

Vision PPO Schedule of Benefits

M130A-10/0



MetLife®

Benefit	In-Network Coverage	Out-of-Network Reimbursement	Frequency
Eye Examination (one per frequency) <ul style="list-style-type: none"> Comprehensive exam of visual functions and prescription of corrective eyewear 	Covered after a \$10 copay	Covered up to \$45 allowance	12 months
Materials/Eyewear (Either glasses or contacts allowed per frequency)	\$0 copay	Not applicable	Not applicable
Standard Corrective Lenses <ul style="list-style-type: none"> Single vision Lined bifocal Lined trifocal Lenticular 	Covered after eyewear copay	Covered up to: <ul style="list-style-type: none"> \$30 allowance \$50 allowance \$65 allowance \$100 allowance 	12 months
Standard Lens Options¹ <ul style="list-style-type: none"> Ultraviolet coating Polycarbonate (child up to age 18) Polycarbonate (adult) Progressive Scratch-resistant coating Tints Anti-reflective coating Photochromic 	Covered after eyewear copay	Applied to the allowance for the applicable corrective lens	12 months
<ul style="list-style-type: none"> Polycarbonate (adult) Progressive Scratch-resistant coating Tints Anti-reflective coating Photochromic 	These lens options are available with "not to exceed" pricing/maximum copay. ¹	\$50 allowance Applied to the allowance for the applicable corrective lens	
Frame Allowance (20% off the additional amount when patients choose a frame that exceeds the allowance. Available from all in-network providers, except Costco locations.) <ul style="list-style-type: none"> Costco 	Covered up to: <ul style="list-style-type: none"> \$130 allowance after eyewear copay \$70 allowance after eyewear copay 	Covered up to: <ul style="list-style-type: none"> \$70 allowance 	12 months
Contact Lenses <ul style="list-style-type: none"> Contact Fitting and evaluation Elective lenses Necessary 	Standard or Premium fit covered in full with a copay not to exceed \$60	Applied to the allowance for the contact lenses	12 months
	Covered up to \$130 allowance	Covered up to \$105 allowance	
	Covered after eyewear copay	Covered up to \$210 allowance	
Value Added Features			
<ul style="list-style-type: none"> Additional Lens Options¹ 	Average 20-25% savings on all other lens options.		
<ul style="list-style-type: none"> Additional Discounts on Glasses and Sunglasses 	20% discount off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens options.		
<ul style="list-style-type: none"> Laser Vision Correction 	Discounts averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Discounts only available from MetLife participating facilities.		

WARNING: 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.

¹ All lens options are available at participating private practice provider offices, and not to exceed copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. At this time, all lens options and "not to exceed" copays and pricing are not available at Costco. Please contact your local Costco to confirm the availability of lens options and pricing prior to receiving services.

Exclusions and Limitations of Benefits

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

1. Services and/or materials not specifically included in the Schedule of Benefits as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Schedule of Benefits.
3. Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
4. Two pairs of glasses instead of bifocals.
5. 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.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical and surgical treatment of the eye.
8. Prescription and non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services and supplies received by You or Your Dependent before the Vision Insurance starts for that person.
14. Missed appointments.
15. 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.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. 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.
18. 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.
19. 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.
20. Services and materials obtained while outside the United States, except for emergency vision care.
21. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

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.

Metropolitan Life Insurance Company, New York, NY 10166