

# Aetna Vision<sup>SM</sup> Preferred

visit [www.aetnavision.com](http://www.aetnavision.com)

## Summary of Benefits for City of Alexandria

Effective Date: 07-01-2014  
External Plan ID:  
Line Value:  
Frequency: 12/12/12

### In Network

### Out of Network<sup>\*</sup>

#### Exam

#### Aetna Vision Network

**Use your Exam coverage once every calendar year.**

|                                     |                                    |                    |
|-------------------------------------|------------------------------------|--------------------|
| Routine/Comprehensive Eye Exam      | \$0 Copay                          | \$30 Reimbursement |
| Standard Contact lens Fit/Follow up | Member pays discounted fee of \$40 | Not Covered        |
| Premium Contact Lens Fit/Follow-Up  | Member pays 90% of retail          | Not Covered        |

#### Eyeglass Lenses /Lens options

**Use your Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.**

|                                                    |                                                                                           |                    |
|----------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------|
| Single Vision lenses                               | \$15 Copay                                                                                | \$25 Reimbursement |
| Bifocal Vision lenses                              | \$15 Copay                                                                                | \$40 Reimbursement |
| Trifocal Vision lenses                             | \$15 Copay                                                                                | \$55 Reimbursement |
| Lenticular Vision lenses                           | \$15 Copay                                                                                | \$55 Reimbursement |
| Standard Progressive Vision lenses                 | \$80 Copay                                                                                | \$40 Reimbursement |
| Premium Progressive Vision lenses <sup>1</sup>     | 20% Discount off retail minus \$120 plan allowance plus \$80 Copay = member out-of-pocket | \$40 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                                                                                 | \$5 Reimbursement  |
| Standard Polycarbonate lenses - Adult              | Member pays discounted fee of \$40                                                        | Not Covered        |
| Standard Polycarbonate Lenses - Children to age 19 | \$0 Copay                                                                                 | \$5 Reimbursement  |
| Standard Anti-Reflective Coating                   | Member pays discounted fee of \$45                                                        | Not Covered        |
| Photochromic/Transitions plastic                   | Member pays 80% of Retail                                                                 | Not Covered        |
| Polarized                                          | Member pays 80% of Retail                                                                 | Not Covered        |

#### Contact Lenses

**Use your Contact Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.**

|                                    |                                                                    |                     |
|------------------------------------|--------------------------------------------------------------------|---------------------|
| Conventional contact lenses        | \$150 Allowance**<br>Additional 15% off balance over the allowance | \$120 Reimbursement |
| Disposable contact lenses          | \$150 Allowance                                                    | \$120 Reimbursement |
| Medically necessary contact lenses | \$0 Copay                                                          | \$200 Reimbursement |

#### Frames

**Use your Frame coverage once every calendar year.**

|                                                                   |                                                                   |                    |
|-------------------------------------------------------------------|-------------------------------------------------------------------|--------------------|
| Any Frame available, including frames for prescription sunglasses | \$150 Allowance<br>Additional 20% off balance over the Allowance. | \$75 Reimbursement |
|-------------------------------------------------------------------|-------------------------------------------------------------------|--------------------|

#### Discounts

**Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.**

|                                                                                                                                                | In Network                                                                                                                                                                                        | Out of Network |
|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances** have been exhausted. | Up to a 40% Discount                                                                                                                                                                              | No Discount    |
| Non-covered items such as cleaning cloths and contact lens solution <sup>2</sup>                                                               | 20% Discount                                                                                                                                                                                      | No Discount    |
| Lasik Laser vision correction or PRK from U.S. Laser Network <sup>3</sup> only. Call 1-800-422-6600                                            | 15% discount off retail or 5% discount off the promotional price                                                                                                                                  | No Discount    |
| Retinal Imaging <sup>4</sup>                                                                                                                   | Member pays a discounted fee up to \$39                                                                                                                                                           | No Discount    |
| Replacement contact lenses                                                                                                                     | Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit <a href="http://www.aetnavision.com">www.aetnavision.com</a> for details | No Discount    |

## Partial list of exclusions and limitations

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

\*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 [www.aetnavision.com](http://www.aetnavision.com) or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

\*\*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>Non covered discounts may not be available in all states.

<sup>3</sup>Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

<sup>4</sup>Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

### Key Definitions

**Copayment** - The fixed amount paid by the member under the plan. Providers should collect all copayments

**Allowance** - Dollar amount to be applied toward the cost of materials or a service

**Reimbursement** - Dollar amount to be paid to the member from Aetna up to the providers' billed charge

**Out-of-Pocket** - The amount the member must pay after benefits have been applied

**Discount** - Percentage off the providers billed charge or retail cost

**Standard Polycarbonate** - 1.5 mm center thickness with spherical curves

**Standard Scratch-Resistant Coating** - Front-side factory scratch coat

**Standard Progressive Lens** - Multi-focal design that produce a gradual change in focus without lines or junctions

**Conventional Contact Lens** - Lenses intended for ongoing, daily-wear use; rigid gas-permeable lenses are included

**Disposable Contact Lens** - Lenses that are designed and labeled to be replaced at specified time intervals (e.g., daily, weekly, monthly)

**Medically Necessary Contact Lenses** - To correct visual acuity to 20/40 or better if such correction is not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

Coverage is not provided for the following:

- Special vision procedures, such as orthoptics, vision therapy, or vision training.
- Vision services that are covered in whole or in part; under any other part of this plan; or under any other plan of group benefits provided by the policyholder; or under any workers' compensation law or any other law of like purpose.
- For an eye exam which is required by an employer as a condition of employment; or an employer is required to provide under a labor agreement; or is required by any law of a government.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- Replacement of lost, stolen or broken prescription lenses or frames.
- Any exams given during a stay in a hospital or other facility for medical care.

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.

This quote is based on a contract situs of Virginia. Extraterritorial state requirements may apply to members residing in specific States. If your plan covers members in other states, impacts to your plan of benefits and rates adjustments (if any) will be evaluated and communicated to you at the point of sale.

This material is for information only, and is not an offer or invitation to contract.

