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

Aetna Vision℠ Preferred

visit www.aetnavision.com

Morgan Auto Group

Effective Date: 11-01-2015
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	**$10 Copay**	$40 Reimbursement
Standard Contact lens Fit/Follow up	**Member pays discounted fee of $40**	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.		
Single Vision lenses	**$25 Copay**	$20 Reimbursement
Bifocal Vision lenses	**$25 Copay**	$40 Reimbursement
Trifocal Vision lenses	**$25 Copay**	$60 Reimbursement
Lenticular Vision lenses	**$25 Copay**	$100 Reimbursement
Standard Progessive Vision lenses	**$90 Copay**	$40 Reimbursement
Premium Progressive Vision lenses[1]	**20% Discount off retail minus $120 plan allowance plus $90 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	**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 80% of Retail**	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.		
Conventional contact lenses	**$150 Allowance** **Additional 15% off balance over the allowance**	$80 Reimbursement
Disposable contact lenses	**$150 Allowance**	$80 Reimbursement
Medically necessary contact lenses	**$0 Copay**	$250 Reimbursement
Frames		
Use your Frame coverage once every 2 calendar years.		
Any Frame available, including frames for prescription sunglasses	**$150 Allowance** **Additional 20% off balance over the Allowance.**	$70 Reimbursement

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 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.