Preferred Provider Organization (PPO)
Vision Plan

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact your employer for additional information.

Prepared exclusively for:

Policyholder:	University of Rochester
Group policy number:	GP-0804712-C
Schedule of Benefits:	1
Group policy effective date:	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	December 22, 2022
Plan revision effective date:	January 1, 2023

Underwritten by Aetna Life Insurance Company in the state of New York.

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.

Plan features

Eligible vision services	In-network coverage	Out-of-network coverage
Vision examination		
Routine eye exam	$10 **copayment**	$25 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 visit	

Standard plastic prescription lenses		
Single Vision	$10 **copayment**	$20 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Bifocal	$10 **copayment**	$40 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Trifocal	$10 **copayment**	$65 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Lenticular	$10 **copayment**	$65 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Standard progressive	$75 **copayment**	$40 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Premium progressive	$75 **copayment** then the plan pays up to $120 **maximum allowance**	$40 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 pair of lenses	
Frames		
	$130 **maximum allowance**	$65 **scheduled limit**
Maximum benefit per 24 consecutive month period	1 frame	

Contact Lenses		
Conventional contact lenses	$115 **maximum allowance**	$80 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Disposable contact lenses	$115 **maximum allowance**	$92 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Non-conventional (**medically necessary**) **contact lenses**	$0 **copayment**	$200 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	