Aetna Vision℠ Preferred

www.aetnavision.com

Summary of Benefits for K&B Transportation, Inc.

Effective 1/1/24	In Network	Out of Network*
Exam	Aetna Vision Network	
Use your Exam coverage once every rolling 12 months		
Eye Exam with Dilation as Necessary	$10 Copay	$38 Reimbursement
Standard Contact Lens Fit/Follow-Up	Member pays discounted fee of up to $40	Not Covered
Premium Contact Lens Fit/Follow-Up	Member pays 90% of retail	Not Covered
Eyeglass Lenses / Lens options	maximum benefit per 12 months	
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Standard Plastic Single Vision Lenses	$10 Copay	$28 Reimbursement
Standard Plastic Bifocal Vision Lenses	$10 Copay	$44 Reimbursement
Standard Plastic Trifocal Vision Lenses	$10 Copay	$72 Reimbursement
Standard Plastic Lenticular Vision Lenses	$10 Copay	$72 Reimbursement
Stardard Progressive Vision Lenses (copay includes bifocal cost)	$75 Copay	$44 Reimbursement
Premium Progressive Vision Lenses	Tier 1 = $95 Copay Tier 2 = $105 Copay Tier 3 = $120 Copay	$44 Reimbursement
Tier 4 Premium progressive	$75 copay then the plan pays up to $120 maximum allowance	$44 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	$12 Reimbursement
Standard Polycarbonate Lenses-Adult	Member pays discounted fee of $40	Not Covered
Standard Polycarbonate Lenses-Child to age 19	$0 Copay	$32 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of $45	Not Covered
Premium Anti-Reflective Coating (Tier amount based on brand)	Tier 1 = $57 Copay Tier 2 = $68 Copay Tier 3 = 20% discount off retail	Not Covered
Photochromic/Transitions Plastic	Member pays discounted fee of $75	Not Covered
Polarized and other Lens Add Ons	Member pays 80% of retail	Not Covered

Contact Lenses (contact lens allowance includes materials only)		
Use your Lens coverage once every rolling 12 months to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses		
Conventional Contact Lenses	$130 Allowance	$104 Reimbursement
Disposable Contact Lenses	$130 Allowance	$104 Reimbursement
Medically Necessary Contact Lenses	$0 Copay	$200 Reimbursement
Standard polycarbonate for covered dependent children under 19 years of age	$0 Copay	$32 Reimbursement

Effective 1/1/24	**In Network**	**Out of Network***
Frames		
Use your Frame coverage once every rolling 24 months		
Any Frame available, including frames for prescription sunglasses	$130 Allowance Additional 15% off balance over allowance	$65 Reimbursement
In Network Discounts		
Additional pairs of eyeglasses or prescription sunglasses	Up to a 40% Discount	
Non-covered items	20% Discount	
Lasik Laser vision correction or PRK from US Laser Network only. Call 800-422-6600	15% discount off retail or 5% discount off the promotional price	
Hearing Discounts Hearing Care Solutions 866-344-7756 Amplifon Hearing Health Care 877-301-0840	Save on hearing aids, exams, batteries, repairs, and more	
Retinal Imaging	Member pays a discounted fee of up to $39	

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, Benefit Period frequency limits, 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 services you receive that are not a **covered benefit** or that exceed your Benefit Period frequency limit.
- This plan also has a **maximum allowance** for specific **covered benefits**. These are dollar amount maximums for **covered benefits**.

How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at 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.