MetLife

Waco Independent School District Dental Plan Benefits

For the savings you need, the flexibility you want and service you can trust.

Benefit Summary

Coverage Type	PDP In-Network	Out-of-Network
Type A – cleanings, oral examinations	100% of PDP Fee*	100% of PDP Fee*
Type B – fillings,	80% of PDP Fee*	80% of PDP Fee*
Type C – bridges and dentures	50% of PDP Fee*	50% of PDP Fee*
Type D – orthodontia	50% of PDP Fee*	50% of PDP Fee*
Deductible†	**In-Network**	**Out-of-Network**
Individual	$50.00	$50.00
Family	$150.00	$150.00
Annual Maximum Benefit	**In-Network**	**Out-of-Network**
Per Person	$1,250	$1,250
Orthodontia Lifetime Maximum	**In-Network**	**Out-of-Network**
Per Person	$1,000	$1,000

* PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any co-payments, deductibles, cost sharing and benefits maximums.
† Applies only to Type B & C Services.

Monthly Rates

The following monthly rates are effective through 12/31/2013. Your premium will be paid through convenient payroll deduction.

Eligibility Options

Employee	$20.42
Employee + One	$40.86
Employee + Family	$63.28

PDP Savings* Example

This hypothetical example** shows how receiving services from a PDP (in-network) dentist can save you money.

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

- PDP Fee: $375.00
- Dentist's Usual Fee: $600.00

IN-NETWORK When you receive care from a participating PDP dentist		**OUT-OF-NETWORK** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$600.00	Dentist's Usual Fee is:	$600.00
The PDP Fee is:	$375.00	The PDP Fee is:	$375.00
Your Plan Pays:		***Your Plan Pays:***	
50 X $375 PDP Fee:	- $187.50	50% X $375 PDP Fee:	- $187.50
Your Out-of-Pocket Cost:	$187.50	Your Out-of-Pocket Cost:	$412.50

In this example, you save $225.00 ($412.50 minus $187.50)…
by using a participating PDP dentist.

*Savings from enrolling in the MetLife PDP Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.
**Please note: These examples assume that your annual deductible has been met.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	• 1 in 6 months
Oral Examinations	• 1 in 6 months
Topical Fluoride Applications	• One fluoride treatment per 12 months for dependent children up to 13th birthday.
X-rays	• Full mouth X-rays: one in 5 years. • Bitewing X-rays: one set per 12 months
Sealants	• One application of sealant material every 60 months for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 13th birthday.

Type B - Basic Restorative	How Many/How Often
Fillings Simple Extractions Surgical Extractions Crown, Denture, and Bridge Repair/Recementations	• Replacements if original is at least 24 months.
General Anesthesia Oral Surgery	• When dentally necessary in connection with oral surgery, extractions or other covered dental services.
Space Maintainers	• Space Maintainers for dependent children up to 14th birthday, once per lifetime per tooth area.

Type C - Major Restorative	How Many/How Often
Implants	• Replacement: once every 10 years • Initial placement to replace one or more natural teeth, which are lost while covered by the Plan.
Bridges and Dentures	• Dentures and bridgework replacement: one every 10 years. • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	• Replacement: once every 10 years.
Endodontics	• Root canal treatment limited to once per tooth.
Periodontics	• Periodontal scaling and root planing once per quadrant, every 24 months. • Periodontal surgery once per quadrant, every 36 months. • Total number of periodontal maintenance treatments and prophylaxis cannot exceed two treatments in a calendar year.

Type D - Orthodontia	How Many/How Often
	• You, Your Spouse, and Your Children up to age 25, 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.

The service categories and plan limitations shown above represent an overview of your Plan Benefits. This document presents the majority of services within each category, but is not a complete description of the Plan.

Common Questions… Important Answers

Who is a participating Preferred Dentist Program (PDP) dentist? A participating dentist is a general dentist or specialist who has agreed to accept MetLife's negotiated fees as payment in-full for services provided to plan participants. PDP 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.

How do I find a participating PDP dentist? There are more than 158,000 participating PDP dentist locations nationwide, including over 39,000 specialist locations. You can receive a list of these participating PDP dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 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 (PDP) offer any discounts on non-covered services? MetLife's negotiated fees with PDP (in-network) dentists 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 you receive services from a PDP dentist that are not covered under your plan or where the maximum has been met, in those states where permitted by law, you may only be responsible for the PDP (in-network) fee.

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment for the approved service. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the service provided and your plan's payment for the approved service. Please note: any plan deductibles must be met before benefits are paid.

Can my dentist apply for PDP participation? Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply, tell your dentist to visit www.metdental.com, or call 1-877-MET-DDS9 for an application. The website and phone number are designed for use by dental professionals only.

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 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. MetLife recommends 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're 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 provided by go2dental.com where you can learn more about approximate fees for services such as exams, cleanings, fillings, crowns and more. Simply visit www.metlife.com/mybenefits and use the Dental Procedure Fee Tool to help you estimate the in-network (PDP fees) and out-of-network fees* for dental services in your area.

* Out-of-network fee information is provided by go2dental.com, Inc., an industry source independent of MetLife. This site does not provide the benefit payment information used by MetLife when processing your claims. Prior to receiving services, we recommend that you obtain pre-treatment estimates through your dentist.

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 the services they provide are separate and apart form 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.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- 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 picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the 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;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Initial installation of a fixed and permanent Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;
- 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;
- Addition of teeth to a partial removable Denture to replace one or more natural teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth;
- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Diagnosis and treatment of temporomandibular joint (TMJ) disorders.
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images.

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the scheduled PDP fee or, if non PDP, the actual charge, for the service actually rendered and the scheduled PDP fee or R&C fee (if non PDP) for the service upon which the plan benefit is based. 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 plans 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.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) 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 31 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.

Metropolitan Life Insurance Company, New York, NY 10166 L0611190733(exp0812)(All States)(DC,GU,MP,PR,VI)

VisionSavings Eyecare Program Available through MetLife

See the attached Q&A for additional information about your VisionSavings benefits.

Plan Design for: Waco I.S.D.
Effective Date: 1-1

Coverage Type:	Cost
Eye Examinations	
Spectacle Exam	$5 off normal fee
Contact Exam	$10 off normal fee
Frames	
Priced up to $60.99 Retail	$25.00
Priced from $61.00 to $80.99 Retail	$35.00
Priced from $81.00 to $100.99 Retail	$45.00
Priced from $101.00 and over	65% of Retail
Lenses *(Standard uncoated plastic)*	
Single Vision	$30.00
Bifocal	$50.00
Trifocal	$60.00
Lenticular	$100.00
Specialty Lenses	80% of Retail
Lens Options *(Add to lens prices above)*	
Standard — Progressive (no-line bifocal)	$50.00
Polycarbonate	$30.00
Scratch Resistant Coating	$12.00
Anti-Reflective Coating	$35.00
Ultraviolet Coating	$12.00
Solid Tint	$8.00
Gradient Tint	$8.00
Photochromic	$30.00
Glass (only for non-minors)	$15.00
Contact Lenses	
Non-Disposable	20% discount on regular retail prices
Disposable	10% discount on regular retail prices
All Other Materials	
Non-Rx Sunglasses, accessories, etc.	20% Discount from regular retail prices
LASIK SURGERY	
If the surgeon's lowest advertised price is:	**The savings is:**
$499 to $600 per eye	$25 per eye
$601 to $700 per eye	$35 per eye
$701 to $900 per eye	$50 per eye
$901 to $1,100 per eye	$75 per eye
$1,101 to $1,300 per eye	$125 per eye
$1,301 to $1,500 per eye	$200 per eye
$1,501 to $1,800 per eye	$250 per eye
1,801 to $2,000 per eye	$350 per eye
$2,001 to $2,200 per eye	$400 per eye
Over $2,200 per eye	$550 per eye

The savings shown above are based on conventional LASIK procedures. New procedures are periodically approved by the FDA. NuVision Network Providers may offer these treatments to you; however, your discount may be different based on the new procedure. In all cases, the LASIK program includes: 1) Comprehensive post-operative care including free enhancements, if needed, for one full year; 2) Reimbursement for initial prescription on post-operative eye drops, if prescribed by your surgeon (excludes artificial tears).

Metropolitan Life Insurance Company, New York, NY 10166 L06075771[exp0608]

VisionSavings Eyecare Program Overview
Frequently Asked Questions

Who can use the program?
With the **VisionSavings Eyecare Program**[1], you and your dependents can receive discounts on eyecare services and eyewear products at participating providers nationwideYou and your dependents can use the program as often as you need to.

How do I use the VisionSavings Eyecare Program?
Simply call any of the participating providers to schedule an appointment. Identify yourself as a **VisionSavings Eyecare Program** member when making an appointment. Present your identification number to verify participation at the time of service. (Your identification number is 47234.) The provider will apply applicable discounts at the time of service.

How do I locate a provider?
You can locate a provider at www.colemanagedvision.com/metlifevisionsavings. Simply enter the 5-digit ZIP code for the area you are interested in finding a location and select network locations for eye examinations, eyewear or both. Maps are available for each location by clicking on the underlined location name.

You can also use your **VisionSavings Eyecare Program** at these participating optical retailers[2]:
- Pearle Vision
- Sears Optical
- Target Optical
- JCPenney Optical Center

How do I get the LASIK discount?
Through the NuVision LASIK Network™, you and your dependents can receive discounts on the surgeon's lowest advertised price for LASIK surgery. The initial consultation is always free of charge, even if you choose not to proceed with the LASIK surgery. To schedule a free evaluation with a participating NuVision LASIK Network™[4] surgeon in your area, call 1-888-705-2020.

Do my dependents have to visit the same provider that I select?
No, you and your dependents each have the freedom to choose any participating provider.

Can I get an eye examination from one provider and my glasses or contact lenses from another?
Yes. You can get an eye examination from one provider and your glasses or contact lenses from another, unless you are a first-time contact lens wearer. In this case, you must purchase your new contacts from your exam provider and return for one or two follow-up visits to ensure your lenses are fitted properly.

Some states do not require doctors to release your prescription for eyeglasses to you. Ask your exam provider before he or she performs the exam if he or she is willing to release your prescription.

Can I order my contact lenses through the mail?
Yes, if you have worn contact lenses before and have a current prescription. Simply call Contacts Direct at 800-987-LENS, and a representative will assist you with the ordering process. If you are a first-time contact lens wearer, you must purchase your new contacts from your exam provider and return for one or two follow-up visits to ensure that your lenses are fitted properly.

Do I need to submit a Claim form?
No, there are no claim forms to submit. The discount is applied at time of service.

[1] The VisionSavings Eyecare Program is offered by Cole Vision Corporation (d/b/a Cole Managed Vision), Mason, Ohio. Cole Vision Corporation is not affiliated with Metropolitan Life Insurance Company and its affiliates.
[2] Some retail locations may not participate in the VisionSavings Eyecare Program. Please call in advance.
NuVision LASIK NetworkTM is a registered trademark of NuVision, Inc., which is not affiliated with Metropolitan Life Insurance Company and its affiliates. Participating providers are independent contractors solely responsible for vision examinations and products.
[3] Some Pearle Vision franchises do not participate.