The MetLife Federal Vision Plan

MetLife.com/FEDVIP-Vision

(888) 865-6854 TDD (888) 260-5376

MetLife

2021

A Nationwide PPO Vision Plan

MetLife Vision is available nationwide and overseas.

IMPORTANT
- Rates: Back Cover
- Summary of Benefits: Page 23

Enrollment options:

- Standard Option - Self Only
- Standard Option - Self Plus One
- Standard Option - Self and Family
- High Option - Self Only
- High Option - Self Plus One
- High Option - Self and Family

FEDVIP
Federal Employees
Dental And Vision Insurance Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-38, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of The MetLife Federal Vision Plan under Metropolitan Life Insurance Company (MetLife) contract OPM02-FEDVIP-02AP-12 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

MetLife
501 US Highway 22
Bridgewater, NJ 08807
(888) 865-6854 TDD (888) 260-5376

MetLife.com/FEDVIP-Vision

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. If you are enrolled in this plan, you are entitled to the benefits described in this brochure

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage. You and your family members do not have a right to benefits that were available before January 1, 2021 unless those benefits are also shown in this brochure.

OPM negotiates rates with each carrier annually. Rates are shown at the end of this brochure.

The MetLife Federal Vision Insurance Plan is responsible for the selection of In-Network providers in your area. Contact us at (888) 865-6854 TDD (888) 260-5376 for the names of participating providers or to request a provider directory. You may also view current in-Network providers via our web website at MetLife.com/FEDVIP- Vision. Continued participation of any specific provider cannot be guaranteed. Thus, you should make coverage decisions based on the plan benefits, not based on a specific provider. When you phone for an appointment, please remember to verify that the provider is currently in the MetLife network. You cannot change plans, outside of Open Season, because of changes to the provider network. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

This MetLife Federal Vision Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

Discrimination is Against the Law.

The MetLife Federal Dental Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, MetLife does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Table of Contents

How We've Changed for 2021

The MetLife Federal Vision Plan is a new FEDVIP vision plan for 2021. The plan offers both a High option and a Standard option of benefits.

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com. Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2020 Open Season, your coverage will begin on January 1, 2021. Premium deductions will start with the first full pay period beginning on/after January 1, 2021. You may use your benefits as soon as your eligibility is confirmed.
Annual Enrollment Opportunity	Each year, an Open Season will be held during which you may enroll or change your vision/dental plan enrollment. This year, Open Season runs from November 9, 2020 through December 14, 2020. You do not need to re-enroll each Open Season, unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation. Enrollment in the FEHB Program or the Health Insurance Marketplace (Exchange) is not required.

Federal Annuitants

You are eligible to enroll if you:

- Retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS) or another retirement system for employees of the Federal Government;
- Retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

Your FEDVIP enrollment will continue into retirement if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end, if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/ illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

TRICARE-eligible Individual

An individual who is eligible for FEDVIP dental coverage based on the individual's eligibility to previously be covered under the TRICARE Retiree Dental Program or an individual eligible for FEDVIP vision coverage based on the individual's enrollment in a specified TRICARE health plan.

Retired members of the uniformed services and National Guard/Reserve components, including "gray-area" retirees under age 60 and their families are eligible for FEDVIP dental coverage. These individuals, if enrolled in a TRICARE health plan, are also eligible for FEDVIP vision coverage. In addition, uniformed services active duty family members who are enrolled in a TRICARE health plan are eligible for FEDVIP vision coverage.

Family Members

Except with respect to TRICARE-eligible individuals, family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.BENEFEDS.com or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, an unremarried former spouse who meets the U.S Department of Defense's 20-20-20 or 20-20-15 eligibility requirements, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in FEDVIP and do not want to change plans or options, your enrollment will continue automatically. Please Note: your plans' premiums may change for 2021.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family. However, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during Open Season, November 9, through December 14, 2020 (midnight, EST). Coverage is effective January 1, 2021.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM. **If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.**

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-paystatus (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	**Yes (if enrollment cancelled during LWOP)**	No	No	No	**Yes (if enrollment cancelled during LWOP)**
Annuity/ compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

• There is no time limit for a change based on moving from a regional plan's service area; and

• You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days haven't yet elapsed. That means once you have enrolled in either a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during Open Season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under the FEDVIP plans:

• Temporary Continuation of Coverage (TCC);

• spouse equity coverage; or

• right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account

(HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA),

you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to $550 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of $100. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

For a health care or limited expense account, each participant must contribute a minimum of $100 to a maximum of $2,750.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees, or to TRICARE eligible individuals.**

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you can use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Using your FSA pre-tax dollars for your eyecare and eyewear needs is a great way to get more out of your benefit dollar.

Using your FSAFEDS account for your eyecare and eyewear expenses is simple:

• Visit your provider for your routine eye examination and eyewear

• Pay any out-of-pocket expenses

• Submit your expenses for reimbursement.

Section 3 How You Obtain Benefits

Identification Cards/ Enrollment Confirmation

When you enroll for the first time, you will receive a welcome letter along with an identification card ("ID Card"). It is important to bring your FEDVIP and FEHB ID card to every vision appointment because most FEHB plans offer some level of vision benefits separate from your FEDVIP coverage. Presenting both ID cards can ensure that you receive the maximum allowable benefit under each Program. If you require a replacement ID card, you will be able to view and print your ID card via MyBenefits after entering MetLife.com/FEDVIP-Vision. An ID card is neither a guarantee of benefits nor does your provider need it to render vision services. Your provider may call (800) 615-1883 to confirm your enrollment in the Plan and the benefits available to you.

Where You Get Covered Care

You can obtain care from any licensed vision provider. However, you will get the most out of your benefits when you see a MetLife Vision in-network provider.

Plan Providers

We list our In-Network Plan providers on our website at: MetLife.com/FEDVIP-Vision. When you make your appointment please inform the provider's office you are enrolled in the FEDVIP MetLife Vision Program and that you wish to use your In-Network benefits. This will also serve to confirm that the provider is a MetLife network provider. Your provider may contact customer service at (800) 615-1883.

In-Network

Care that you receive from a MetLife Vision provider is considered In-Network. MetLife's network consists of independently credentialed and contracted providers. To find a MetLife Vision provider in your area go to: MetLife.com/FEDVIP-Vision. You may also contact customer service at (888) 865-6854.

Out-of-Network

Care that you receive from a licensed provider that does not participate in the MetLife Vision Plan is considered Out-of-Network. To find an In-Network MetLife Vision provider in your area go to: MetLife.com/FEDVIP-Vision. You may also contact customer service at (888) 865-6854

FEHB First Payor

If you have vision coverage through your FEHB plan and coverage under FEDVIP, your FEHB plan will be the first payor of any benefit payments. When services are rendered by a provider, who participates with both your FEHB and your FEDVIP plan, the FEDVIP plan allowance will be the prevailing charge in these cases. We are responsible for facilitating the process with the primary FEHB payor. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance.

Coordination of Benefits

IF	THEN
You have vision coverage through a non-FEHB plan and MetLife Vision coverage under FEDVIP (covered through a spouse)	MetLife Vision is the primary payor and your non-FEHB plan is secondary.
If your **covered dependent child** has coverage through a non-FEHB plan and MetLife Vision coverage under FEDVIP.	The parent's plan whose birthday occurs first in the calendar year is primary. If birthday's are the same (disregarding the year) for both parents, the primary payor is the plan that has provided coverage the longest.

Limited Access Area

If you live in an area that does not have adequate access to a MetLife Vision network provider and you receive covered services from an Out-of-Network provider, MetLife will reimburse you up to the plan allowance. You are responsible for any difference between the amount billed and MetLife's payment. Follow Out-of-Network claim submission instructions. The determination of limited access is based on a ratio of Federal eligibles to MetLife Vision providers as well as the distance to MetLife Vision providers within the participants USPS ZIP code. MetLife reviews the limited access areas quarterly to ensure you have adequate access to our in-network vision providers.

Plan Allowance: The maximum benefit payment for services provided in areas not meeting the access standards are shown in the chart below. You are responsible for charges billed over the amounts shown.

Eye Exam	up to $65
Lenses:	
Single vision	up to $55
Lined bifocals	up to $75
Lined trifocals	up to $95
Lenticular	up to $125
Frames	Up to $120
Contact Lenses:	
Elective	up to $105
Necessary	up to $210

Pre-Authorization

Pre-authorization is only required for payment of Low Vision benefits. See section 5 for further details regarding Low Vision coverage.

Section 4 Your Cost for Covered Services

This is what you will pay out-of-pocket for covered services:

Co-pays

A co-pay is a fixed amount of money you pay to the provider when you receive services.

For Example: Both the High and Standard options do not have a co-pay for routine eye examinations. However, the Standard option has a $20 materials co-pay and the High option does not have a materials co-pay. A materials co-pay is a single payment that applies to the purchase of standard eyeglasses (lenses and/or frames). There may be co-pays for optional lens treatments or non-standard services. Please refer to Section 5 of this brochure for additional detail.

Benefit Frequency

Both the Standard and High options allow one routine examination every calendar year; one pair of eyeglass lenses every calendar year; one eyeglass frame every calendar year. A contact lens benefit is available every calendar year in place of eyeglasses

In-Network Services

You maximize your benefits when you visit a MetLife Vision in-network doctor. Your eye exam and prescription glasses or contacts are covered after any co-payments. You can also receive 20% savings on any out-of-pocket costs over your frame allowance and an average 20% - 25% savings on other lens enhancements. (Based on applicable laws. Benefits may vary by doctor locations. See your doctor for pricing.) There are also no claim forms to submit when you see an In-Network doctor.

Out-of-Network Services

MetLife will partially reimburse services performed by out-of-network providers. Refer to the Summary of Benefits section. You must pay the bill at the time of service and submit the claim to MetLife for partial reimbursement.

When you visit an out-of-network provider, you will be reimbursed according to the following schedule:

Eye Exam	up to $45
Lenses:	
Single vision	up to $45
Lined bifocals	up to $65
Lined trifocals	up to $85
Lenticular	up to $125
Frames	Up to $55 in the standard option or up to $70 in the high option
Contact Lenses:	
Elective	up to $105
Necessary	up to $210

Section 5 Vision Services and Supplies

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the provisions, including limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted protocols.

Benefit Description	You Pay In-Network*	
Diagnostic	**Standard**	**High**
Eye examination - fully covered (once every calendar year).	$0	$0
Eyewear	**Standard**	**High**
You may choose prescription glasses or contact lenses.		
Lenses - fully covered (once every calendar year) Plastic single vision, lined bifocal, lined trifocal, lenticular lenses and popular lens enhancements	$20 Materials co-pay. A materials co-pay is a single payment that applies to the purchase of standard eyeglasses (lenses and frames).	$0
**** Lens Enhancements**		
Impact-resistant lenses (polycarbonate lenses)	$0	$0
Scratch-resistant coating	$0	$0
Anti-reflective coating	Standard Anti-reflective $41 Premium Anti-reflective $58 Ultra-premium Anti-reflective $69 Custom Anti-reflective $85	**Independent Provider:** Standard Anti-reflective $26 Premium Anti-reflective $43 Ultra-premium Anti-reflective $54 Custom Anti-reflective $70 **Retail Provider:** Standard Anti-reflective $41 Premium Anti-reflective $58 Ultra-premium Anti-reflective $69 Custom Anti-reflective $85
UV protection	$0	$0
Tints	$0 - $17	$0
Photochromic lenses (Light indoors, dark outdoors)	$75	$75
Progressive lenses Standard	$0	$0
Progressive lenses Premium	$95-$105	$95-$105
Progressive lenses Custom	$150-$175	$150-$175

Eyewear - continued on next page

Benefit Description	You Pay In-Network*	
Eyewear (cont.)	**Standard**	**High**
Frames - covered (once every calendar year)	After $20 materials co-pay. A materials co-pay is a single payment that applies to the purchase of standard eyeglasses (lenses and frames). $120 allowance for standard frames. $160 for featured frames. $65 allowance for a wide selection of frames at participating Costco, Walmart and Sam's Club. 20% savings on amount over the allowance and on additional eyewear	$150 allowance for standard frames $200 allowance for featured frames. $85 allowance for a wide selection of frames at participating Costco, Walmart and Sam's Club. 20% savings on amount over the allowance and on additional eyewear
Contact Lenses	**Standard**	**High**
Contact Lenses instead of glasses - Elective (when you choose contacts instead of glasses, your allowance applies to the cost of the contacts). (once every calendar year)	$120 allowance	$150 allowance
Contact Lenses instead of glasses - Necessary (once every calendar year)	Covered in full (after eyewear co-pay).	Covered in full.
Fitting and Evaluation	Up to $55 co-pay.	Up to $55 co-pay.
Extra Savings	**Standard**	**High**
The following extra savings are only available from MetLife Vision Network doctors: • An average 20-25% savings on all other lens enhancements. • 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. • ***Laser vision correction: Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK.This offer is only available at MetLife participating locations.	Available	Available

Some brands of spectacle frames and lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered persons may obtain details regarding frame and lens brand availability from their MetLife Member Doctor or by calling MetLife's Customer service at (888) 865-6854.

*Please refer to Section 4, Your Cost for Covered Services, for the Out-of-Network reimbursement schedule and Section 6, International Services and Supplies, for the international reimbursement schedule.

**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, Walmart and Sam's Club to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by covered person's MetLife Network Doctor or Out-of-Network Provider. Review and approval by MetLife are not required for covered person to be eligible for Necessary Contact Lenses.

***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. Additional savings on laser vision care are only available at participating locations.

Low Vision Coverage

Provides additional benefits to members who are not legally blind, but whose eyesight cannot be corrected to 20/70 with the use of optical lenses. Not available at retail chains including Costco, Walmart and Sam's Club.. **Low vision benefits must be pre-authorized.**

Your In-Network low vision coverage provides:

- Supplemental testing: Maximum of two (2) tests covered in full within a two (2) year period up to the benefit maximum.
- Supplemental aids: 75% of the allowable amount up to the benefit maximum every two (2) years.
- Benefit maximum: $1,000 every two (2) years.

Diabetic EyeCare Plus

In-Network-Provides additional coverage for members who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, members who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. Not available at retail chains including Costco, Walmart and Sam's Club,

- Exam: Covered in full after $20 copay.
- Special Ophthalmological services: Covered in full.

If you choose to go out-of-network, the exam and other ophthalmological services will be processed based on the lesser of the provider's usual fee or 80% of the Medicare allowable charge.

Kids Care

Kids Care - continued on next page

Kids Care (cont.)

Benefit applies only to covered Children under age 18.

In-Network:

Service Intervals:

Exam: One every calendar year.

Lenses/Contacts: One every calendar year.

Frames: Once every calendar year.

Children covered under this supplemental plan benefit are covered for:

One additional comprehensive eye exam covered *less any applicable Co-payment*;

One additional pair of lenses or necessary contact lenses, or elective contact lenses *less any applicable Co-payment*, if:

- The new prescription differs from the original by at least a .50 diopter sphere or cylinder, or
- There is a change in the axis of 15 degrees or more, or
- There is a .5 prism diopter change in at least one eye.

Up to 20% off any amount above the retail allowance. Discounts on additional pairs of prescription glasses.

Out-Of-Network:

Same as primary plan benefits up to the out-of-network exam and materials allowances stated above.

Sun Care

In-Network:

Your frame allowance may be applied toward non-prescription sunglasses. Such benefit will be considered both a lens and frame benefit for determining Service Intervals. Lab-fabricated Plano lenses are not covered.

If you choose to go out of network, your frame allowance may be applied toward non-prescription sunglasses.

Section 6 International Services and Supplies

International Claims Payment

MetLife does not have network doctors overseas. To obtain services, visit any licensed international vision provider and you will be reimbursed based on the international schedule:

Eye Exam	Up to $ 65
Lenses:	
Single vision	Up to $55
Lined bifocal	Up to $75
Lined trifocal	Up to $95
Lenticular	Up to $125
Frame	Up to $120
Contact Lenses:	
Elective	Up to $105
Necessary	Up to $210

Finding an International Provider

Visit the licensed international vision provider of your choice. You will need to submit a claim for reimbursement.

Filing International Claims

The plan participant will be responsible for paying the vision provider and submitting the claims to MetLife for reimbursement at the following address.

Mail completed claim form to:

MetLife Vision
PO Box 385018
Birmingham, AL 35238-5018

Section 7 General Exclusions – Things We Do Not Cover

The following services and materials are not covered:

• Any vision service, treatment, or material not specifically listed as a covered service, treatment, or material.

• Any portion of a charge above the Maximum Benefit Allowance or reimbursement.

• Any eye examination or corrective eyewear required as a condition of employment.

• Services and supplies received by you or your dependent before the Vision Insurance starts.

• 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 Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify MetLife of all such benefits.

• Local, state, and/or federal taxes, except where MetLife is required by law to pay.

• 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, procedures, or materials for which a charge would not have been made in the absence of insurance.

•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.

• Plano lenses (lenses with refractive correction of less than ± 0.50 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.

• Contact lens insurance policies and service agreements.

• Refitting of contact lenses after the initial (90 day) fitting period.

• Contact lens modification, polishing, and cleaning.

Treatments:

• Orthoptics or vision training and any associated supplemental testing.

• Medical and surgical treatment of the eye(s).

Medications:

• Prescription and non-prescription medications.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

To avoid delay in the payment of your claims please have your provider submit your claims directly to MetLife for payment.

MetLife's network vision providers may submit their claims directly to MetLife by accessing Metvision.com where we provide them with real-time results. However, should you wish to send in a paper claim you may download a claim form from the website MetLife.com/FEDVIP-Vision

Mail completed claim form to:

MetLife VISION Claims
PO Box 385018
Birmingham, AL 35238-5018

When a claimant files a claim for vision insurance benefits described in this brochure, both the notice of claim and the required proof should be sent to us within 90 days of the date of a loss. If notice of claim or proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof are given as soon as is reasonably possible.

Certain claim and network administration services are provided through Vision Service Plan, Rancho Cordova, CA (VSP). VSP is not affiliated with MetLife or its affiliates.

Deadline for Filing Your Claim

You must submit your claim to us within 6 months following the delivery of the services in order for them to be considered for Plan benefits.

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **FEDVIP legislation does not provide a role for OPM to review disputed claims.**

Step	Description
1	Ask us in writing to reconsider our initial decision. You must include any pertinent information omitted from the initial claim filing and mail your additional proof to us within 180 days from the date of receipt of our decision.
2	Send your request for reconsideration to: MetLife Vision Claims Appeals PO Box 385018 Birmingham, AL 35238-5018 We will review your request and provide you with a written or electronic explanation of benefit determination within 30 days of the receipt of your request.
3	If you disagree with the decision regarding your request for reconsideration, you may request a second review of the denial. You must submit your request to us in writing to the address shown above along with any additional information you or your doctor can provide to substantiate your claim so that we can reconsider our decision. Failure to do so will disqualify the appeal of your claim. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate our final determination to the covered person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the covered person shall include the specific reasons for the determination.
4	When a covered person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration**.**

Section 9 Definitions of Terms We Use in This Brochure

Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on his or her direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	The MetLife Federal Vision Plan
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, the MetLife Federal Dental Plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (888) 865-6854 and explain the situation, you will be required to state your complaint in writing to us.
- Do not maintain as a family member on your policy:
- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
- Your child over the dependent limiting age.

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes your portion of the expenses we cover; please review the individual sections of this brochure, for more detail.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.
- 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, Walmart, and Sam's Club to confirm the availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

	You Pay	
High Option Benefits	**In-Network**	**Out-of-Network**
Eye Exam: Eye health exam, dilation, prescription and refraction for glasses	$0 total co-pay for exam and/or glasses	Reimbursed up to $45
Lenses – Plastic single vision, lined bifocal, lined trifocal and lenticular lenses. Popular lens enhancements, including:	$0	Single Vision up to $45 Lined Bifocals up to $65 Lined Trifocals up to $85 Lenticular up to $125 Progressive lenses-up to $65
•Impact-resistant lenses (polycarbonate lenses). •Scratch-resistant coating. •Anti-reflective coatings. •UV Protection. •Tints. • Photocromic lenses (Light indoors, dark outdoors) • Standard progressive lenses. • Premium progressive lenses. Custom progressive lenses.	$0 $0 Independent provider-$26-$70 Retail provider $41-$85 $0 $0 $75 $0 $95-$105 $150-$175	
Frames (once every calendar year).	$150 allowance for standard frames and $200 for featured frames. $85 allowance for a wide selection of frames at participating Costco, Walmart and Sam's Club. 20% savings on amount over the allowance and on additional eyewear	Covered up to $70

High Option Benefits - continued on next page

High Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
Contact Lenses (insteadof glasses) -Elective (when you choose contacts instead of glasses, your allowance applies to the cost of the contacts).	$150 allowance for contacts. Contact lens fitting and evaluation up to $55 co-pay.	Up to $105 allowance for contacts.
Contact Lenses instead of glasses - Necessary Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by covered person's network provider or out-of-network provider. Review and approval are not required for covered person to be eligible for necessary contact lenses.	Covered in full (after eyewear co-pay).	Up to $210 allowance,
Extra Savings-The following extra savings are only available from MetLife Vision Network providers: • An average 20-25% savings on all other lens enhancements. • 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. • Retinal Screening-Up to a $39 co-pay on routine retinal screening when performed by a private practice. • Laser Vision Correction-Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and custom LASIK. This offer is only available at MetLife participating locations.	Available	Not Available
Low Vision Coverage (requires pre-authorization): • Low vision exams and low vision aids, every two years. • Low vision benefits must be pre-authorized. If approved, covered every two years. • Not available at retail chains including Costco, Walmart and Sam's Club.	Up to $1,000 maximum.	Supplemental evaluation end aids: Same as in-network benefits.
Diabetic EyeCare Plus: • Exam • Special Ophthalmological services	 • Covered in full after $20 co-pay. • Covered in full.	 The lesser of the provider's usual fee or 80% of the Medicare allowable charge.

High Option Benefits - continued on next page

	You Pay	
High Option Benefits (cont.)	**In-Network**	**Out-of-Network**
Provides additional coverage for members who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, members who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. Not available at retail chains including Costco, Walmart and Sam's Club,	• Covered in full after $20 co-pay. • Covered in full.	The lesser of the provider's usual fee or 80% of the Medicare allowable charge.
Kids Care: Benefit applies only to covered Children under age 18. Service Intervals: Exam: One every calendar year. Lenses/Contacts: One every calendar year. Frames: Once every calendar year.	One additional comprehensive eye exam covered in full (less any applicable co-pay). One additional pair of lenses covered or necessary contact lenses, or elective contact lenses covered in full when needed (less any applicable co-pay and a minimum of prescription change required). Up to 20% off any amount above the retail allowance. Discounts on additional pairs of prescription glasses.	Benefits are the same as your primary plan benefits up to the out-of-network exam and material allowance.
Sun Care: This benefit gives you an additional eyewear coverage	Your frame allowance may be applied toward nonprescription sunglasses. Such benefit will be considered both a lens and frame benefit for determining service intervals. Lab-fabricated Plano lenses are not covered.	Your frame allowance may be applied toward nonprescription sunglasses.

See section 6 for international reimbursement.

	You Pay	
Standard Option Benefits	**In-Network**	**Out-of-Network**
Eye Exam: Eye health exam, dilation, prescription and refraction for glasses	$0 total co-pay for exam and/or glasses	Reimbursed up to $45
Lenses – Plastic single vision, lined bifocal, lined trifocal and lenticular lenses. Popular lens enhancements, including:	After a $20 materials co-pay. A materials co-pay is a single payment that applies to the purchase of standard eyeglasses (lenses and frames).	Single Vision up to $45 Lined Bifocals up to $65 Lined Trifocals up to $85 Lenticular up to $125 Progressive lenses-up to $65
• Impact-resistant lenses (polycarbonate lenses). • Scratch-resistant coating. • Anti-reflective coatings. • UV Protection. • Tints. • Photochromic lenses (Light indoors, dark outdoors). • Progressive lenses Standard. • Progressive lenses Premium. • Progressive lenses Custom	$0 $0 $41-$85 $0 $0-$17 $75 $0 $95-$105 $150-$175	
Frames (covered every calendar year).	After a $20 Materials co-pay. A materials co-pay is a single payment that applies to the purchase of standard eyeglasses (lenses and frames). $120 allowance for standard frames and $160 for featured frames. $65 allowance at participating Costco, Walmart and Sam's Club. 20% savings on amount over the allowance and on additional eyewear	Reimbursed up to $55
Contact Lenses(instead of glasses)-Elective (when you choose contacts instead of glasses, your allowance applies to the cost of the contacts).	$120 allowance for contacts. Contact Lens fitting and evaluation up to $55 co-pay.	Reimbursed up to $105.
Contact Lenses instead of glasses - Necessary Necessary contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by covered person's network provider or out-of-network provider. Review and approval are not required for covered person to be eligible for necessary contact lenses**.**	Covered in full (after eyewear co-pay).	Reimbursed up to $210.
Extra Savings-The following extra savings are only available from MetLife Vision Network providers: • An average 20-25% savings on all other lens enhancements.	Available	Not available

Standard Option Benefits - continued on next page

	You Pay	
Standard Option Benefits (cont.)	**In-Network**	**Out-of-Network**
• 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. • Retinal Screening-Up to a $39 co-pay on routine retinal screening when performed by a private practice. • Laser Vision Correction-Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and custom LASIK. This offer is only available at MetLife participating locations	Available	Not available
Low Vision Coverage (requires pre-authorization): • Low vision exams and low vision aids, every two years. • Low vision benefits must be pre-authorized. If approved, covered every two years. • Not available at retail chains including Costco, Walmart and Sam's Club	Up to a $1,000 maximum every two years.	Supplemental evaluation end aids: Same as in-network benefits.
Diabetic EyeCare Plus: Provides additional coverage for members who have been diagnosed with type 1 or type 2 diabetes and have specific ophthalmological conditions. It also provides benefits for those with glaucoma and age-related macular degeneration (AMD). In addition, members who have diabetes but don't show signs of diabetic eye disease are eligible to receive preventive retinal screenings. Not available at retail chains including Costco, Walmart and Sam's Club, • Exam • Special Ophthalmological services	Covered in full after $20 co-pay. Covered in full.	The lesser of the provider's usual fee or 80% of the Medicare allowable charge.
Kids Care: • Benefit applies only to covered Children under age 18. Service intervals • Exam: One every calendar year. • Lenses/Contacts: One every calendar year. • Frames: Once every calendar year. Children covered under this supplemental plan benefit are covered for: • One additional comprehensive eye exam covered less any applicable co-payment.	One additional comprehensive eye exam covered in full (less any applicable co-pay). One additional pair of lenses covered or necessary contact lenses, or elective contact lenses covered in full when needed (less any applicable co-pay and a minimum of prescription change required). Up to 20% off any amount above the retail allowance.	Discounts on additional pairs of prescription glasses.

Standard Option Benefits - continued on next page

	You Pay	
Standard Option Benefits (cont.)	**In-Network**	**Out-of-Network**
• One additional pair of lenses or necessary contact lenses, or elective contact lenses less any applicable co-payment.	One additional comprehensive eye exam covered in full (less any applicable co-pay). One additional pair of lenses covered or necessary contact lenses, or elective contact lenses covered in full when needed (less any applicable co-pay and a minimum of prescription change required). Up to 20% off any amount above the retail allowance.	Discounts on additional pairs of prescription glasses.
Sun Care: This benefit gives you an additional eyewear coverage.	Your frame allowance may be applied toward non-prescription sunglasses. Such benefit will be considered both a lens and frame benefit for determining service intervals. Lab-fabricated Plano lenses are not covered	Your frame allowance may be applied toward non-prescription sunglasses.

Notes

Rate Information

MetLife Vision is a nationwide vision plan that does not require rating regions. The following are nationwide and international rates.

High - Bi-Weekly			High - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$5.46	**$10.91**	**$16.37**	**$11.83**	**$23.64**	**$35.47**

Standard - Bi-Weekly			Standard - Monthly		
Self Only	**Self Plus One**	**Self and Family**	**Self Only**	**Self Plus One**	**Self and Family**
$3.25	**$6.49**	**$9.74**	**$7.04**	**$14.06**	**$21.10**