USI Affinity Dental Plan Benefits

MetLife

Network: PDP Plus

Benefit Summary

	Platinum		Gold		Silver	
Coverage Type	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Type A – Preventive	100% of Negotiated Fee*	100% of Negotiated Fee*	100% of Negotiated Fee*	100% of Negotiated Fee*	100% of Negotiated Fee*	100% of Negotiated Fee*
Type B – Basic	80% of Negotiated Fee*	80% of Negotiated Fee*	70% of Negotiated Fee*	70% of Negotiated Fee*	50% of Negotiated Fee*	50% of Negotiated Fee*
Type C – Major	50% of Negotiated Fee*	50% of Negotiated Fee *	40% of Negotiated Fee*	40% of Negotiated Fee*	Not Covered	Not Covered
Type D – Orthodontia	50% of Negotiated Fee*	50% of Negotiated Fee*	Not Covered	Not Covered	Not Covered	Not Covered
Deductible†	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Individual	$25.00†	$25.00†	$50.00†	$50.00†	$50.00†	$50.00†
Family	$75.00†	$75.00†	$150.00†	$150.00†	$150.00†	$150.00†
Annual Maximum Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Per Person	$3,000 (Annual Combined)		$1,500 (Annual Combined)		$1,000 (Annual Combined)	
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Per Person	$2,000 (Annual Combined)		Not Covered		Not Covered	
Network	**PDP Plus**					

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

† Applies only to Type B & C Services.

Dental Monthly Premiums

	Member only	Member + Spouse	Member + Children	Member + Family
Platinum Plan				
Area 1	$ 48.97	$ 99.36	$ 100.94	$ 160.70
Area 2	$ 53.10	$ 107.72	$ 109.44	$ 174.23
Area 3	$ 58.89	$ 119.47	$ 121.36	$ 193.23
Area 4	$ 65.37	$ 132.63	$ 134.73	$ 214.50
Area 5	$ 71.82	$ 145.70	$ 148.01	$ 235.64
Gold Plan				
	Member only	Member + Spouse	Member + Children	Member + Family
Area 1	$ 33.98	$ 69.28	$ 70.07	$ 112.49
Area 2	$ 36.84	$ 75.12	$ 75.97	$ 121.97
Area 3	$ 40.87	$ 83.30	$ 84.25	$ 135.26
Area 4	$ 45.35	$ 92.48	$ 93.52	$ 150.15
Area 5	$ 49.83	$ 101.60	$ 102.74	$ 164.96
Silver Plan				
	Member only	Member + Spouse	Member + Children	Member + Family
Area 1	$ 21.69	$ 43.29	$ 44.76	$ 71.54
Area 2	$ 23.52	$ 46.94	$ 48.53	$ 77.57
Area 3	$ 26.08	$ 52.05	$ 53.82	$ 86.02
Area 4	$ 28.95	$ 57.78	$ 59.75	$ 95.49
Area 5	$ 31.80	$ 63.48	$ 65.64	$ 104.91

These rates are valid through 12/31/17

USI Affinity DENTAL

AREA SCHEDULE

How to use this chart:

To determine the appropriate premium rates for a dental plan, look up the enroller's state of residence on this chart, and then look up the enroller's 3-digit zip code, if applicable. Use the Area number that applies to your state/zip to determine the premium rate from the area rate schedule.

State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369
	2	355-361, 365-366
Alaska	5	995-999
Arizona	2	850-857
	3	859-865
Arkansas	2	716-729
California	2	923-925
	3	900, 905-922, 926-938, 952-953, 955-961
	4	901-904, 939, 945-946, 948, 950-951
	5	940-944, 947, 949, 954
Colorado	3	800-816
Connecticut	4	060-069
Delaware	4	197-199
D.C.	3	200, 202-205
Florida	2	320-322, 325-329, 334-338, 342-349
	3	323-324, 333, 339-341
	4	330-332
Georgia	2	306-310, 312, 319
	3	300-305, 311, 313-318, 398
Hawaii	3	967-968
Idaho	2	832-838
Illinois	1	624, 628-629
	2	609-623, 625-627
	4	600-608
Indiana	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	4	463-464
Iowa	1	508-510, 512-516
	2	500-507, 520-528
	3	511
Kansas	2	660-662, 664-679
Kentucky	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
Louisiana	2	700-701, 703-708, 710-714
Maine	3	042-044, 046-047, 049
	4	039-041, 045, 048
Maryland	2	210-219
	3	206-209
Massachusetts	4	010, 012-013
	5	011, 014-027
Michigan	2	486
	3	480-485, 487-499
Minnesota	3	550-551, 553-567
Mississippi	2	386-397
Missouri	1	645
	2	630-644, 646-659

State	Area	First 3 Digits of Zip Code (if applicable)
Montana	2	590-599
Nebraska	1	680-684, 689-690
	2	685-688, 691-693
Nevada	2	889-891
	4	893-898
New Hampshire	4	030, 032, 034-038
	5	031, 033
New Jersey	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
New Mexico	2	870-875, 877-884
New York	2	104, 124-129, 133-136, 142
	3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	4	063, 105-108, 111-114, 116
	5	100-102
North Carolina	3	270-289
North Dakota	2	580-588
Ohio	2	430-459
Oklahoma	2	730-731, 734-741, 743-749
Oregon	3	970-979
Pennsylvania	1	150-156, 159-161, 163-164, 171-172, 185, 187
	2	157-158, 162, 165-168, 170, 173-176, 180-184, 186, 188, 190-192
	3	169, 177-179, 189, 193-196
Puerto Rico	1	006-007, 009
Rhode Island	4	028-029
South Carolina	3	290-299
South Dakota	2	570-577
Tennessee	2	**370-385**
Texas	1	782
	2	754-759, 764-769, 773-774, 776-781, 783-785, 788-789, 794-799
	3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Utah	1	840-847
Vermont	4	050-054, 056-059
Virginia	2	230-246
	3	201, 220-229
Virgin Islands	3	008
Washington	3	990-992, 994
	4	986-989, 993
	5	980-985
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831

coverage is available

Denotes state where coverage is not available at this time

MetLife

In Network Savings* Example

This hypothetical example** shows how receiving services from a participating dentist can help save you money.

Your Dentist says you need a Crown, a Type C service —

- Negotiated Fee: $670.00
- Dentist's Usual Fee: $1,462.00

IN-NETWORK-Platinum Plan When you receive care from a participating dentist		**OUT-OF-NETWORK-Platinum Plan** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$1,462.00	Dentist's Usual Fee is:	$1,462.00
The Negotiated Fee is:	$ 670.00	The Negotiated Fee is:	$ 670.00
Your Plan Pays:		***Your Plan Pays:***	
50% X $670 Negotiated Fee:	- $335.00	50% X $670 Negotiated Fee:	- $335.00
Your Out-of-Pocket Cost:	$ 335.00	Your Out-of-Pocket Cost:	$1,127.00

In this example, you save $792.00 ($1,127 minus $335.00)… by using a participating dentist.

IN-NETWORK-Gold Plan When you receive care from a participating dentist		**OUT-OF-NETWORK-Gold Plan** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$1,462.00	Dentist's Usual Fee is:	$1,462.00
The Negotiated Fee is:	$ 670.00	The Negotiated Fee is:	$670.00
Your Plan Pays:		***Your Plan Pays:***	
40% X $670 Negotiated Fee:	- $268.00	40% X $670 Negotiated Fee:	- $268.00
Your Out-of-Pocket Cost:	$ 402.00	Your Out-of-Pocket Cost:	$1,194.00

In this example, you save $792.00 ($1,194.00 minus $402.00)… by using a participating dentist.

IN-NETWORK-Silver Plan When you receive care from a participating dentist		**OUT-OF-NETWORK-Silver Plan** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$1,462.00	Dentist's Usual Fee is:	$1,462.00
The Negotiated Fee is:	$ 670.00	The Negotiated Fee is:	$670.00
Your Plan Pays:		***Your Plan Pays:***	
$0.00	$0.00	$0.00	$0.00
Your Out-of-Pocket Cost:	$ 670.00	Your Out-of-Pocket Cost:	$1,462.00

In this example, you save $792.00 ($1,462.00 minus $670.00)… by using a participating dentist.

*Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.

**Please note: This is a hypothetical example that reviews a porcelain/ceramic crown (D2740) in the Philadelphia area, zip 19151. It assumes that the annual deductible has been met.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often – All Plans
Oral Examinations	• One time in 6 months.
Prophylaxis (cleanings)	• One time in 6 months.
Sealants	• One application of sealant material every 3 years for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday.
Space Maintainers	• One in 3 years for dependent children up to 14th birthday .
Topical Fluoride Applications	• Two times in 12 months for a dependent child under age 19.
X-rays	• Full mouth X-rays: one per 5 calendar years. • Bitewing X-rays: one set per calendar year for adults and one set per calendar year for dependent children under age 19.
Type B - Basic Restorative	**How Many/How Often – All Plans**
Amalgam Fillings	• One replacement per surface in 24 months
Resin Composite Fillings (excludes coverage for composite fillings on molars)	• Unlimited.
Examinations-Problem Focused	• Combined with Examinations Limit.
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in 12 months. • Non-Surgical procedures
Endodontics	• Pulpotomy, Pulp Capping, Pulp Therapy
Oral Surgery	• Simple and Surgical Extractions.
Prefabricated Crowns	• One per tooth in 10 calendar years.
Type C - Major Restorative	**How Many/How Often – Platinum & Gold Plans only**
Periodontics	• Periodontal Surgery: one per quadrant in any 36 month period.
Full Mouth Debridement	• One per lifetime
Endodontics	• Root Canal treatment limited to one per tooth per lifetime.
Crown Buildups/Post Core	• One per tooth in 10 calendar years.
Crowns/Inlays/Onlays	• Replacement: one every 10 calendar years per tooth.
Dentures	• Rebases/Relines: one in 36 months. • Adjustments: one in 12 months. • Repairs: one in 12 months. • Recementations: one in 12 months.
Bridges and Dentures	• Dentures and bridgework replacement: one every 10 calendar years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Tissue Conditioning	• One in 36 months.
Implants	• Replacement: one per tooth position every 10 calendar years. • Repairs: one per tooth in 12 months. • Supported Prosthetic: one per tooth every 10 calendar years.
Occlusal Adjustments	• One in 12 months.
Consultations	• Two in 12 months.
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Type D - Orthodontia	**How Many/How Often – Platinum Plan only**
	• Your Children, up to age 19, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.

Frequently Asked Questions

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 covered 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. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. 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 who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or by calling 1-855-700-7993 (Option 1) to have a list faxed or mailed to you on or after your effective date.

What services are covered by my plan? All services defined under your group dental benefits plan are covered.

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/mybenefits or request one by calling 1-855-700-7993 (Option 1) on or after your effective date.

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.

*Travel Assistance services are administered by AXA Assistance USA, Inc. Certain benefits provided under the Travel Assistance program are underwritten by Virginia Surety Company, Inc. AXA Assistance and Virginia Surety are not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance 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, subject to applicable law. 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, subject to applicable law.

Dental Exclusions

- 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. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child).
- Services or appliances which restore or alter occlusion or vertical dimension.
- Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease.
- Restorations or appliances used for the purpose of periodontal splinting.
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco.
- Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss.
- 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.
- Fixed and removable appliances for correction of harmful habits.
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards.
- Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota.

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service on or after your effective date. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99-TRUST (7/10)) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 90 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife 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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USI Affinity Vision Plan Summary

MetLife

Vision				
Class Description	All Eligible Members		All Eligible Members	
Plan Name	M100D-20/20—**Low Plan**		M150A-0/0—**High Plan**	
Reimbursement	**In-Network Coverage (Using a Network Provider)**	**Out-of-Network Reimbursement (Using a Non-Network Provider)**	**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	$0 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	Up to $39 copay	Applied to the exam allowance
Materials / Eyewear (Either Glasses or Contacts)				
Standard Corrective Lenses • **Single vision**	$20 copay	$30 allowance	$0 copay	$30 allowance
• **Lined bifocal**	$20 copay	$50 allowance	$0 copay	$50 allowance
• **Lined trifocal**	$20 copay	$65 allowance	$0 copay	$65 allowance
• **Lenticular**	$20 copay	$100 allowance	$0 copay	$100 allowance
Standard Lens Enhancement				
• **Ultraviolet coating**	Covered in Full	Applied to the allowance for the applicable corrective lens	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	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements[1]				
• **Progressive Standard**	Up to $55 copay	$50 allowance	Up to $55 copay	$50 allowance
• **Progressive Premium/Custom**	Premium: Up to $95-$105 copay Custom: Up to $150-$175 copay	$50 allowance	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	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	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	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	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	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.) • **Costco**	$100 allowance $55 allowance	$55 allowance	$150 allowance $85 allowance	$70 allowance
Contact Lenses				
• **Elective**	$100 allowance	$80 allowance	$150 allowance	$105 allowance
• **Necessary**	Covered in full after eyewear copay	$210 allowance	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	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.

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Frequency / Exclusions

Class Description: All Eligible Members	
Frequencies	
▪ Examinations	▪ 1 per 12 Months
▪ Standard Corrective Lenses	▪ 1 per 12 Months
▪ Frames	▪ 1 per 24 Months—Low Plan; 1 per 12 Months—High Plan
▪ 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-prescription 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, 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.
- 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.

[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.

USI Affinity Vision monthly area rates

Low Plan

M100-20/20	Member	Member+ Spouse	Member+ Child(ren)	Family
Area 1	$6.96	$13.94	$11.80	$19.46
Area 2	$7.04	$14.12	$11.95	$19.70
Area 3	$7.36	$14.75	$12.49	$20.59
Area 4	$7.90	$15.83	$13.40	$22.09
Area 5	$8.31	$16.65	$14.10	$23.25

High Plan

M150-0/0	Member	Member+ Spouse	Member+ Child(ren)	Family
Area 1	$12.27	$24.54	$20.78	$34.27
Area 2	$12.42	$24.85	$21.04	$34.70
Area 3	$12.98	$25.97	$21.99	$36.26
Area 4	$13.93	$27.87	$23.60	$38.91
Area 5	$14.65	$29.32	$24.83	$40.94

Areas are determined based on zip code – see attached area schedule.
Rates are guaranteed from June 1, 2015 – May 31, 2017

USI Affinity VISION

AREA SCHEDULE

How to use this chart:

To determine the appropriate premium rates for a dental plan, look up your state of residence on this chart, and then look up your 3-digit zip code, if applicable. Use the Area number that applies to your state/zip to determine the premium rate. Blue denotes state is unavailable.

State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369
	2	355-361, 365-366
Alaska	5	995-999
Arizona	2	850-857
	3	859-865
Arkansas	2	716-729
California	2	923-925
	3	900, 905-922, 926-938, 952-953, 955-961
	4	901-904, 939, 945-946, 948, 950-951
	5	940-944, 947, 949, 954
Colorado	3	800-816
Connecticut	4	060-069
Delaware	4	197-199
D.C.	3	200, 202-205
Florida	2	320-322, 325-329, 334-338, 342-349
	3	323-324, 333, 339-341
	4	330-332
Georgia	2	306-310, 312, 319
	3	300-305, 311, 313-318, 398
Hawaii	3	967-968
Idaho	2	832-838
Illinois	1	624, 628-629
	2	609-623, 625-627
	4	600-608
Indiana	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	4	463-464
Iowa	1	508-510, 512-516
	2	500-507, 520-528
	3	511
Kansas	2	660-662, 664-679
Kentucky	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
Louisiana	2	700-701, 703-708, 710-714
Maine	3	042-044, 046-047, 049
	4	039-041, 045, 048
Maryland	2	210-219
	3	206-209
Massachusetts	4	010, 012-013
	5	011, 014-027
Michigan	2	486
	3	480-485, 487-499
Minnesota	3	550-551, 553-567
Mississippi	2	386-397
Missouri	1	645
	2	630-644, 646-659

State	Area	First 3 Digits of Zip Code (if applicable)
Montana	2	590-599
Nebraska	1	680-684, 689-690
	2	685-688, 691-693
Nevada	2	889-891
	4	893-898
New Hampshire	4	030, 032, 034-038
	5	031, 033
New Jersey	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
New Mexico	2	870-875, 877-884
New York	2	104, 124-129, 133-136, 142
	3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	4	063, 105-108, 111-114, 116
	5	100-102
North Carolina	3	270-289
North Dakota	2	580-588
Ohio	2	430-459
Oklahoma	2	730-731, 734-741, 743-749
Oregon	3	970-979
Pennsylvania	1	150-156, 159-161, 163-164, 171-172, 185, 187
	2	157-158, 162, 165-168, 170, 173-176, 180-184, 186, 188, 190-192
	3	169, 177-179, 189, 193-196
Puerto Rico	1	006-007, 009
Rhode Island	4	028-029
South Carolina	3	290-299
South Dakota	2	570-577
Tennessee	2	**370-385**
Texas	1	782
	2	754-759, 764-769, 773-774, 776-781, 783-785, 788-789, 794-799
	3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Utah	1	840-847
Vermont	4	050-054, 056-059
Virginia	2	230-246
	3	201, 220-229
Virgin Islands	3	008
Washington	3	990-992, 994
	4	986-989, 993
	5	980-985
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831

Denotes state where coverage is available
Denotes state where coverage is not available at this time

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