

Summary of Benefits VISION - Superior Vision 1

Superior Vision by MetLife		
Class Description	All Active Full Time Employees (30 Hours)	
Reimbursement	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.	\$10 copay	\$45 allowance after \$0 copay
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		
Glasses		
Standard Corrective Lenses <ul style="list-style-type: none"> • Single vision • Lined bifocal • Lined trifocal • Lenticular 	\$10 copay \$10 copay \$10 copay \$10 copay	\$30 allowance* \$50 allowance* \$65 allowance* \$100 allowance* *after \$0 copay

Standard Lens Enhancement		
<ul style="list-style-type: none"> • Ultraviolet coating 	Up to \$12	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Standard Polycarbonate (child up to age 18) 	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements¹		
<ul style="list-style-type: none"> • Progressive Standard 	Up to \$55	\$50 allowance
<ul style="list-style-type: none"> • Progressive Premium 	Up to \$110	\$50 allowance
<ul style="list-style-type: none"> • Progressive Ultra 	Up to \$150	\$50 allowance
<ul style="list-style-type: none"> • Progressive Ultimate 	Up to \$225	\$50 allowance
<ul style="list-style-type: none"> • Standard Polycarbonate (adult) 	Up to \$40	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Scratch-resistant coating (variable by type) 	Up to \$15 - \$30	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Tints (plastic lenses – Solid) 	Up to \$15	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Tints (plastic lenses) – Gradient 	Up to \$18	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Anti-reflective coating (variable by type) 	Up to \$50 - \$120	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Photochromic (variable by type) 	Up to \$80	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Blue Light Filtering 	Up to \$15	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Digital Single Vision 	Up to \$30	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • Polarized 	Up to \$75	Applied to the allowance for the applicable corrective lens
<ul style="list-style-type: none"> • High Index (1.67/1.74) 	Up to \$80 / \$120	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, Walmart and Sam's Club.)	\$150 allowance	\$70 allowance
Contact Lenses		
<ul style="list-style-type: none"> • Elective 	\$150 allowance	\$105 allowance
<ul style="list-style-type: none"> • Necessary 	Covered in full	\$210 allowance

<ul style="list-style-type: none"> Contact Fitting and Evaluation 	Standard: Covered in Full after \$25 copay Specialty: \$50 allowance after \$25 copay	Applied to the contact lens allowance
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.	
ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements. ²	
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the Superior Vision by MetLife vision benefit program. ²	
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. ²	
SAVINGS ON ADDITIONAL EXAMS	30% savings on additional exams. ²	
ADDITIONAL SAVINGS ON CONTACTS	10% off any amount over your disposable contact lens allowance or 20% off any amount over your conventional contact lens allowance. ² 10% - 20% discount on additional contacts. ²	

¹Not 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.

²These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

Frequency / Exclusions

Class Description: All Active Full Time Employees	
Frequencies	
▪ Examinations	▪ 1 per 12 Months
▪ Standard Corrective Lenses	▪ 1 per 12 Months
▪ Frames	▪ 1 per 12 Months
▪ Contact Lenses	▪ 1 per 12 Months
Either glasses or contacts allowed per frequency	

Exclusions
<ul style="list-style-type: none"> ▪ 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 $\pm .50$ 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. ▪ 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 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.