



## Temple University Summary of Aetna Vision<sup>SM</sup> Preferred Benefits - Basic

Plan Year: 09-01-2025 - 08-31-2026

AVP Basic (NV)

Plan ID: 1038941 102

### In Network

### Out of Network\*

#### Exam

Aetna Vision Network

#### Use your Exam coverage once every plan year

|                                     |                                          |                    |
|-------------------------------------|------------------------------------------|--------------------|
| Eye Exam with dilation as necessary | \$20 Copay                               | \$30 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

#### Use your Lens coverage once every plan year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses

|                                                |                                                                                  |                    |
|------------------------------------------------|----------------------------------------------------------------------------------|--------------------|
| Standard Plastic Single Vision Lenses          | \$20 Copay                                                                       | \$15 Reimbursement |
| Standard Plastic Bifocal Vision Lenses         | \$20 Copay                                                                       | \$30 Reimbursement |
| Standard Plastic Trifocal Vision Lenses        | \$20 Copay                                                                       | \$60 Reimbursement |
| Standard Plastic Lenticular Vision Lenses      | \$20 Copay                                                                       | \$60 Reimbursement |
| Standard Progressive Vision Lenses             | \$85 Copay                                                                       | \$30 Reimbursement |
| Premium Progressive Vision Lenses <sup>1</sup> | Tier 1 = \$105 Copay<br>Tier 2 = \$115 Copay<br>Tier 3 = \$130 Copay             | \$30 Reimbursement |
| Other Premium Progressive Vision Lenses        | Tier 4 = \$85 copay, 20% off retail price less \$120 allowance                   | \$30 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                  | \$40 Copay                                                                       | Not Covered        |
| Standard Anti-Reflective Coating               | Member pays discounted fee of \$45                                               | Not Covered        |
| Premium Anti-Reflective Coating                | Tier 1 = \$57 Copay<br>Tier 2 = \$68 Copay<br>Tier 3 = member pays 80% of retail | Not Covered        |
| Photocromatic / 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

#### Use your Lens coverage once every plan year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses

|                                    |                                                                           |                     |
|------------------------------------|---------------------------------------------------------------------------|---------------------|
| Conventional Contact Lenses        | \$0 Copay, \$130 Allowance**<br>Additional 15% off balance over allowance | \$104 Reimbursement |
| Disposable Contact Lenses          | \$130 allowance, plus balance over \$130                                  | \$104 Reimbursement |
| Medically Necessary Contact Lenses | \$0 Copay, Paid-in-Full                                                   | \$210 Reimbursement |

#### Frames

#### Use your frame coverage once every plan year

|                                                                   |                                                                           |                     |
|-------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------|
| Any Frame available, including frames for prescription sunglasses | \$0 Copay, \$130 Allowance**<br>Additional 20% off balance over allowance | \$104 Reimbursement |
|-------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------|

#### In Network Discounts

|                                                                                               |                                                                  |
|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Additional pairs of eyeglasses or prescription sunglasses <sup>2</sup>                        | Up to a 40% Discount                                             |
| Non-covered items <sup>3</sup>                                                                | 20% Discount                                                     |
| Lasik Laser vision correction or PRK from U.S. Laser Network <sup>4</sup> 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                          |

#### Partial list of Exclusions and Limitations

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. These are the plan's main exclusions and limitations. See the booklet-certificate for a complete description. The plan does not cover: special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (nonprescription) lenses; nonprescription 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.

Policies and plans are insured and/or administered 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.

Providers in the Aetna Vision network are contracted and credentialed through EyeMed Vision Care, LLC according to EyeMed's requirements. EyeMed and Aetna are independent contractors and not agents of each other. Provider participation may change without notice. Refer to Aetna.com for more information about Aetna® plan

Aetna Student HealthSM is the brand name for products and services provided by Aetna Life Insurance Company, Aetna Health and Life Insurance Company and their affiliates.

\*Students 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 aetnavision.com or by calling 1-877-973-3238. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111. Electronic claim form submission is available.

Enrolled students can access their secure member website once their plan becomes effective. Enrolled students will receive a welcome packet with ID card mailed to the address on file within 15 business days after enrollment is processed.

\*\*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.

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, CRCordinator@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.

©2025 Aetna Inc.