Aetna Life Insurance Company
151 Farmington Ave
Hartford, CT 06156

Preferred Provider Organization (PPO)
Vision Plan

Schedule of Benefits

Prepared exclusively for:

Policyholder:	Martinsville City Public Schools
Group policy number:	GP-0109301
Control number**:**	0142577
Schedule of Benefits:	1A
Group policy effective date:	July 1, 2021
Plan effective date:	July 1, 2021
Plan issue date:	March 20, 2024
Plan revision effective date:	July 1, 2024

Underwritten by Aetna Life Insurance Company in the Commonwealth of Virginia

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, benefit frequency limits, and maximums, if any, that apply to the services you get under this plan.

How to read your schedule of benefits

- You are responsible for full payment of any vision care service you receive that is not a **covered benefit** or that exceeds your benefit frequency limit.
- This plan also has **maximum allowances** for specific in-network **covered benefits**. These are dollar amount maximums for **covered benefits**.
- This plan has **scheduled limits** for specific out-of-network **covered benefits**. These are dollar amount maximums for **covered benefits**.
- You are responsible to pay any **copayments** listed in the schedule of benefits below, if they apply.

How to contact us for help

We are here to answer your questions.

- Log in to your member website at https://www.aetna.com/
- Call Member Services at the toll-free number on your ID card

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on your plan **copayment** or maximum benefit when the service or supply is provided, not when payment is made. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Benefit frequency limits

In-network and out-of-network combined

Vision examinations

Description	Limit
Vision examinations	Once every **12 months**

Vision materials

Description	Limit
Frames	1 pair every **24 months**
Lenses	1 pair every **12 months**
Contact lenses	1 order every **12 months**

Vision materials important note: During each benefit frequency period, your plan will cover either **prescription** eyeglass lenses or **prescription** contact lenses.

Eligible vision services

Vision examinations

Description	In-network coverage	Out-of-network coverage
Comprehensive eye exam	$10 **copayment**	$30 **scheduled limit**

Vision materials

Frames

Description	In-network coverage	Out-of-network coverage
Eyeglass frame	$0 **copayment** then the plan pays up to $150 **maximum allowance**	$75 **scheduled limit**

Standard plastic prescription lenses

Description	In-network coverage	Out-of-network coverage
Single Vision	$20 **copayment**	$25 **scheduled limit**
Bifocal	$20 **copayment**	$40 **scheduled limit**
Trifocal	$20 **copayment**	$56 **scheduled limit**
Lenticular	$20 **copayment**	$56 **scheduled limit**

Standard progressive	$85 **copayment**	$40 **scheduled limit**
Premium progressive	$85 **copayment** then the plan pays up to $120 **maximum allowance**	$40 **scheduled limit**

Contact lenses

Only one of the following contact lens types may be used for the contact lenses benefit per benefit period

Description	In-network coverage	Out-of-network coverage
Conventional contact lenses	$0 **copayment** then the plan pays up to $130 **maximum allowance**	$104 **scheduled limit**
Disposable contact lenses	$0 **copayment** then the plan pays up to $130 **maximum allowance**	$104 **scheduled limit**
Description	**In-network coverage**	**Out-of-network coverage**
Non-conventional (medically necessary) contact lenses	$0 **copayment**	$200 **scheduled limit**

Lens options

Description	In-network coverage	Out-of-network coverage
Standard polycarbonate lenses (Dependent child under 19 years of age)	$0 **copayment**	$35 **scheduled limit**
Scratch coating	$0 **copayment**	$15 **scheduled limit**