USI Affinity Vision Plan Benefits

MetLife

Vision				
Class Description	All Eligible Members		All Eligible Members	
Plan Name	M100D-20/20—**Low Plan**		M150A-0/0—**High Plan**	
Reimbursement	**In-Network Coverage (Using a Network Provider)**	**Out-of-Network Reimbursement (Using a Non-Network Provider)**	**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.	$20 copay	$45 allowance	$0 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	Up to $39 copay	Applied to the exam allowance
Materials / Eyewear (Either Glasses or Contacts) **Standard Corrective Lenses** • **Single vision**	$20 copay	$30 allowance	$0 copay	$30 allowance
• **Lined bifocal**	$20 copay	$50 allowance	$0 copay	$50 allowance
• **Lined trifocal**	$20 copay	$65 allowance	$0 copay	$65 allowance
• **Lenticular**	$20 copay	$100 allowance	$0 copay	$100 allowance
Standard Lens Enhancement				
• **Ultraviolet coating**	Covered in Full	Applied to the allowance for the applicable corrective lens	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	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements[1]				
• **Progressive Standard**	Up to $55 copay	$50 allowance	Up to $55 copay	$50 allowance
• **Progressive Premium/Custom**	Premium: Up to $95-$105 copay Custom: Up to $150-$175 copay	$50 allowance	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	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	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	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	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	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.)	$100 allowance	$55 allowance	$150 allowance	$70 allowance
• **Costco**	$55 allowance		$85 allowance	
Contact Lenses				
• **Elective**	$100 allowance	$80 allowance	$150 allowance	$105 allowance
• **Necessary**	Covered in full after eyewear copay	$210 allowance	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	Standard or Premium fit: Covered in full with a maximum copay of $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 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.

Frequency / Exclusions

Class Description: All Eligible Members	Frequencies
▪ Examinations	▪ 1 per 12 Months
▪ Standard Corrective Lenses	▪ 1 per 12 Months
▪ Frames	▪ 1 per 24 Months—Low Plan; 1 per 12 Months—High Plan
▪ 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, 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.

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Vision monthly premium

Low Plan

M100-20/20	Member	Member+ Spouse	Member+ Child(ren)	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

High Plan

M150-0/0	Member	Member+ Spouse	Member+ Child(ren)	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

Areas are determined based on zip code – see attached area schedule.
Rates are guaranteed from June 1, 2017 – December 31, 2019

USI Affinity VISION

AREA SCHEDULE

How to use this chart:

To determine the appropriate premium rates for a dental plan, look up your state of residence on this chart, 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. Blue denotes state is unavailable.

State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369
	2	355-361, 365-366
Alaska	5	995-999
Arizona	2	850-857
	3	859-865
Arkansas	2	716-729
California	2	923-925
	3	900, 905-922, 926-938, 952-953, 955-961
	4	901-904, 939, 945-946, 948, 950-951
	5	940-944, 947, 949, 954
Colorado	3	800-816
Connecticut	4	060-069
Delaware	4	197-199
D.C.	3	200, 202-205
Florida	2	320-322, 325-329, 334-338, 342-349
	3	323-324, 333, 339-341
	4	330-332
Georgia	2	306-310, 312, 319
	3	300-305, 311, 313-318, 398
Hawaii	3	967-968
Idaho	2	832-838
Illinois	1	624, 628-629
	2	609-623, 625-627
	4	600-608
Indiana	1	471, 475
	2	460-462, 465-470, 472-474, 476-479
	4	463-464
Iowa	1	508-510, 512-516
	2	500-507, 520-528
	3	511
Kansas	2	660-662, 664-679
Kentucky	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
Louisiana	2	700-701, 703-708, 710-714
Maine	3	042-044, 046-047, 049
	4	039-041, 045, 048
Maryland	2	210-219
	3	206-209
Massachusetts	4	010, 012-013
	5	011, 014-027
Michigan	2	486
	3	480-485, 487-499
Minnesota	3	550-551, 553-567
Mississippi	2	386-397
Missouri	1	645
	2	630-644, 646-659
Montana	2	590-599
Nebraska	1	680-684, 689-690
	2	685-688, 691-693
Nevada	2	889-891
	4	893-898
New Hampshire	4	030, 032, 034-038
	5	031, 033
New Jersey	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
New Mexico	2	870-875, 877-884
New York	2	104, 124-129, 133-136, 142
	3	103, 109-110, 115, 117-123, 130-132, 137-141, 143-149
	4	063, 105-108, 111-114, 116
	5	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	3	970-979
Pennsylvania	1	150-156, 159-161, 163-164, 171-172, 185, 187
	2	157-158, 162, 165-168, 170, 173-176, 180-184, 186, 188, 190-192
	3	169, 177-179, 189, 193-196
Puerto Rico	1	006-007, 009
Rhode Island	4	028-029
South Carolina	3	290-299
South Dakota	2	570-577
Tennessee	2	**370-385**
Texas	1	782
	2	754-759, 764-769, 773-774, 776-781, 783-785, 788-789, 794-799
	3	750-753, 760-763, 770-772, 775, 786-787, 790-793, 885
Utah	1	840-847
Vermont	4	050-054, 056-059
Virginia	2	230-246
	3	201, 220-229
Virgin Islands	3	008
Washington	3	990-992, 994
	4	986-989, 993
	5	980-985
West Virginia	2	247-268
Wisconsin	3	530-532, 534-535, 537-549
Wyoming	2	820-831

Denotes state where coverage is available

Denotes state where coverage is not available at this time

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