Summary of Benefits
VISION - Vision Option 1 RQ 1

VSP Choice		
Class Description	All Active Full Time Employees (30 Hours)	
Plan Name	M130D-10/25	
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
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**	$25 copay	$30 allowance
• **Lined bifocal**	$25 copay	$50 allowance
• **Lined trifocal**	$25 copay	$65 allowance
• **Lenticular**	$25 copay	$100 allowance

Standard Lens Enhancement		
• **Ultraviolet coating**	Covered in Full	Applied to the allowance for the applicable corrective lens
• **Standard 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
• **Standard 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 (plastic lenses)**	Pink I & II: $0 copay Solid Plastic: $15 Copay Plastic Gradient Dye: $17 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, Walmart and Sam's Club.)	$130 allowance $150 allowance on featured frames	$70 allowance
• **Costco, Walmart and Sam's Club**	$70 allowance	
Contact Lenses		
• **Elective**	$130 allowance	$105 allowance
• **Necessary**	Covered in full after eyewear copay	$210 allowance
• **Contact Fitting and Evaluation**	Standard or Premium fit: Copay not to exceed $60"	Applied to the contact lens allowance
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.	

[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, Walmart and Sam's Club 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.

Vision	Rate per Employee	Lives	Est Monthly Premium	Est Annual Premium
▪ Employee Only	$7.34	25	$319	$3,823
▪ Employee + Spouse	$14.72	3		
▪ Employee + Child(ren)	$12.46	4		
▪ Employee + Family	$20.54	2		
▪ Total		34		
Rates are guaranteed from September 1, 2023 - December 31, 2024 (16)				

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 24 Months
▪ Contact Lenses	▪ 1 per 12 Months
Either glasses or contacts allowed per frequency	

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 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.

Highlights
Broker Commissions included in the rate: Flat 10.00%
Expected Participation: 47%
Employee Contributions: 100%
Financial Arrangement: Non-retrospectively Experience Rated
Situs is IOWA
SIC Code: 8051
Dependent Child Definition: A Child is covered up to age 26; A student is covered up to age 26.
This quote assumes the plan is a Section 125 plan.
An Open Enrollment period occurring annually is included