ 1 in 24 months
▪ Periodontal Maintenance	▪ 4 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 4)
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Labs & Other Tests	
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	
▪ Pulpotomy	
▪ Pulp Capping	
▪ Pulp Therapy	
▪ Apexification & Recalcification	
▪ Periodontal Surgery – Soft & Connective Tissue Grafts	
▪ Periodontics – Non-Surgical	
▪ Oral Surgery: Simple Extractions	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Consultations	▪ 1 in 12 months
▪ Prefabricated Crowns	▪ 1 per tooth in 10 calendar years
▪ Crown Buildups / Post Core	▪ 1 per tooth in 10 calendar years
▪ Repairs	▪ 1 in 12 months
▪ Recementations	▪ 1 in 12 months
▪ Dentures	▪ 1 in 10 calendar years
▪ Immediate Temporary Dentures – Complete / Partial	▪ 1 replacement in 12 months
▪ Dentures – Rebases / Relines	▪ 1 in 36 months
▪ Denture Adjustments	▪ 1 in 12 months
▪ Fixed Bridges	▪ 1 in 10 calendar years

▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 10 calendar years
▪ Implant Services	▪ 1 per tooth position in 60 months
▪ Implant Repairs	▪ 1 per tooth in 12 months
▪ Implant Supported Prosthetic	▪ 1 per tooth in 60 Months
▪ Tissue Conditioning	▪ 1 in 36 months
▪ Occlusal Adjustments	▪ 1 in 12 months
▪ General Anesthesia	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

Exclusions
All Active Full Time Employees
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ 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 or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn Child; or required for the treatment of a congenital cleft in the lip or palate, or both. ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests.

- Precision attachments associated with fixed and removable prostheses.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Duplicate prosthetic devices or appliances.
- Replacement of a lost or stolen appliance, cast restoration or denture.
- Intra and extraoral photographic images.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

Highlights
Broker Commissions included in the rate: Flat 10.00%
Expected Participation: 57% and at least 10 covered lives.
Employee Contributions: 100%
Financial Arrangement: Non-retrospectively Experience Rated
Situs is SOUTH CAROLINA
Only those residing in the United States are eligible for benefits
Dependent Child Definition: A Child is covered up to age 26, A student is covered up to age 26.
Ortho coverage applies to: Child Only. Children are covered to age 19.
This quote assumes the plan is not a Section 125 plan.
Late Entrant 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:** Type A Services .....No waiting period Type B Services (Fillings).....6 month waiting period Type B Services – All Other Services .....12 month waiting period Type C Services .....24 month waiting period Orthodontic Services (if applicable).....24 month waiting period

Summary of Benefits
VISION - Vol Vision Option 2

Vision		
Class Description	All Active Full Time Employees (30 Hours)	
Plan Name	M130D-20/20	
Reimbursement	**In-Network Coverage (Using a Network Provider)**	**Out-of-Network Reimbursement (Using a Non-Network Provider)**
Eye Examination		
Comprehensive exam of visual functions and prescription of corrective eyewear.	**$20 copay**	$45 allowance
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Materials / Eyewear (Either Glasses or Contacts)		
Standard Corrective Lenses		
• **Single vision**	$20 copay	$30 allowance
• **Lined bifocal**	$20 copay	$50 allowance
• **Lined trifocal**	$20 copay	$65 allowance
• **Lenticular**	$20 copay	$100 allowance

Standard Lens Enhancement		
• **Ultraviolet coating**	Covered in Full	Applied to the allowance for the applicable corrective lens
• **Polycarbonate (child up to age 18)**	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements[1]		
• **Progressive Standard**	Up to $55 copay	$50 allowance
• **Progressive Premium/Custom**	Premium: Up to $95-$105 copay Custom: Up to $150-$175 copay	$50 allowance
• **Polycarbonate (adult)**	Single Vision: Up to $31 copay Multifocal: Up to $35 copay	Applied to the allowance for the applicable corrective lens
• **Scratch-resistant coating (variable by type)**	Up to $17 - $33 copay	Applied to the allowance for the applicable corrective lens
• **Tints (variable by type)**	Single Vision: Up to $17 - $34 copay Multifocal: Up to $17 - $44 copay	Applied to the allowance for the applicable corrective lens
• **Anti-reflective coating (variable by type)**	Up to $41 - $85 copay	Applied to the allowance for the applicable corrective lens
• **Photochromic (variable by type)**	Up to $47 - $82 copay	Applied to the allowance for the applicable corrective lens
Frame Allowance (You will receive an additional **20%** off any amount that you pay over your allowance. This offer is available from all participating locations except Costco.)	$130 allowance	$70 allowance
• **Costco**	$70 allowance	
Contact Lenses		
• **Elective**	$130 allowance	$105 allowance
• **Necessary**	Covered in full after eyewear copay	$210 allowance
• **Contact Fitting and Evaluation**	Standard or Premium fit: Covered in full with a maximum copay of $60	Applied to the contact lens allowance
Value Added Features		
Additional Savings on Glasses and Sunglasses[1]	Get 20% off the cost for 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. Offer is only available at MetLife participating locations.

[1]Member costs for listed lens enhancements will be limited to copays that MetLife has negotiated with participating providers. These copays can be viewed by members after enrollment at www.metlife.com/mybenefits. 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. Laser vision care discounts are only available from participating locations.

Vision	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
▪ Employee Only	$8.35	20	$300	$3,598
▪ Employee + Spouse	$16.74	4		
▪ Employee + Child(ren)	$14.17	3		
▪ Employee + Family	$23.37	1		
▪ Total		28		
Rates are guaranteed from December 1, 2016 - November 30, 2018 (24 months)				

Frequency / Exclusions

Class Description: All Active Full Time Employees	
	Frequencies
▪ Examinations	▪ 1 per 12 Months
▪ Standard Corrective Lenses	▪ 1 per 12 Months
▪ Frames	▪ 1 per 24 Months
▪ Contact Lenses	▪ 1 per 12 Months
Either glasses or contacts allowed per frequency	

Exclusions

- Services and/or materials not specifically included in the Summary of Benefits as covered Plan Benefits.
- Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Summary of Benefits.
- 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, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Prescription and non-perscription medications.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where MetLife is required by law to pay.
- Any eye examination or any corrective eyewear required as a condition of employment.
- Services and supplies received by You or Your Dependent before the Vision Insurance starts for that person.
- 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.
- 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 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.

Highlights
Broker Commissions included in the rate: Flat 10.00%
Expected Participation: 55% Employee Contributions: 100% Financial Arrangement: Non-retrospectively Experience Rated
Situs is SOUTH CAROLINA
SIC Code: 5013
Dependent Child Definition: A Child is covered up to age 26; A student is covered up to age 26.
This quote assumes the plan is not a Section 125 plan.
An Open Enrollment period occurring annually is included