My Benefit Advisor Vision Plan Benefits

A Summary of Covered Services — Choose a Plan

	In-Network Coverage (Using a Network Provider)		Out-of-Network Reimbursement (Using a Non-Network Provider)	
	HIGH PLAN	**LOW PLAN**	**HIGH PLAN**	**LOW PLAN**
Eye Examination				
Comprehensive exam of visual functions and prescription of corrective eyewear.	$0 copay	$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	$0 copay	$20 copay	$30 allowance	
• Lined bifocal	$0 copay	$20 copay	$50 allowance	
• Lined trifocal	$0 copay	$20 copay	$65 allowance	
• Lenticular	$0 copay	$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.)	$150 allowance	$100 allowance	$70 allowance	$55 allowance
• Costco	$85 allowance	$55 allowance		
Contact Lenses				
• Elective	$150 allowance	$100 allowance	$105 allowance	$80 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	
Frequency Allowance *(Glasses or Contacts)*				
• Examinations	1 per 12 Months		1 per 12 Months	
• Standard Corrective Lenses	1 per 12 Months		1 per 12 Months	
• Frames	1 per 12 Months	1 per 24 Months	1 per 12 Months	1 per 24 Months
• Contact Lenses	1 per 12 Months		1 per 12 Months	
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.			

*Your actual savings from enrolling in the MetLife Vision plan will depend on various factors, including plan premiums, number of visits by your family per year and the cost of services rendered. Be sure to review the Schedule of Benefits for your plans specific benefits and other important details.

[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.

My Benefit Advisor Rate Summary
Vision Monthly Rates

HIGH PLAN

	Member	Member +Spouse	Member +Child(ren)	Member +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

LOW PLAN

	Member	Member +Spouse	Member +Child(ren)	Member +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

Areas are determined based on zip code – see attached area schedule.
Rates are guaranteed from June 1, 2017 – December 31, 2018.

My Benefit Advisor Vision
Area Schedule

How to use this chart:
To determine the appropriate premium rates for a vision plan, look up your state of residence, 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 from the above schedule.

State	Area	**First 3 Digits of Zip Code** (if applicable)
Alabama	1 2	350-354, 362-364, 367-369 355-361, 365-366
Alaska		Not Available
Arizona	2 3	850-857 859-865
Arkansas	2	716-729
California	2 3 4 5	923-925 900, 905-922, 926-938, 952-953, 955-961 901-904, 939, 945-946, 948, 950-951 940-944, 947, 949, 954
Colorado	3	800-816
Connecticut	4	060-069
Delaware	4	197-199
D.C.	3 2	200, 202-205 320-322, 325-329, 334-338, 342-349
Florida	3 4	323-324, 333, 339-341 330-332
Georgia	2 3	306-310, 312, 319 300-305, 311, 313-318, 398
Hawaii	3	967-968
Idaho		Not Available
Illinois	1 2 4	624, 628-629 609-623, 625-627 600-608
Indiana	1 2 4	471, 475 460-462, 465-470, 472-474, 476-479 463-464
Iowa	1 2 3	508-510, 512-516 500-507, 520-528 511
Kansas	2	660-662, 664-679
Kentucky	1 2	400-404, 406-409, 411-419, 425-427 405, 410, 420-424
Louisiana		Not Available
Maine		Not Available
Maryland		Not Available
Massachusetts	4 5	010, 012-013 011, 014-027
Michigan	2 3	486 480-485, 487-499
Minnesota	3	550-551, 553-567
Mississippi	2	386-397
Missouri	1 2	645 630-644, 646-659

State	Area	**First 3 Digits of Zip Code** (if applicable)
Montana		Not Available
Nebraska	1 2	680-684, 689-690 685-688, 691-693
Nevada	2 4	889-891 893-898
New Hampshire		Not Available
New Jersey	2 3 4	071-072 070, 073, 077, 080-087 074-076, 078-079, 088-089
New Mexico	2	870-875, 877-884
New York	2 3 4 5	104, 124-129, 133-136, 142 103, 109-110, 115, 117-123, 130-132, 137-141, 143-149 063, 105-108, 111-114, 116 100-102
North Carolina	3	270-289
North Dakota	2	580-588
Ohio	2	430-459
Oklahoma	2	730-731, 734-741, 743-749
Oregon		Not Available
Pennsylvania	1 2 3	150-156, 159-161, 163-164, 171-172, 185, 187 157-158, 162, 165-168, 170, 173-176, 180-184, 186, 188, 190-192 169, 177-179, 189, 193-196
Puerto Rico	1	006-007, 009
Rhode Island	4	028-029
South Carolina	3	290-299
South Dakota		Not Available
Tennessee	2	370-385
Texas	1 2 3	782 754-759, 764-769, 773-774, 776-781, 783-785, 788-789, 794-799 750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Utah	1	840-847
Vermont	4	050-054, 056-059
Virginia	2 3	230-246 201, 220-229
Virgin Islands	3	008
Washington		Not Available
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831

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

Questions? Call My Benefit Advisor at 1-855-874-0267.

Coverage may not be available in all states. Please call My Benefit Advisor at 1-855-874-0267 for more information.

Group Vision Insurance Policy Form GPNP99-TRUST issued by Metropolitan Life Insurance Company, New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

MY BENEFIT ADVISOR

MetLife