Preferred Provider Organization (PPO)
Vision Insurance 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:	California Institute of Technology
Group policy number:	GP-866280
Group control number:	CN-869106
	Schedule of Benefits 1A
Group policy effective date:	January 1, 2020
Insurance plan effective date:	January 1, 2020
Insurance plan issue date:	December 11, 2019

Underwritten by Aetna Life Insurance Company in the state of California.

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, Benefit Period and 12 consecutive month 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 and 12 consecutive month 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 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.

General coverage provisions

This section explains the:

- **Copayment**
- **Scheduled limit**
- **Maximum allowance**

listed in this *Schedule of Benefits*.

Copayment

This is a specified dollar amount that must be paid by you at the time you receive **eligible vision services** from a **network provider**.

Scheduled limit

This is the most that the plan will reimburse for **eligible vision services** incurred by any one covered person from an **out-of-network provider**. You are responsible for any charges above the scheduled limit.

Maximum allowance

This is the most the plan will pay for **eligible vision services** incurred by any one covered person in a Benefit Period from an in-network provider. You are responsible for any charges above the **maximum allowance**.

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 visions 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	
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 a $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 12 consecutive month period	1 frame	
Contact Lens		
Conventional contact lens	$115 **maximum allowance**	$80 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Disposable contact lens	$115 **maximum allowance**	$80 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	
Medically necessary contact lens	$0 **copayment**	$200 **scheduled limit**
Maximum benefit per 12 consecutive month period	1 order	