



## Summary of Benefits

| Aetna Vision <sup>SM</sup> Preferred E200 12M                                                       |                                                                                                                                         |                     |
|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------|
| Plan ID 1054512104<br>TPID 79012<br>Line Value 868                                                  | Member cost In-Network                                                                                                                  | Out of Network*     |
| Vision Care Services                                                                                |                                                                                                                                         |                     |
| Aetna Vision Network                                                                                |                                                                                                                                         |                     |
| Eye Exam with Dilation as necessary                                                                 | \$0 Copay                                                                                                                               | \$36 Reimbursement  |
| Standard Contact Lens Fit/Follow-Up                                                                 | Member pays discounted fee of \$40                                                                                                      | Not Covered         |
| Premium Contact Lens Fit/Follow-Up                                                                  | 10% off retail price                                                                                                                    | Not Covered         |
| Retinal Imaging                                                                                     | Member pays discounted fee of \$39                                                                                                      | Not Covered         |
| Standard Plastic Single Vision Lenses                                                               | \$0 Copay                                                                                                                               | \$30 Reimbursement  |
| Standard Plastic Bifocal Vision Lenses                                                              | \$0 Copay                                                                                                                               | \$45 Reimbursement  |
| Standard Plastic Trifocal Vision Lenses                                                             | \$0 Copay                                                                                                                               | \$72 Reimbursement  |
| Standard Plastic Lenticular Vision Lenses                                                           | \$0 Copay                                                                                                                               | \$72 Reimbursement  |
| Standard Progressive Vision Lenses <sup>1</sup>                                                     | \$65 Copay                                                                                                                              | \$45 Reimbursement  |
| Premium Progressive Vision Lenses <sup>1</sup><br>(Tier amount based on brand)                      | Tier 1 = \$85 Copay<br>Tier 2 = \$95 Copay<br>Tier 3 = \$110 Copay                                                                      | \$45 Reimbursement  |
| Other Premium Progressive Lenses <sup>1</sup>                                                       | \$65 Copay, 20% off retail price<br>less \$120 allowance                                                                                | \$45 Reimbursement  |
| UV Treatment                                                                                        | Member pays discounted fee of \$15                                                                                                      | Not Covered         |
| Tint (Solid And Gradient)                                                                           | Member pays discounted fee of \$15                                                                                                      | Not Covered         |
| Standard Plastic Scratch Coating                                                                    | \$0 Copay                                                                                                                               | \$15 Reimbursement  |
| Standard Polycarbonate Lenses - Adult                                                               | \$0 Copay                                                                                                                               | \$35 Reimbursement  |
| Standard Polycarbonate Lenses - Kids under age 19                                                   | \$0 Copay                                                                                                                               | \$35 Reimbursement  |
| Standard Anti-Reflective Coating <sup>1</sup>                                                       | Member pays discounted fee of \$45                                                                                                      | Not Covered         |
| Premium Anti-Reflective Coating <sup>1</sup><br>(Tier amount based on brand)                        | Tier 1<br>Member pays discounted fee of \$57<br>Tier 2<br>Member pays discounted fee of \$68<br>Tier 3<br>20% discount off retail price | Not Covered         |
| Photochromic/Transitions Plastic                                                                    | Member pays discounted fee of \$75                                                                                                      | Not Covered         |
| Polarized And Other Lens Add Ons                                                                    | 20% off retail price                                                                                                                    | Not Covered         |
| Conventional Contact Lenses                                                                         | \$200 Allowance**<br>Additional 15% off balance over \$200                                                                              | \$136 Reimbursement |
| Disposable Contact Lenses                                                                           | \$200 Allowance                                                                                                                         | \$160 Reimbursement |
| Medically Necessary Contact Lenses                                                                  | \$0 Copay                                                                                                                               | \$200 Reimbursement |
| Frame                                                                                               | \$200 Allowance**<br>Additional 20% off balance over \$200                                                                              | \$90 Reimbursement  |
| Frequency:                                                                                          |                                                                                                                                         |                     |
| Exam                                                                                                | Once every 12 rolling months                                                                                                            |                     |
| Eyeglass Lenses or Contact Lenses                                                                   | Once every 12 rolling months                                                                                                            |                     |
| Frame                                                                                               | Once every 12 rolling months                                                                                                            |                     |
| In-Network Discounts                                                                                |                                                                                                                                         |                     |
| Additional pairs of eyeglasses or prescription sunglasses <sup>2</sup>                              | Up to a 40% discount off retail price                                                                                                   |                     |
| Non-covered items <sup>3</sup>                                                                      | 20% discount off retail price                                                                                                           |                     |
| Lasik Laser vision correction or PRK from U.S. Laser Network <sup>4</sup> only. Call 1-800-422-6600 | 15% discount off retail or 5% discount off the promotional price                                                                        |                     |

## Partial list of Exclusions and Limitations

Exclusions and limitations for vision include: any charges in excess of the benefits, dollar or supply limits listed above; special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (non-prescription) lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses. Other exclusions and limitations may also apply.

\*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge.

Claim forms can be found at [AetnaVision.com](http://AetnaVision.com) or by calling customer service at 1-877-973-3238.

Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

\*\*Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

<sup>1</sup>Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.

<sup>2</sup>Additional pair discount applies to purchases made after the plan allowances have been exhausted.

<sup>3</sup>Non covered discounts may not be available in all states.

<sup>4</sup>Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

Vision insurance plans are underwritten by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change.

Providers in the Aetna Vision network are contracted and credentialed through EyeMed Vision Care, LLC according to EyeMed's requirements. EyeMed and Aetna are independent contractors and not agents of each other. Provider participation may change without notice.

Refer to [Aetna.com](http://Aetna.com) for more information about Aetna® plans.

Policy forms issued in Idaho include: AL HGrpPol-Vision 03

Policy forms issued in Missouri include: AL HGrpPol-Vision 02

Policy forms issued in Oklahoma include: AL HGrpPol-Vision 02

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