Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Vision℠ Preferred

visit www.aetnavision.com

Summary of Benefits for New York Presbyterian

Effective Date: 01-01-2019
Frequency: 24/24/24
Line Value: 373
Enhanced Plan: #1018467-101

	In Network	Out of Network*
Exam	**Aetna Vision Network**	
Use your Exam coverage once every 2 calendar years.		
Routine/Comprehensive Eye Exam	**$10 Copay**	$40 Reimbursement
Standard Contact lens Fit/Follow up	**Member pays discounted fee of $55**	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 2 calendar years to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.		
Single Vision lenses	**$0 Copay**	$25 Reimbursement
Bifocal Vision lenses	**$0 Copay**	$40 Reimbursement
Trifocal Vision lenses	**$0 Copay**	$55 Reimbursement
Lenticular Vision lenses	**$0 Copay**	$55 Reimbursement
Standard Progessive Vision lenses	**$65 Copay**	$40 Reimbursement
Premium Progressive Vision lenses[1]	**Member pays bifocal copay plus $85-$110 (amount varies by Brand)**	$40 Reimbursement
Other Premium Progressive lenses	**20% Discount off retail minus $120 plan allowance plus $65 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**	$11 Reimbursement
Standard Polycarbonate lenses - Adult	**Member pays discounted fee of $40**	Not Covered
Standard Polycarbonate Lenses - Children to age 19	**$0 Copay**	$28 Reimbursement
Standard Anti-Reflective Coating	**Member pays discounted fee of $45**	Not Covered
Photochromic/Transitions plastic	**Member pays discounted fee of $75**	Not Covered
Polarized	**Member pays 80% of Retail**	Not Covered
Contact Lenses		
Use your Contact Lens coverage once every 2 calendar years to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.		
Conventional contact lenses	**$130 Allowance** ** **Additional 15% off balance over the allowance**	$105 Reimbursement
Disposable contact lenses	**$130 Allowance**	$105 Reimbursement
Medically necessary contact lenses	**$0 Copay**	$210 Reimbursement
Frames		
Use your Frame coverage once every 2 calendar years.		
Any Frame available, including frames for prescription sunglasses	**$130 Allowance** **Additional 20% off balance over the Allowance.**	$45 Reimbursement

Affordable Care Act – Fees and Assessments

The Affordable Care Act (ACA) imposes several new fees/assessments, including the Health Insurance Providers Fee (the "Fee"). The Fee became effective on January 1, 2014. The Fee will be suspended for 2017, but reinstated starting in 2018.This recurring annual industry fee is assessed based on each insurer's share of the fully insured market. A total of $8.0 billion was collected across the industry for 2014. The total assessment increases each year, to an estimated $14.3 billion in 2018 and will then increase at the rate of premium growth thereafter. This rate quote includes, where permitted, and as applicable, an estimated proportionate allocation of expenses associated with the Fee. Aetna reserves the right to modify these rates, or and as applicable, an estimated proportionate allocation of expenses associated with the Fee. Aetna reserves the right to modify these rates, or otherwise recoup such Fee based on subsequent state regulatory approval, future regulatory guidance or if estimates are materially insufficient.

Commissions

0% commissions have been included in our rates.

Rate Guarantee

Our quoted rates are guaranteed for the first 48 months of the policy period and are valid as of the plan effective date.

Customer/Employee Contributions & Participation

There is no minimum participation requirement for the first year. Beginning with the first renewal we will require a minimum participation level of 25% of eligibles.

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[2]	**20% Discount**	No Discount
Lasik Laser vision correction or PRK from U.S. Laser Network[3] only. Call 1-800-422-6600	**15% discount off retail or 5% discount off the promotional price**	No Discount
Retinal Imaging[4]	**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 www.aetnavision.com 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 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.

[1]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.

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

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

[4]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 New York. 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.

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.

Aetna Vision Preferred Progressive and Anti-Reflective Tier Classifications

Progressive Price List*	Member Out-of-Pocket (Excludes Lens Copay)
Standard Progressive (Add-on to Bifocal)	$65
Premium Progressives (Add-on to Bifocal) as Follows:	
Tier 1	$85
Tier 2	$95
Tier 3	$110
Tier 4	Standard Progressive copay plus 80% of charge less $120 Allowance
Anti-Reflective Coating Price List*	**Member Out-of-Pocket (Excludes Lens Copay)**
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	$57
Tier 2	$68
Tier 3	80% of charge
Other Add-ons Price List	**Member Out-of-Pocket (Excludes Lens Copay)**
Photochromic (Plastic)	$75
Polarized	80% of charge
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.	
*Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.	