# **Toledo Bar Association Plan Summary**

Help lower your and your family's out-of-pocket costs on eye exams, glasses, lenses and more with the Toledo Bar Association Vision Insurance plan. With competitive co-payments and nationwide access to discounts, you'll be seeing your way to clear savings in no time.<sup>1</sup>

## **Eligibility**

Active members<sup>2</sup> of the Toledo Bar Association in good standing, their spouses/domestic partners, and dependent children<sup>3</sup> may apply.

### **Summary of Covered Services**

|                                                                                                                                        | In-Network Coverage<br>(Using a Network Provider) | Out-of-Network Coverage<br>(Using a Non-Network Provider)   |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------|--|--|--|--|
| Eye Examination                                                                                                                        |                                                   |                                                             |  |  |  |  |
| Comprehensive exam of visual functions and prescription of corrective eyewear.                                                         | \$10 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. | \$39 copay                                        | Applied to the exam allowance                               |  |  |  |  |
| Materials / Eyewear (Either Glasses or                                                                                                 | Contacts)                                         |                                                             |  |  |  |  |
| Standard Corrective Lenses                                                                                                             |                                                   |                                                             |  |  |  |  |
| Single vision                                                                                                                          | \$25 copay                                        | \$30 allowance                                              |  |  |  |  |
| Lined bifocal                                                                                                                          | \$25 copay                                        | \$50 allowance                                              |  |  |  |  |
| Lined trifocal                                                                                                                         | \$25 copay                                        | \$65 allowance                                              |  |  |  |  |
| Lenticular                                                                                                                             | \$25 copay                                        | \$100 allowance                                             |  |  |  |  |
| Standard Lens Enhancement                                                                                                              |                                                   |                                                             |  |  |  |  |
| Ultraviolet coating                                                                                                                    | \$12                                              | 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 |  |  |  |  |

| Additional Lens Enhancements <sup>4</sup>                                   |                                                                                       |                                                             |  |  |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------|--|--|
| Progressive Standard                                                        | \$55                                                                                  | \$50 allowance                                              |  |  |
| Progressive Premium                                                         | \$110                                                                                 | \$50 allowance                                              |  |  |
| Polycarbonate (adult)                                                       | \$40                                                                                  | Applied to the allowance for the applicable corrective lens |  |  |
| Scratch-resistant coating (variable by type)                                | \$15 – \$30                                                                           | Applied to the allowance for the applicable corrective lens |  |  |
| Tints (variable by type)                                                    | \$15 – \$18 Applied to the allowance for the a corrective lens                        |                                                             |  |  |
| Anti-reflective coating (variable by type)                                  | \$50 – \$120                                                                          | Applied to the allowance for the applicable corrective lens |  |  |
| Photochromic (variable by type)                                             | \$80                                                                                  | Applied to the allowance for the applicable corrective lens |  |  |
| Frame                                                                       |                                                                                       |                                                             |  |  |
| Allowance                                                                   | \$130 allowance                                                                       | \$70 allowance                                              |  |  |
| (in-network) locations except Costco,  Contact Lenses (instead of eyeglasse |                                                                                       |                                                             |  |  |
| Elective                                                                    | \$130 allowance                                                                       | \$105 allowance                                             |  |  |
| Necessary                                                                   | Covered in full                                                                       | \$210 allowance                                             |  |  |
| Contact Fitting and Evaluation                                              | Standard: covered in full after \$25 copay Specialty: \$50 allowance after \$25 copay | Applied to the contact lens allowance                       |  |  |
| Frequency (Glasses or Contacts)                                             |                                                                                       |                                                             |  |  |
| Eye Examination                                                             | 1 per 12 Months                                                                       |                                                             |  |  |
| Standard Corrective Lenses                                                  | 1 per 12 Months                                                                       |                                                             |  |  |
| Standard Lens Enhancement                                                   | 1 per 12 Months                                                                       |                                                             |  |  |
| Frame                                                                       | 1 per 12 Months                                                                       |                                                             |  |  |
|                                                                             |                                                                                       |                                                             |  |  |

| In-Network Value Added Features              |                                                                                                                                                                                                        |  |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Additional lens enhancements                 | In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements. <sup>4</sup>                                                                                |  |
| Additional Savings on Glasses and Sunglasses | Get 20% off the cost for additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. <sup>4</sup> At times, other promotional offers may also be available. |  |
| Laser Vision correction                      | ngs of 20% - 35% off the national average price of traditional LASIK are available at 1,000 locations across our nationwide network of laser vision correction providers                               |  |

#### How do I pay for my coverage?

Please contact the plan administrator Benafica at 1-651-369-5031 for information about your payment options.

- 1. Your actual savings from enrolling in a vision plan will depend on various factors, including the plan chosen, plan premiums, number of visits to an eye care professional by your family per year, and the cost of services and materials received. Be sure to review the Schedule of Benefits for your plan's specific benefits and other important details.
- 2. You must be a member in good standing of the Toledo Bar Association to qualify for this insurance plan.
- 3. Refers to your dependent children through age 26.
- 4. Lens enhancements are available at participating private practices. Pricing is subject to change without notice. Please check with your provider for details and availability prior to receiving services. Additional discounts may not be available in certain states or at certain retail locations.

Coverage may not be available in all states. Please contact Benafica LLC at 1-651-369-5031 or affinity@benafica.com for more information.

**Metropolitan Life Insurance Company** | 200 Park Avenue | New York, NY 10166 © 2025 MetLife Services and Solutions, LLC





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Navigating life together



## **GROUP VISION INSURANCE RATES**

| SEMI-ANNUAL PREMIUMS             |                 |                     |                 |  |  |  |
|----------------------------------|-----------------|---------------------|-----------------|--|--|--|
| High Option Superior Vision Plan |                 |                     |                 |  |  |  |
| Member Only                      | Member + Spouse | Member + Child(ren) | Member + Family |  |  |  |
| 41.04                            | 82.08           | 96.00               | 147.30          |  |  |  |

Rates shown are as of October 1, 2025, and are subject to change. Rates shown are for semi-annual premiums. Other payment modes are available. Coverage in not available to residents of AK, ID, LA, ME, MD, MT, NH, OR, SD, TX & WA. Please contact your plan administrator, Benafica LLC at 1-651-369-5031 for information. Refer to the Plan Summary for additional information.

Vision benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Certain claims and network administration services are provided through: Davis Vision, Inc. ("Davis Vision"), a New York corporation; Superior Vision Services, Inc. ("Superior Vision"), a Delaware corporation; or Vision Service Plan (VSP), Rancho Cordova, CA. Davis Vision and Superior Vision are part of the MetLife family of companies. VSP is not affiliated with Metropolitan Life Insurance Company or its affiliates. Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Contact your Plan Administrator, Benafica, for costs and complete details.

MetLife Group Vision insurance is issued by: Metropolitan Life Insurance Company 200 Park Avenue New York, NY 10166 under Policy Form GPNP99-TRUST

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