SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT	BENEFIT AMOUNTS AND HIGHLIGHTS
Provider Network:	**Superior Vision Network**

Vision Insurance For You and Your Dependents

	Exam	Lenses	Frame	Contacts
Service Interval	12 months	12 months	12 months	12 months

	In-Network	Out-of-Network
Exam Co-Payment *Co-Payment shall not apply to Retinal Imaging*	$20	$0
Materials Co-Payment *Co-Payment shall not apply to Contact Lenses*	$20	$0

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
EYE EXAMINATION (one per frequency)	Covered in full after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	$45 allowance after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	
RETINAL IMAGING	Covered in full with a Co-Payment not to exceed $39 Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
STANDARD CORRECTIVE LENSES	Covered in full after any applicable Co-Payment Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	$30 allowance
		Lined Bifocal	$50 allowance
		Lined Trifocal	$65 allowance
		Lenticular	$100 allowance

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
STANDARD LENS OPTIONS	Standard Polycarbonate (child up to age 18)	Covered in full	Applied to the allowance for the applicable corrective lens
These lens options are available with a "not to exceed" pricing/maximum member out of pocket amount.[1]	Progressive – Standard	$55	$50 allowance
	Progressive – Premium	$110	
	Progressive – Ultra	$150	
	Progressive – Ultimate	$225	
	Ultra Violet Coating	$12	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (adult)	$40	
	Scratch Resistant Coating	Tier 1 - $15 Tier 2 - $30	
	Anti-Reflective Coating	Tier 1 - $50 Tier 2 - $70 Tier 3 - $85 Tier 4 - $120	
	Tints/Dyes – Solid	$15	
	Tints/Dyes – Gradient	$18	
	Photochromic	$80	
	Blue Light Filtering	$15	
	Digital Single Vision	$30	
	Polarized	$75	
	High Index (1.67/1.74)	$80/$120	
FRAMES	Covered up to a $150 allowance after any applicable Co-Payment		$70 allowance after any applicable Co-Payment
CONTACT LENSES			
FITTING AND EVALUATION	**Standard Fit:** Covered in full after $25 Co-Payment **Specialty Fit:** $50 allowance after $25 Co-Payment		Applied to the allowance for contact lenses
ELECTIVE	**$150 allowance** Contact lenses are provided in place of lens and frame benefits available herein.		**$105 allowance** Contact lenses are provided in place of lens and frame benefits available herein.

SCHEDULE OF BENEFITS (continued)

NECESSARY	**Covered in full** Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	**$210 allowance** Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.

[1] 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.

Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)	
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]

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

Superior Vision by MetLife			
Employee	$ 6.65	N/A	
Employee + Children	$ 13.32	N/A	
Employee + Spouse	$ 13.65	N/A	
Family	$ 20.30	N/A	