Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **TM 05927509-G**

Employer: **Buford City Schools**

Effective Date: **January 1, 2026**

The certificate is changed as follows:

The attached replaces the Schedule of Benefits in your certificate.

This rider is to be attached to and made a part of the Certificate.

SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNTS AND HIGHLIGHTS
Provider Network	**Vision PPO Network**

Vision Insurance For You and Your Dependents

For All Active Full-Time Employees

Service Interval (months)	Exam	Lenses*	Frame*	Contacts*
	12 months	12 months	12 months	12 months

Exam In-Network Co-Payment *Co-Payment shall not apply to Retinal Imaging*	$10

Materials In-Network Co-Payment *Co-Payment shall not apply to Elective Contact Lenses*	$15

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
EYE EXAMINATION **(one per frequency)**	Covered in full after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	Covered up to $45 allowance Comprehensive examination of visual functions and prescription of corrective eyewear.
RETINAL IMAGING	Covered in full with a Co-Payment not to exceed $39. Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination
STANDARD CORRECTIVE LENSES	Single Vision Covered in full after any applicable Co-Payment	Covered up to $30 allowance
	Lined Bifocal Covered in full after any applicable Co-Payment	Covered up to $50 allowance

	Lined Trifocal Covered in full after any applicable Co-Payment	Covered up to $65 allowance
	Lenticular Covered in full after any applicable Co-Payment	Covered up to $100 allowance

STANDARD LENS OPTIONS[1]	Ultra Violet Coating Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (child up to age 18) Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Standard Progressive Covered in full after any applicable Co-Payment Premium Progressive This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Standard Progressive $50 allowance; or Premium Progressive $50 allowance
	Standard Polycarbonate (adult) This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Applied to the allowance for the applicable corrective lens
	Scratch Resistant Coating This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Applied to the allowance for the applicable corrective lens
	Tints This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Applied to the allowance for the applicable corrective lens
	Anti-Reflective Coating This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Applied to the allowance for the applicable corrective lens

	Photochromic This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.[1]	Applied to the allowance for the applicable corrective lens

FRAMES	Covered up to a $175 allowance less any applicable Co-Payment. Frames are covered up to the allowance of $95 less any applicable Co-Payment. at Costco, Walmart and Sam's Club and $175 less any applicable Co-Payment. at other optical retail locations.	Covered up to a $70 allowance

CONTACT LENSES	**In-Network Coverage (Using an In-Network Vision Provider)**	**Out-of-Network Coverage (Using an Out-of-Network Vision Provider)**
FITTING AND EVALUATION	**Standard and Premium fit:** Covered in full with a Co-Payment not to exceed $60.	Applied to the allowance for the contact lenses

ELECTIVE	Covered up to $175 allowance Contact lenses are provided in place of lens and frame benefits available herein.	Covered up to $105 allowance Contact lenses are provided in place of lens and frame benefits available herein.

NECESSARY	Covered in full after any applicable Co-Payment Necessary contact lenses are a Plan Benefit when specific criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	Covered up to $210 allowance Necessary contact lenses are a Plan Benefit when specific criteria are satisfied and when prescribed by Covered Person's Out-of-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.

SUPPLEMENTAL PLAN BENEFITS	**In-Network Coverage (Using an In-Network Vision Provider)**	**Out-of-Network Coverage (Using an Out-of-Network Vision Provider)**
SECOND PAIR	This benefit gives you additional eyewear coverage. You can get: • Two pairs of prescription eyeglasses; or • One pair of prescription eyeglasses and an allowance toward contact lenses, or • Double your contact lens allowance.	Service intervals are the same as shown at left for In-Network Coverage. Benefits payable are the same as the primary plan benefits up to the Out-of-Network exam and materials allowances stated above.

SCHEDULE OF BENEFITS (continued)

[1]All lens enhancements are available at participating private practice provider offices, and not to exceed maximum member out of pocket amounts and pricing are subject to change without notice. Please check with your provider for details and maximum member out of pocket amounts applicable to your lens choice. At this time, all lens enhancements and "not to exceed" maximum member out of pocket amounts and pricing are not available at Costco, Walmart and Sam's Club. Please contact your local Costco, Walmart and Sam's Club to confirm the availability of lens enhancements and pricing prior to receiving services.

Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)	
ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements.[2] At times, other promotional offers may also be available.
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. [2]
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance.[2]
ADDITIONAL ALLOWANCE ON FEATURED FRAMES	For certain frames, an additional $20 allowance.[2]

[2] These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.