

# Vision Plan Summary

Metropolitan Life Insurance Company

## 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. If you choose an out-of-network provider you will have increased out-of-pocket expenses, pay in full at the time of services, and file a claim with Davis Vision for reimbursement.

• Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

## In-network value added features:

**Laser vision correction:** Savings of 40% - 50% off the national average price of traditional LASIK are available at over 1,000 locations across our nationwide network of laser vision correction providers. Contact QualSight LASIK at (877) 201-3602 for more information.

**Additional savings on glasses and sunglasses<sup>1</sup>:** Members may receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate may be available. Contact lenses may be available at a 10% discount.

**Additional savings on lens enhancements<sup>1</sup>:** Average 20-25% savings on all lens enhancements not otherwise covered under the Davis Vision by MetLife vision insurance program.

## Monthly Premiums

Employee Only:	\$ 6.94
Employee + Spouse:	\$11.10
Employee + Child:	\$11.34
Employee + Family:	\$18.27

## In-network benefits

There are no claims for you to file when you go to a participating vision specialist. Simply pay any copays or member out of pocket amount (MOOP) and, if applicable, any amount over your frame/contact allowance at the time of service.

### Frequency

### Eye exam

Once every **12 months**

• Eye health exam, dilation, prescription and refraction for glasses: Covered in full after a **\$10** copay.

• Retinal imaging: Up to a **\$39** copay on routine retinal screening when performed by a private practice provider.

### Frame<sup>2</sup>

Once every **24 months**

• Allowance: **\$130**

• Exclusive Collection Frame Copay (in lieu of Allowance) Fashion / Designer / Premier: Covered in full / Covered in full / Covered in full

Participating providers typically do not display the Collection but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered, with no additional member out-of-pocket expense. Special lens designs, materials, powers and frames may require additional cost. Collection is available at most participating independent provider offices. Collection is subject to change.

### Standard corrective lenses<sup>2</sup>

Once every **12 months**

• Single vision, lined bifocal, lined trifocal, lenticular: Covered in full after **\$25** eyewear copay.

### Standard lens enhancements

Once every **12 months**

• Standard polycarbonate (child up to age 18)<sup>3</sup>: Covered in full.

• Progressive lenses, Standard Polycarbonate (adult), UV coating, Scratch-resistant coatings, Tints, Anti-reflective, Photochromic, Blue Light filtering, Digital Single Vision, Polarized, High Index (1.67 / 1.74): Your cost will be limited to a member out of pocket amount (MOOP) that MetLife has negotiated for you. These amounts may be viewed after enrollment at [metlife.com/mybenefits](http://metlife.com/mybenefits).<sup>4</sup>

### Contact lenses instead of eye glasses

Once every **12 months**

• Contact fitting and evaluation: 15% discount.

• Elective lenses: **\$130** allowance.

• Necessary lenses: Covered in full.

<sup>1</sup> These features may not be available in all states and with all In-Network Vision Providers. Discounts are not available at Walmart and Sam's Club. Please check with your In-Network Vision Provider.

<sup>2</sup> Materials copay applies to lenses and frames only, not contact lenses.

<sup>3</sup> Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.

<sup>4</sup> The above list highlights some of the most popular lens enhancements and is not a complete listing. Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

**Additional savings on frames<sup>1</sup>:**

20% off any amount over your frames allowance.

**Free one-year breakage warranty:**

All eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The one-year breakage warranty applies to all plan-covered eyeglasses (i.e., all spectacle lenses, Davis Vision Exclusive Collection frames and national retailer frames, where our Exclusive Collection is not displayed). Warranty does not apply to Glasses.com.

**Additional savings on contacts<sup>1</sup>:**

15% off any amount over your contact lens allowance. 15% discount on additional contacts.

**Hearing discounts:** A National Hearing Network of hearing care professionals, featuring Your Hearing Network, offers Davis Vision members discounts on services, hearing aids and accessories. These discounts should be verified prior to service.

Conventional contacts: You will receive an additional **20%** savings on the amount that you pay over your allowance.<sup>1</sup>

Disposable contacts: You will receive an additional **10%** savings on the amount that you pay over your allowance.<sup>1</sup>

**We're here to help**

Find a Vision provider at  
[www.metlife.com/vision](http://www.metlife.com/vision)

Download a claim form at  
[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

For general questions go to  
[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)  
or call 1-833-EYE-LIFE (1-833-393-5433)

**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](http://www.metlife.com/mybenefits) for detailed out-of-network benefits information.

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|---|--|---|
| <ul style="list-style-type: none"><li>• Eye exam: up to <b>\$45</b> after <b>\$0</b> copay.</li><li>• Materials after a <b>\$0</b> copay.</li><li>• Frames: up to <b>\$70</b></li></ul> | <ul style="list-style-type: none"><li>• Single vision lenses: up to <b>\$30</b></li><li>• Lined bifocal lenses: up to <b>\$50</b></li><li>• Lined trifocal lenses: up to <b>\$65</b></li><li>• Lenticular lenses: up to <b>\$100</b></li></ul> | <ul style="list-style-type: none"><li>• Progressive lenses: up to <b>\$50</b></li></ul> |
| <hr/>   |  |   |
| <ul style="list-style-type: none"><li>• Contact lenses:</li><li>• Elective up to <b>\$105</b></li><li>• Necessary up to <b>\$210</b></li></ul>  |  |   |

## 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 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, except at the normal intervals when Plan Benefits are otherwise available.

- 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 medications

**Include this bullet only if the Covered Contacts plan enhancement is sold:**

- The following items are not covered under the covered contact lenses enhancement: Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia); replacement of lost or damaged lenses; insurance policies or service agreements; plano lenses (i.e., when patient's refractive error is less than a  $\pm 0.50$  diopter power); plano lenses to change eye color cosmetically; artistically painted lenses; additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90 day) fitting period.

**Include this bullet only if the Computer Vision Care plan enhancement is sold:**

- CVC Disclaimer: the following are not allowed. If these items are provided, the patient's benefit for lenses and frame will not be covered: photochromic, plano lenses, polarized, clip-on lenses, didymium lenses, mirror coating, sunglasses, any tint greater than 20% absorption and progressive lenses other than those listed.

**The following plan options are not ready for sale and all these sections should be removed until further notice.**

**Covered Contact Lenses** (in addition to eyeglasses)

Once every **X** months

**In-Network**

Contact fitting and evaluation:  
Covered in full

Elective lenses: Covered in full  
after \$50 copay

Covered members are entitled to one pair of hard, soft or multifocal contact lenses; Disposable contact lenses are covered (up to a one-year supply) when purchased one per eligibility period.

Necessary lenses: Covered in full  
after eyewear copay

The following items are not covered under the covered contact lenses enhancement: Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia); replacement of lost or damaged lenses; insurance policies or service agreements; plano lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power); plano lenses to change eye color cosmetically; artistically painted lenses; additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90-day) fitting period.

**Out-of-Network**

**Computer Vision Care (CVC)**

Once every **X** months

Provides benefits to help correct and identify vision problems related to regular computer and digital device use. Dependents are not covered. Not available at retail chains including Costco, Walmart, and Sam's Club.

**In-Network**

CVC exam: Prior to your exam, you will need to give your eye doctor a completed Computer Vision Care Questionnaire, which can be found at [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). Covered in full after \$X copay.

**Once every X months**

CVC frame: \$XX allowance. You also get 20% off any amount over your allowance.

**Once every X months**

CVC lenses: single-vision, bifocal, trifocal, lenticular and specific computer vision lenses. Covered in full. Covered in full after \$XX eyewear copay.

**Out-of-Network**

Exam — \$14

Frame — \$45

Lenses — \$30 – \$100

	<b>Once every X months</b> CVC lens enhancements: polycarbonate, anti-reflective, scratch-resistant, near-variable-focus lenses, occupational progressive lenses. Coverage is the same as the benefit for “Standard lens enhancements” listed previously.	Vision Therapy — \$200
	<b>Once every 12 months</b> Associated Vision Therapy (specific to computer use): Includes one annual supplemental evaluation up to \$200 allowance.	
<b>Diabetic Eyecare Plus Program</b>		
Provides additional coverage for members who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, members who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. Not available at retail chains including Costco, Walmart, and Sam's Club.	<b>In-Network</b>	<b>Out-of-Network</b>
	Exam: Covered in full Covered in full after \$XX copay.	Exam and other ophthalmological services
	Special Ophthalmological Services: Covered in full.	The lesser of the provider's usual fee or 80% of the Medicare allowable charge.
<b>Low Vision</b>		
<b>Once every 24 months</b>  Provides additional benefits to members who are not legally blind, but whose eyesight cannot be corrected to 20/70 with the use of optical lenses. Not available at retail chains including Costco, Walmart, and Sam's Club.	<b>In-Network</b>	<b>Out-of-Network</b>
	Supplemental testing: Maximum of two (2) tests covered in full within a two (2) year period up to the benefit maximum.	Supplemental evaluation and aids: Same as in-network benefits.
	Supplemental aids: 75% of the allowable amount up to the benefit maximum every two (2) years.	
	Benefit maximum: \$1,000 every two (2) years.	
<b>Vision Therapy</b>		
<b>Once every 12 months</b>  Provides additional benefits to members who qualify, to get treatment to help correct or improve dysfunctions like, but not limited to, lazy eye, eye focusing and general eye movement ability. Not available at retail chains including Costco, Walmart, and Sam's Club	<b>In-Network</b>	<b>Out-of-Network</b>
	Supplemental evaluation: Up to \$85 per year for one approved evaluation.	Supplemental evaluation and vision therapy sessions: Same as in-network benefits.
	MetLife Vision pays 75% of the allowable amount. Member pays 25% of the allowable amount. Maximum of \$750 per year.	
<b>Second Pair</b>		
This benefit gives you additional eyewear coverage.	<b>In-Network</b>	<b>Out-of-Network</b>
	Two pairs of prescription eyeglasses; or	

One pair of prescription eyeglasses and an allowance toward contact lenses; or	
Double your contact lens allowance	

#### If Safety Eyecare was sold: Safety Eye Care

##### Once every XX months

Provides benefits for specialized safety eyewear to help protect your eyes. Not available at retail chains including Costco, Walmart and Sam's Club. Dependents are not covered.

Safety eye exam: Prior to your exam, you will need to give your eye doctor a completed Safety Questionnaire, which can be found at [metlife.com/mybenefits](https://www.metlife.com/mybenefits). Covered in full.

Safety frame: **\$65** allowance. You also get **20%** savings on the amount over your allowance.

Safety lenses: single vision, lined bifocal, lined trifocal, lenticular: **Covered in full. Covered in full after \$XX eyewear copay.<sup>1</sup>**

Safety lens enhancements: Same as the "Standard lens enhancements" listed previously with two exclusions: plano and rimless lens are not covered.

##### Safety eye care out of network:

Exam: \$8

Frames: \$25

Lenses: \$35 – \$90

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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.

MetLife Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through Davis Vision, Inc. ("Davis Vision"), a New York corporation. Davis Vision is part of the MetLife family of companies.

Savings from enrolling in a MetLife Vision Plan will depend on various factors, including plan premiums, number of visits to an eye care professional by your family per year and the cost of services and materials received. Be sure to review the Schedule of Benefits for your plan's specific benefits and other important details.

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.