#13

Comparison of Voluntary Vision Rates

Coverage	MetLife	Dearborn	Diff/mo	Diff/Yr
Employee Only	$9.60	$6.20	$3.40	$40.80
Employee and Spouse	$15.39	$11.80	$3.59	$43.08
Employee and Child(ren)	$17.39	$12.43	$4.96	$59.52
Family	$25.95	$18.28	$7.67	$92.04

Summary of Benefits
VISION - VC_M100A 0/0_Q1

Vision		
Class Description	All Active Full Time Employees (30 Hours)	
Plan Name	M100A	
Reimbursement **Eye Examination**	**In-Network Coverage**	**Out-of-Network Reimbursement**
Comprehensive exam of visual functions and prescription of corrective eyewear.	Covered after a $0 copay	Covered up to a $45 allowance
Retinal Imaging **Materials / Eyewear**	Discount not to exceed $39	Applied to the allowance for the Eye Examination
Either Glasses or Contacts	$0 copay	Not Applicable
Standard Corrective Lenses		
• **Single vision**	Covered after eyewear copay	Covered up to $30 allowance
• **Lined bifocal**		Covered up to $50 allowance
• **Lined trifocal**		Covered up to $65 allowance
• **Lenticular**		Covered up to $100 allowance

Standard Lens Options • **Ultraviolet coating** • **Polycarbonate (child up to age 18)**	Covered after eyewear copay	Applied to the allowance for the applicable corrective lens
• **Progressive Standard** • **Progressive Premium**	These lens options are available with ""not to exceed"" pricing/maximum copay	$50 Allowance
• **Polycarbonate (adult)** • **Scratch-resistant coating** • **Tints** • **Anti-reflective coating** • **Photochromic**	These lens options are available with ""not to exceed"" pricing/maximum copay	Applied to the allowance for the applicable corrective lens
Frame Allowance • **Costco**	Covered up to: $100 allowance after eyewear copay $55 allowance after eyewear copay	Covered up to: $55 allowance
Contact Lenses • **Contact Fitting and Evaluation**	Standard or Premium fit: Covered in full with a copay not to exceed $60	Applied to the allowance for the contact lenses
• **Elective lenses**	Covered up to $100 allowance	Covered up to $80 allowance
• **Necessary**	Covered after eyewear copay	Covered up to $210 allowance
Value Added Features		
Additional Lens Options	Average 20-25% savings on all other lens options	
Additional Discounts on Glasses and Sunglasses	20% discount off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens options.	
Laser Vision correction	Discounts averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK, and Customer LASIK. Discounts only available from MetLife participating facilities.	

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
▪ 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-perscription 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.

Dearborn National

EyeMed

Voluntary Vision Insurance Benefit Summary

Eligibility: All Active Full-Time Employees Working 30 Hours or More Per Week

Dependent Definition: To age 26

Vision Plan: 12/12/24 $130

Vision Care Service	Member Cost In-Network	Out of Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	Up to $30
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Exam Options:		
Standard Contact Lens Fit and Follow Up:	Up to $40 for Standard; 10% off retail price for Premium	N/A
Frames:		
Any available frame at provider location	$0 Copay; **$130** Allowance, 20% off balance over $130	Up to $65
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $25
Bifocal	$25 Copay	Up to $40
Trifocal	$25 Copay	Up to $55
Lenticular	$25 Copay	Up to $55
Standard Progressive Lens	$75 Copay	Up to $40
Premium Progressive Lens	See table on page 2	Up to $40
Lens Options		
UV treatment	$15	N/A
Tint (solid and gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $5
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$0	Up to $5
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Photocromatic/Transitions Plastic	$75	N/A
Premium Anti-reflective	See Below Table	N/A
Contact Lenses (Contact lens allowance includes materials only)		
Conventional	$0 Copay; $130 allowance, 15% off balance over $130	Up to $104
Disposable	$0 Copay; $130 allowance, plus balance over $130	Up to $104
Medically Necessary	$0 Copay, Paid in full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off Retail Price or 5% off Promotional Price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A

Group Vision Insurance Benefit Summary *continued*

Progressive Price List*	Member Cost In-Network
Standard Progressive	$75 Copay
Premium Progressives as Follows:	
Tier 1	$95 Copay
Tier 2	$105 Copay
Tier 3	$120 Copay
Tier 4	$75 Copay, 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Cost In-Network**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member cost In-Network**
Photochromic (plastic)	$75
Polarized	80% of charge

Dearborn National Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands

For a current listing of brands by tier, go to:
www.eyemedvisioncare.com/theme/pdf/miccrosite-template/eyemedlenslist.pdf

Dearborn National

eyemed

Texas Association of Counties

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. Medical and/or surgical treatment of the eye, eyes or supporting structures;
3. Any eye or Vision Examination, or any] corrective eyewear required by a Policyholder as a condition of employment ; safety eyewear
4. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5. Plano (non-prescription) lenses and/or contact lenses;
6. Non-prescription sunglasses;
7. Two pair of glasses in lieu of bifocals;
8. Services or materials provided by any other group benefit plan providing vision care;
9. Certain name brand Vision Materials for which the manufacturer maintains a no-discount practice;
10. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.