



**aetna**<sup>®</sup>  
**Aetna Vision<sup>SM</sup> Preferred**

**Summary of Benefits for Manatee County Government**

Effective Date: 01/01/2019  
 Frequency: 12/12/24

**In Network**

**Out of Network\***

**Exam**

**Aetna Vision Network**

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

Routine/Comprehensive Eye Exam	<b>\$10 Copay</b>	\$23 Reimbursement
Standard Contact Lens Fit/Follow up	<b>Member pays discounted fee of \$40</b>	Not Covered
Premium Contact Lens Fit/Follow-Up	<b>Member pays 90% of retail</b>	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 contacts lenses**

Standard Plastic Single Vision Lenses	<b>\$25 Copay</b>	\$35 Reimbursement
Standard Plastic Bifocal Vision Lenses	<b>\$25 Copay</b>	\$55 Reimbursement
Standard Plastic Trifocal Vision Lenses	<b>\$25 Copay</b>	\$90 Reimbursement
Standard Plastic Lenticular Vision Lenses	<b>\$25 Copay</b>	\$90 Reimbursement
Standard Progressive Vision Lenses	<b>\$90 Copay</b>	\$55 Reimbursement
Premium Progressive Vision Lenses <sup>1</sup>	<b>20% Discount off retail minus \$120 plan allowance plus \$90 Copay = member out-of-pocket</b>	\$55 Reimbursement
UV Treatment	<b>Member pays discounted fee of \$15</b>	Not Covered
Tint (Solid and Gradient)	<b>Member pays discounted fee of \$15</b>	Not Covered
Standard Plastic Scratch Coating	<b>\$0 Copay</b>	\$15 Reimbursement
Standard Polycarbonate Lenses - Adult	<b>Member pays discounted fee of \$40</b>	Not Covered
Standard Polycarbonate Lenses - Child to age 19	<b>\$0 Copay</b>	\$15 Reimbursement
Standard Anti-Reflective Coating	<b>Member pays discounted fee of \$45</b>	Not Covered
Photochromic/Transitions Plastic	<b>Member pays 80% of retail</b>	Not Covered
Polarized and Other Lens Add Ons	<b>Member pays 80% of retail</b>	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	<b>\$130 Allowance** Additional 15% off balance over the allowance</b>	\$104 Reimbursement
Disposable Contact Lenses	<b>\$130 Allowance</b>	\$104 Reimbursement
Medically Necessary Contact Lenses	<b>\$0 Copay</b>	\$200 Reimbursement

**Frames**

**Use your Frame coverage once every 2 calendar years**

Any Frame available, including frames for prescription sunglasses	<b>\$130 Allowance** Additional 20% off balance over the allowance.</b>	\$72 Reimbursement
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**Rates**

<b>Tiers</b>	<b>Monthly Rate &amp; Premium</b>	
Employee Only		\$4.92
Employee + Spouse		\$9.35
Employee + Child(ren)		\$9.84
Employee + Family		\$14.47

## 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 <sup>2</sup>	Up to a 40% Discount
Non-covered vision items <sup>3</sup>	20% Discount
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
Retinal Imaging <sup>5</sup>	Member pays a discounted fee up to \$39
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.

## 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 [www.aetnavision.com](http://www.aetnavision.com) or by calling customer service Monday-Sunday at 877-973-3238. 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>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.

<sup>5</sup>Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.

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 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 Florida. 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.

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.

