Summary of Benefits for Alachua County Public Schools
Aetna Vision℠ Preferred

Effective Date: 01/01/2024 **External Plan ID: 1051200101** **Line Value: 820** **Frequency (Exam/Frame/Lens): 12/24/12** **Enhanced Plan-WAL** **Primary Quote** **820858 - Package A**	**In Network Member Cost Aetna Vision Network**	**Out of Network Member Reimbursement***
Exam		
Use your Exam Coverage once every Calendar Year		
Eye Exam with Dilation as Necessary	$10 Copay	$30 Reimbursement
Retinal Imaging	Member pays discounted fee of $39	Not Covered
Standard Contact Lens Fit /Follow Up[1]	Member pays discounted fee of $40	Not Covered
Premium Contact Lens Fit /Follow Up[1]	10% off Retail Price	Not Covered
Frames		
Use your Frame Coverage once every two Calendar Years		
Any Frame available, including frames for prescription sunglasses	$0 Copay; $130 Allowance**, 20% off balance over allowance	$65 Reimbursement
Standard Plastic Lenses		
Use your Lens/Lens Option Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Single Vision	$15 Copay	$25 Reimbursement
Bifocal	$15 Copay	$40 Reimbursement
Trifocal	$15 Copay	$60 Reimbursement
Lenticular	$15 Copay	$100 Reimbursement
Standard Progressive Lens (copay includes bifocal cost)	$30 Copay	$40 Reimbursement
Premium Progressive Lens Tier 1 (copay includes bifocal cost)[2]	$100 Copay	$40 Reimbursement
Premium Progressive Lens Tier 2 (copay includes bifocal cost)[2]	$110 Copay	$40 Reimbursement
Premium Progressive Lens Tier 3 (copay includes bifocal cost)[2]	$125 Copay	$40 Reimbursement
Premium Progressive Lens Tier 4 (copay includes bifocal cost)[2]	$80 Copay; 80% of Charge less $120 allowance	$40 Reimbursement
Lens Options		
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	Member pays discounted fee of $15	Not Covered
Polycarbonate Lenses - Adult	Member pays discounted fee of $40	Not Covered
Polycarbonate Lenses - Children to age 19	Member pays discounted fee of $40	Not Covered
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Premium Anti-Reflective Coating Tier 1[2]	Member pays discounted fee of $57	Not Covered
Premium Anti-Reflective Coating Tier 2[2]	Member pays discounted fee of $68	Not Covered
Premium Anti-Reflective Coating Tier 3[2]	20% off Retail Price	Not Covered
Photochromic/Transitions Plastic - Adult	Member pays discounted fee of $75	Not Covered
Photochromic/Transitions Plastic - Child to age 19	Member pays discounted fee of $75	Not Covered
Other Add-Ons	20% off Retail Price	Not Covered

Contact Lenses		
Use your Contact Lens Coverage once every Calendar Year to purchase 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional	$0 Copay; $130 Allowance**, 15% off balance over allowance	$104 Reimbursement
Disposable	$0 Copay; $130 Allowance	$104 Reimbursement
Medically Necessary	Covered in Full	$200 Reimbursement
Diabetes Benefit		
Use your diabetic benefit up to two services per benefit year for Type 1 and Type 2 diabetics		
Office Service Visit (Medical Follow Up Exam)	$0 Copay	$77
Retinal Imaging (Not covered if Extended Ophthalmoscopy is provided within 6 months)	$0 Copay	$50
Extended Ophthalmoscopy (Not covered if Retinal Imaging is provided within 6 months)	$0 Copay	$15
Gonioscopy	$0 Copay	$15
Scanning Laser	$0 Copay	$33

In Network Discounts	
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands	
Additional pairs of eyeglasses or prescription sunglasses[3]	**Up to 40% off prescription eyeglasses/sunglasses and 15% off conventional contact lenses once the funded benefit has been used**
Non-covered Items[4]	**20% off Retail Price**
Lasik Laser vision correction or PRK from **U.S. Laser Network**[5]. Call 1-800-422-6600	**15% discount off retail or 5% discount off promotional price**
Hearing Discounts[6] - two ways to save: **Hearing Care Solutions** 1-866-344-7756 **Amplifon Hearing Health Care** 1-877-301-0840	**Save on hearing aids, exams, batteries, repairs and more**

Partial list of exclusions and limitations

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.

*Out of network coverage is available. To receive reimbursement up to the amounts listed above, a claim form with itemized receipt is required. Reimbursement will not exceed the providers actual charge. Claims forms can be found at aetnavision.com or by calling customer service Monday through Sunday at 1-877-973-3238. Completed claim forms can be submitted electronically or mailed to Aetna, PO Box 8504 Mason, OH 45040-7111. You also have access to Allied Providers, such as Costco Vision, who will apply your out-of-network benefits at the point of service and handle the claim submission process for you.

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

[1]Contact lens fit and two follow-up visits are allowed once an eye exam has been completed.

[2]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. Premium Progressive Lens cost includes bifocal cost.

[3]Additional pair discount applies to purchases made after the plan allowances have been exhausted. Discounts are not insurance.

[4]Non covered discounts may not be available in all states.

[5]Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

[6]Aetna does not endorse any vendor, product or service associated with these discount offers. Vendors are independent of Aetna, not agents or employees. Programs, products and services may not be available at all times. Certain offers may not be available in some states. Products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care (formerly HearPO).

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

Policies and plans are insured and/or administered 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. These are the plan's main exclusions and limitations. See the booklet-certificate for a complete description. The plan does not cover: special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (nonprescription) lenses; nonprescription 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.

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 for more information about Aetna® plans.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 877-973-3238. If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512. 1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD). Help for those who speak another language and for the hearing impaired.

For language assistance in your language call 877-973-3238. Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación.