

Aetna VisionSM Preferred

visit www.aetnavision.com

Summary of Benefits for Orlando Utilities Commission

Effective Date: 01-01-2016
 Frequency: 0/12/24
 Enhanced Plan

In Network

Out of Network¹

Exam Aetna Vision Network

Exams not covered.

Exam	In Network	Out of Network ¹
Routine/Comprehensive Eye Exam	Not Covered	Not Covered
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 calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.

Exam	In Network	Out of Network ¹
Single Vision lenses	\$25 Copay	\$30 Reimbursement
Bifocal Vision lenses	\$25 Copay	\$50 Reimbursement
Trifocal Vision lenses	\$25 Copay	\$70 Reimbursement
Lenticular Vision lenses	\$25 Copay	\$70 Reimbursement
Standard Progressive Vision lenses	\$90 Copay	\$50 Reimbursement
Premium Progressive Vision lenses ¹	Member pays discounted fee of \$25 plus \$85-\$110 (amount varies by Brand)	\$50 Reimbursement
Other Premium Progressive lenses	20% Discount off retail minus \$120 plan allowance plus \$90 Copay = member out-of-pocket	\$50 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	Member pays discounted fee of \$15	Not Covered
Standard Polycarbonate lenses - Adult	Member pays discounted fee of \$40	Not Covered
Standard 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
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 calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.

Exam	In Network	Out of Network ¹
Conventional contact lenses	\$130 Allowance** Additional 15% off balance over the allowance	\$130 Reimbursement
Disposable contact lenses	\$130 Allowance	\$130 Reimbursement
Medically necessary contact lenses	\$0 Copay	\$210 Reimbursement

Frames

Use your Frame coverage once every 2 calendar years.

Exam	In Network	Out of Network ¹
Any Frame available, including frames for prescription sunglasses	\$130 Allowance Additional 20% off balance over the Allowance.	\$91 Reimbursement

Rates

Tiers	Lives	Monthly Rate & Premium
Employee	319	\$4.25
Employee plus 1 Dependent	113	\$8.08
Employee and Family	134	\$11.87
Totals	566	\$3,859.44

Patient Protection and Affordable Care Act – Fees and Assessments

The Patient Protection and Affordable Care Act imposes a new fee, the Health Insurer Fee (hereinafter Fee). The Fee is effective as of January 1, 2014.

This rate quote includes an estimated 3.26% of premium for the proportionate allocation of expenses associated with this Fee. Aetna reserves the right to modify these rates, or otherwise recoup such Fee if estimates are materially insufficient.

Health Insurer Fee

This recurring annual industry fee will be assessed based on each insurer's share of the fully insured market. A total of \$8.0 billion will be collected for 2014. The total assessment will increase each year, to \$14.3 billion in 2018 and will then increase at the rate of premium growth thereafter.

Commissions

0% commissions have been included in our rates.

Rate Guarantee

Our quoted rates are guaranteed for the first 24 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.

¹Premium 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.

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

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

⁴Retinal 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 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.

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



Orlando Utilities Commission
Supplement

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	\$90 copay
Premium Progressives as Follows:	
Tier 1	\$110 Copay
Tier 2	\$120 Copay
Tier 3	\$135 Copay
Tier 4	\$90 Copay, 80% of charge less \$120 Allowance
Anti-Reflective Coating Price List*	Member Cost In-Network
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 Cost In-Network
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.	