

# American Bar Association Vision Plan Benefits

## A Summary of Covered Services — Choose a Plan

	In-Network Coverage (Using a Network Provider)		Out-of-Network Reimbursement (Using a Non-Network Provider)	
	HIGH PLAN	LOW PLAN	HIGH PLAN	LOW PLAN
<b>Eye Examination</b>				
<b>Comprehensive exam of visual functions and prescription of corrective eyewear.</b>	\$0 copay	\$20 copay	\$45 allowance	
<b>Retinal Imaging</b> 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	
<b>Materials / Eyewear (Either Glasses or Contacts)</b>				
<b>Standard Corrective Lenses</b>				
• Single vision	\$0 copay	\$20 copay	\$30 allowance	
• Lined bifocal	\$0 copay	\$20 copay	\$50 allowance	
• Lined trifocal	\$0 copay	\$20 copay	\$65 allowance	
• Lenticular	\$0 copay	\$20 copay	\$100 allowance	
<b>Standard Lens Enhancement</b>				
• Ultraviolet coating	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	
<b>Additional Lens Enhancements<sup>1</sup></b>				
• 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	
• 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 (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	
• 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	
<b>Frame Allowance</b>				
(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.)	\$150 allowance	\$100 allowance	\$70 allowance	\$55 allowance
• Costco	\$85 allowance	\$55 allowance		
<b>Contact Lenses</b>				
• Elective	\$150 allowance	\$100 allowance	\$105 allowance	\$80 allowance
• Necessary	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	
<b>Frequency Allowance (Glasses or Contacts)</b>				
• Examinations	1 per 12 Months		1 per 12 Months	
• Standard Corrective Lenses	1 per 12 Months		1 per 12 Months	
• Frames	1 per 12 Months	1 per 24 Months	1 per 12 Months	1 per 24 Months
• Contact Lenses	1 per 12 Months		1 per 12 Months	
<b>Value Added Features</b>				
Additional Savings on Glasses and Sunglasses <sup>1</sup>	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 <sup>2</sup>	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.			

<sup>1</sup> 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](http://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.

<sup>2</sup> 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.

# American Bar Association Rate Summary

## Vision Monthly Rates

### HIGH PLAN

	Member	Member +Spouse	Member +Child(ren)	Member +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 January 1, 2017 – December 31, 2017

### LOW PLAN

	Member	Member +Spouse	Member +Child(ren)	Member +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

# American Bar Association Vision

## Area Schedule

### How to use this chart:

To determine the appropriate premium rates for a vision plan, look up your state of residence, 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 from the above schedule.

State	Area	First 3 Digits of Zip Code (if applicable)
Alabama	1	350-354, 362-364, 367-369
	2	355-361, 365-366
Alaska		Not Available
Arizona		Not Available
Arkansas	2	
	2	923-925
California	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
	5	
Colorado	3	
Connecticut	4	
Delaware	4	
D.C.	3	
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	
Idaho		Not Available
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	
Kentucky	1	400-404, 406-409, 411-419, 425-427
	2	405, 410, 420-424
Louisiana		Not Available
Maine		Not Available
Maryland		Not Available
Massachusetts	4	010, 012-013
	5	011, 014-027
Michigan	2	486
	3	480-485, 487-499
Minnesota	3	
Mississippi	2	
Missouri	1	645
	2	630-644, 646-659

State	Area	First 3 Digits of Zip Code (if applicable)
Montana		Not Available
Nebraska	1	680-684, 689-690
	2	685-688, 691-693
Nevada	2	889-891
	4	893-898
New Hampshire		Not Available
New Jersey	2	071-072
	3	070, 073, 077, 080-087
	4	074-076, 078-079, 088-089
New Mexico		Not Available
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	
North Dakota	2	
Ohio	2	
Oklahoma	2	
Oregon		Not Available
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	
Rhode Island	4	
South Carolina	3	
South Dakota		Not Available
Tennessee	2	
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	
Vermont	4	
Virginia	2	230-246
	3	201, 220-229
Virgin Islands	3	
Washington		Not Available
West Virginia		Not Available
Wisconsin	3	
Wyoming	2	

## 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  $\pm .50$  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, Association's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
- Services: (a) for which the Association of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Association, 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 Association 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.

Coverage may not be available in all states. Please contact USI Affinity at 1-855-874-0264 for additional details.

Group Vision Insurance Policy Form GPNP99-TRUST issued by Metropolitan Life Insurance Company, New York, NY. Certain claim and network administration services are provided through Vision Service Plan (VSP), Rancho Cordova, CA. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates.

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