Vision Insurance

Vision coverage is provided through MetLife. The below chart is a brief outline of the plan. Please refer to the summary plan description for complete plan details. You can find an in-network provider by visiting www.metlife.com.

	Vision Plan	
	In-Network Benefits	Out-of-Network Benefits
Copays		
Routine Exams	$10 copay	Up to $45 Reimbursement
Materials	$10 copay	Set Reimbursements – See below
Lenses		
Single Vision Lenses	Covered in Full after Materials Copay	Up to $30 Reimbursement
Bifocal Lenses	Covered in Full after Materials Copay	Up to $50 Reimbursement
Trifocal Lenses	Covered in Full after Materials Copay	Up to $65 Reimbursement
Lenticular Lenses	Covered in Full after Materials Copay	Up to $100 Reimbursement
Frames		
Retail Chain Provider	$130 retail allowance	Up to $70 Reimbursement
Contact Lenses *In lieu of frames/ lenses*		
Standard Contact Lens Fitting	$25 copay	Applied to the contact lens allowance
Medically Necessary Contacts	Covered in Full after Materials Copay	Up to $210 Reimbursement
Elective	Up to $130 allowance	Up to $105 allowance
Other Services		
Laser Correction Surgery	Savings of 40% - 50% off the national average price	No Benefit
Frequency of Services		
Routine Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses (Elective)	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

Employee Contributions (Per Pay Period)	
	Vision Plan
Employee	$1.27
Employee & Spouse	$2.40
Employee & Child(ren)	$2.55
Employee & Family	$3.72