

<i>SERFF Tracking Number:</i>	<i>AENX-126560200</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45271</i>
<i>Company Tracking Number:</i>	<i>GH AR0262701F01</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>2010 Vision</i>		
<i>Project Name/Number:</i>	<i>2010 Vision/GH AR0262701F01</i>		

Filing at a Glance

Company: Aetna Life Insurance Company

Product Name: 2010 Vision

TOI: H20G Group Health - Vision

Sub-TOI: H20G.000 Health - Vision

Filing Type: Form

SERFF Tr Num: AENX-126560200 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45271

Co Tr Num: GH AR0262701F01

State Status: Approved-Closed

Author: SPI AetnaSPI

Reviewer(s): Rosalind Minor

Date Submitted: 03/26/2010

Disposition Date: 04/02/2010

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2010 Vision

Project Number: GH AR0262701F01

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/02/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 04/02/2010

Created By: SPI AetnaSPI

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: SPI AetnaSPI

Filing Description:

The enclosed forms describe revisions to Aetna's Vision Expense Coverage product which can be sold to customers as a Basic Vision Expense Benefit, a [Limited] Comprehensive Vision Expense Benefit or a [Limited] Comprehensive PPO Vision Expense Benefit. The product has been re-designed to meet market needs by providing our customers with greater plan design flexibility and more benefit options, such as:

- The addition of copayments and deductibles to allow for a wider array of cost-sharing options.

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 Product Name: 2010 Vision
 Project Name/Number: 2010 Vision/GH AR0262701F01

- An expanded listing of covered services and supplies.
- The addition of an optional Lasik Surgery benefit.

Company and Contact

Filing Contact Information

John Ciesielski, Product and Regulatory Approvals Manager
 151 Farmington Avenue
 Mail Stop RW61
 Hartford, CT 06156
 CiesielskiJW@Aetna.com
 860-279-1282 [Phone]
 860-952-2069 [FAX]

Filing Company Information

Aetna Life Insurance Company
 151 Farmington Avenue
 Hartford, CT 06156
 (860) 273-7546 ext. [Phone]
 CoCode: 60054
 Group Code: 1
 Group Name: Aetna
 FEIN Number: 06-6033492
 State of Domicile: Connecticut
 Company Type:
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Aetna Life Insurance Company	\$50.00	03/26/2010	35193385

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TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
Product Name: 2010 Vision
Project Name/Number: 2010 Vision/GH AR0262701F01

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/02/2010	04/02/2010

<i>SERFF Tracking Number:</i>	<i>AENX-126560200</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Project Name/Number:</i>	<i>2010 Vision/GH AR0262701F01</i>		

Disposition

Disposition Date: 04/02/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AENX-126560200 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 45271
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 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: 2010 Vision
 Project Name/Number: 2010 Vision/GH AR0262701F01

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter, Attachment A	Approved-Closed	Yes
Supporting Document	Sample Plan designs	Approved-Closed	Yes
Supporting Document	AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
Supporting Document	EOV - AL GE EGR9N022005 V002, EOV - AL GE EGR9N022015 V002, EOV - AL GE EGR9N022020 V002, EOV - AL GE EGR9N022025 V002, EOV - AL GE EGR9N024005 V002, EOV - AL GE EGR9N024010 V002, EOV - AL GE EGR9N028000 V002, EOV - AL GE EGR9N028030 V002, EOV - AL , ...	Approved-Closed	Yes
Form	[Basic] [Comprehensive] Vision Expense Insurance Plan	Approved-Closed	Yes
Form	Schedule of Vision Exams and Other Services	Approved-Closed	Yes
Form	Schedule of Vision Eyewear - Lenses	Approved-Closed	Yes
Form	Schedule of Vision Eyewear - Frames	Approved-Closed	Yes
Form	Schedule of Vision Lens Options	Approved-Closed	Yes
Form	Your Aetna Vision [Expense Insurance] [Plan]	Approved-Closed	Yes
Form	About the [Basic][Comprehensive] Vision [Expense Insurance] [Plan]	Approved-Closed	Yes
Form	[About the [Limited] [Comprehensive]][PPO] Vision [Expense Insurance] [Plan]	Approved-Closed	Yes
Form	[Accessing [Out-of-Network] Providers and Benefits	Approved-Closed	Yes
Form	What the Plan Covers	Approved-Closed	Yes
Form	Vision Supplies. Prescription Lenses. Frames. Benefits for Vision Care Supplies After Your Coverage Terminates	Approved-Closed	Yes
Form	Glossary Letter P	Approved-Closed	Yes
Form	Exclusions that Apply to Vision Care	Approved-Closed	Yes

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	Insurance Coverage		
Form	Glossary Letter S	Approved-Closed	Yes
Form	Enrollment Form	Approved-Closed	Yes

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 Product Name: 2010 Vision
 Project Name/Number: 2010 Vision/GH AR0262701F01

Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/02/2010	GR-9N S-24-005 02	Schedule Pages	[Basic] [Comprehensive] Vision Expense Insurance Plan	Initial		0.000	GR-9N S-24-005 02.PDF
Approved-Closed 04/02/2010	GR-9N S-24-015 02	Schedule Pages	Schedule of Vision Exams and Other Services	Initial		0.000	GR-9N S-24-015 02.PDF
Approved-Closed 04/02/2010	GR-9N S-24-020 01	Schedule Pages	Schedule of Vision Eyewear - Lenses	Initial		0.000	GR-9N S-24-020 01.PDF
Approved-Closed 04/02/2010	GR-9N S-24-030 01	Schedule Pages	Schedule of Vision Eyewear - Frames	Initial		0.000	GR-9N S-24-030 01.PDF
Approved-Closed 04/02/2010	GR-9N S-24-025 01	Schedule Pages	Schedule of Vision Lens Options	Initial		0.000	GR-9N S-24-025 01.PDF
Approved-Closed 04/02/2010	GR-9N 22-005 02	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Your Aetna Vision [Expense Insurance] [Plan]	Initial		0.000	GR-9N 22-005 02.PDF
Approved-Closed 04/02/2010	GR-9N 22-015 02	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	About the [Basic][Comprehensi ve] Vision [Expense Insurance] [Plan]	Initial		46.400	GR-9N 22-015 02.PDF
Approved-Closed 04/02/2010	GR-9N 22-020 02	Certificate Amendmen t, Insert	[About the [Limited] [Comprehensive]][PP O] Vision [Expense	Initial		41.500	GR-9N 22-020 02.PDF

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<i>Product Name:</i>	<i>2010 Vision</i>		
<i>Project Name/Number:</i>	<i>2010 Vision/GH AR0262701F01</i>		
Approved- Closed 04/02/2010	GR-9N 22- 025 02	Page, Insurance] [Plan] Certificate [Accessing [Out-of- Amendmen Network] Providers t, Insert and Benefits Page, Endorseme nt or Rider	Initial 48.800 GR-9N 22- 025 02.PDF
Approved- Closed 04/02/2010	GR-9N 24- 005 02	Certificate What the Plan Amendmen Covers t, Insert Page, Endorseme nt or Rider	Initial 40.700 GR-9N 24- 005 02.PDF
Approved- Closed 04/02/2010	GR-9N 24- 010 02	Certificate Vision Supplies. Amendmen Prescription Lenses. t, Insert Frames. Benefits for Page, Vision Care Supplies Endorseme After Your Coverage nt or Rider Terminates	Initial 40.100 GR-9N 24- 010 02.PDF
Approved- Closed 04/02/2010	GR-9N 34- 080 05	Other Glossary Letter P	Initial 41.500 GR-9N 34- 080 05.PDF
Approved- Closed 04/02/2010	GR-9N 28- 030 002	Certificate Exclusions that Apply Amendmen to Vision Care t, Insert Insurance Coverage Page, Endorseme nt or Rider	Initial 47.800 GR-9N 28- 030 002.PDF
Approved- Closed 04/02/2010	GR-9N 34- 095 005	Certificate Glossary Letter S Amendmen t, Insert Page, Endorseme nt or Rider	Initial 41.200 GR-9N 34- 095 005.PDF
Approved- Closed	GR-68610 912-09)	Application/Enrollment Form Enrollment	Initial 0.000 GR-68610 912-09).PDF

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TOI: H20G Group Health - Vision *Sub-TOI:* H20G.000 Health - Vision
Product Name: 2010 Vision
Project Name/Number: 2010 Vision/GH AR0262701F01
04/02/2010 Form

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004

Aetna Life Insurance Company
[Basic] [Comprehensive] Vision Expense Insurance
[Schedule of Benefits]

PLAN FEATURES

[Deductible]

Deductible	Individual	Family
Per calendar year	\$25 - \$100	\$50 - \$300]

[Unless otherwise indicated, your **deductible** must be met before benefits are paid.]

**Aetna Life Insurance Company
 Schedule of Benefits**

Schedule of [Basic] [Limited] [Comprehensive] Vision Expense Benefits			
PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Comprehensive Eye Exam for adults]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Comprehensive Eye Exam for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Comprehensive Eye Exams per calendar year for adults]	[1-4]	[1-4]	[1-4]
[Comprehensive Eye Exam for dependent children]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit per Comprehensive Eye Exam for dependent children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Comprehensive Eye Exams per calendar year for dependent children]	[1-4]	[1-4]	[1-4]
[Comprehensive Eye Exam for diabetic patients]	<p>[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit per Comprehensive Eye Exam for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Comprehensive Eye Exams per calendar year for diabetic patients]	[1-4]	[1-4]	[1-4]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Comprehensive Eye Exam for post-cataract surgery patients]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Comprehensive Eye Exam for post-cataract surgery patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Comprehensive Eye Exams per calendar year for post-cataract surgery patients]	[1-4]	[1-4]	[1-4]
[Contact Lens Fit and Follow Up]			
[Standard Contact Lens Fit and Follow Up for adults]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible per visit after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit per Standard Contact Lens Fit and Follow Up for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Standard Contact Lens Fit and Follow Ups per calendar year for adults]	[1-4]	[1-4]	[1-4]
[Standard Contact Lens Fit and Follow Up for dependent children]	<p>[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$50 per visit deductible per visit after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit per Standard Contact Lens Fit and Follow Up for dependent children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Standard Contact Lens Fit and Follow Ups per calendar year for dependent children]	[1-4]	[1-4]	[1-4]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Standard Contact Lens Fit and Follow Up for diabetic patients]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible per visit after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Standard Contact Lens Fit and Follow Up for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Standard Contact Lens Fit and Follow Ups per calendar year for diabetic patients]	[1-4]	[1-4]	[1-4]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Standard Contact Lens Fit and Follow Up for post-cataract patients]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible per visit after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Standard Contact Lens Fit and Follow Up for post-cataract patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Contact Lens Fit and Follow Ups per calendar year for post-cataract patients]	[1-4]	[1-4]	[1-4]
[Premium Contact Lens Fit and Follow Up for adults]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit per Premium Contact Lens Fit and Follow Up for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Premium Contact Lens Fit and Follow Ups per calendar year for adults]	[1-4]	[1-4]	[1-4]
[Premium Contact Lens Fit and Follow Up for dependent children]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Premium Contact Lens Fit and Follow Up for dependent children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Premium Contact Lens Fit and Follow Ups per calendar year for dependent children]	[1-4]	[1-4]	[1-4]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Premium Contact Lens Fit and Follow Up for diabetic patients]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit per Premium Contact Lens Fit and Follow Up for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Premium Contact Lens Fit and Follow Ups per calendar year for diabetic patients]	[1-4]	[1-4]	[1-4]
[Premium Contact Lens Fit and Follow Up for post-cataract patients]	[\$10-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% per visit after the calendar year deductible] [No deductible applies] [Not Covered]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit per Premium Contact Lens Fit and Follow Up for post-cataract patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Maximum number of Premium Contact Lens Fit and Follow Ups per calendar year for post-cataract patients]	[1-4]	[1-4]	[1-4]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Orthoptic Treatment Benefit]	<p>[\$0-\$50 per visit copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$0-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$0-\$50 per visit deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% per visit after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for orthoptic treatment per lifetime]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Maximum Lasik Refractive Surgery Benefit per lifetime] Benefit (for one of the following refractive surgical procedures to one or both eyes: LASIK (including Custom Wavefront, Wavefront-Guided or IntraLase-initiated LASIK), LASEK or PRK]	[The plan pays a maximum benefit per surgery of \$100-\$1,000]	[The plan pays a maximum benefit per surgery of \$100-\$1,000]	[The plan pays a maximum benefit per surgery of \$100-\$1,000]

**Aetna Life Insurance Company
 Schedule of Benefits**

Schedule of [Basic] [Limited] [Comprehensive] Vision Expense Benefits			
PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Vision Eyewear [Lenses]			
[Single Vision lenses (2 lenses) for adults]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for single vision lenses once per calendar year for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Single Vision lenses (2 lenses) for Dependent Children]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for single vision lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Single Vision lenses (2 lenses) for diabetic patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for single vision lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Single Vision lenses (2 lenses) for post-cataract patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for single vision lenses once per calendar year for post-cataract patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Bifocal Vision lenses (2 lenses) for adults]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for bifocal vision lenses once per calendar year for adults]	[\$30-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Bifocal Vision lenses (2 lenses) for Dependent Children]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for bifocal vision lenses once per calendar year for Dependent Children]	[\$30-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Bifocal Vision lenses (2 lenses) for diabetic patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for bifocal vision lenses once per calendar year for diabetic patients]	[\$30-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Bifocal Vision lenses (2 lenses) for post-cataract patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for bifocal vision lenses once per calendar year for post-cataract patients]	[\$30-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Trifocal Vision lenses (2 lenses) for adults]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for trifocal vision lenses once per calendar year for adults]	[\$45-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Trifocal Vision lenses (2 lenses) for Dependent Children]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for trifocal vision lenses once per calendar year for Dependent Children]	[\$45-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Trifocal Vision lenses (2 lenses) for diabetic patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for trifocal vision lenses once per calendar year for diabetic patients]	[\$45-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Trifocal Vision lenses (2 lenses) for post-cataract patients]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for trifocal vision lenses once per calendar year for post-cataract patients]	[\$45-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Lenticular Vision lenses (2 lenses) for adults]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for lenticular vision lenses once per calendar year for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Lenticular Vision lenses (2 lenses) for Dependent Children]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for lenticular vision lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Lenticular Vision lenses (2 lenses) for diabetic patients]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for lenticular vision lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Lenticular Vision lenses (2 lenses) for post-cataract patients]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for lenticular vision lenses once per calendar year for post-cataract patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Standard Progressive Vision lenses (2 lenses) for adults]	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for standard progressive vision lenses once per calendar year for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Standard Progressive Vision lenses (2 lenses) for Dependent Children]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for standard progressive vision lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Standard Progressive Vision lenses (2 lenses) for diabetic patients]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for standard progressive vision lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Standard Progressive Vision lenses (2 lenses) for post-cataract patients]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for standard progressive vision lenses once per calendar year for post-cataract patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Premium Progressive Vision lenses (2 lenses) for adults]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for premium progressive vision lenses once per calendar year for adults]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Premium Progressive Vision lenses (2 lenses) for Dependent Children]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for premium progressive vision lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Premium Progressive Vision lenses (2 lenses) for diabetic patients]	[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for premium progressive vision lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
<p>[Premium Progressive Vision lenses (2 lenses) for post-cataract patients]</p>	<p>[\$10-\$150 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$150 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
<p>[Maximum Benefit for premium progressive vision lenses once per calendar year for post-cataract patients]</p>	<p>[\$25-Unlimited]</p>	<p>[\$10-Unlimited]</p>	<p>[\$10-Unlimited]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Contact Lenses]			
[Conventional (2 lenses) for adults]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for conventional lenses once per calendar year for adults]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Conventional (2 lenses) for Dependent Children]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for conventional lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Conventional (2 lenses) for diabetic patients]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for conventional lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Conventional (2 lenses) for post cataract patients]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for conventional lenses once per calendar year for post-cataract surgery patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Disposable contacts (per set) for adults]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for disposable lenses once per calendar year for adults]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Disposable contacts (per set) for Dependent Children]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for disposable lenses once per calendar year for Dependent Children]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Disposable contacts (per set) for diabetic patients]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for disposable lenses once per calendar year for diabetic patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Disposable contacts (per set) for post-cataract patients]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for disposable lenses once per calendar year for post-cataract patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Contact lenses needed for adults to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.]	[\$10-200 copay after the calendar year deductible then the plan pays 80% - 100%] [No deductible applies]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Contact lenses needed for Dependent Children to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.]	[\$10-200 copay after the calendar year deductible then the plan pays 80% - 100%] [No deductible applies]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Contact lenses needed for diabetic patients to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.]	[\$10-200 copay after the calendar year deductible then the plan pays 80% - 100%] [No deductible applies]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Contact lenses needed for post-cataract patients to correct visual acuity to 20/40 or better if such correction not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.]	[\$10-200 copay after the calendar year deductible then the plan pays 80% - 100%] [No deductible applies]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for contact lenses per lifetime]	[\$200-Unlimited]	[\$200-Unlimited]	[\$200-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

Schedule of [Basic] [Limited] [Comprehensive] Vision Expense Benefits			
PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Vision Eyewear – Frames for adults]	<p>[\$10-\$500 copay after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of frames per calendar year for adults]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Vision Eyewear – Frames for Dependent Children]	<p>[\$10-\$500 copay after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for one set of frames per calendar year for Dependent Children]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]
[Vision Eyewear – Frames for diabetic patients]	<p>[\$10-\$500 copay after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of frames per calendar year for diabetic patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Vision Eyewear – Frames for post-cataract patients]	<p>[\$10-\$500 copay after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$500 deductible after the calendar year deductible then the plan pays 50%-100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of frames per calendar year for post-cataract patients]	[\$25-Unlimited]	[\$25-Unlimited]	[\$25-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

Schedule of [Basic] [Limited] [Comprehensive] Vision Expense Benefits			
PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Lens Options]			
[Standard Polycarbonate Lenses (for adults) (one set)]	[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for Standard Polycarbonate lenses once per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Standard Polycarbonate Lenses (for covered Dependent children under [18-27] years of age) (one set)]	[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for Standard Polycarbonate lenses (for covered Dependent children under [18-27] years of age) once per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[UV Treatment]	<p>[\$10-\$30 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for UV treatment per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Tint - Solid or Gradient]	<p>[\$10-\$30 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for tint - solid or gradient per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Standard Plastic Scratch Coating]	[\$10-\$30 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$30 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for standard plastic scratch coating per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Brand Name Standard Progressive Lenses (one set)]	[\$50-\$200 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$50-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$50-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Maximum Benefit for brand name standard progressive lenses once per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Brand Name Premium Progressive Lenses (one set)]	[\$50-\$200 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$50-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$50-\$200 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for brand name premium progressive lenses once per calendar year]	[\$50-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Other Premium Progressive Lenses (one set)]	[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for other premium progressive lenses once per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Brand Name Standard Anti-Reflective Coating]	[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]	[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%] [50%-100% after the calendar year deductible] [No deductible applies] [Not Covered]
[Maximum Benefit for brand name standard anti-reflective coating per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]

**Aetna Life Insurance Company
Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Brand Name Premium Anti-Reflective Coating]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for brand name premium anti-reflective coating per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]
[Other Premium Anti-Reflective Coating]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for other premium anti-reflective coating per calendar year]	[\$25-Unlimited]	[\$5-Unlimited]	[\$5-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[Brand Name Photochromic Lenses (one set)]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of brand name photochromic lenses once per calendar year]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]
[Polarized Lenses (one set)]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of polarized lenses once per calendar year]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

**Aetna Life Insurance Company
 Schedule of Benefits**

PLAN FEATURES	[NETWORK]	[OUT-OF-NETWORK]	[OTHER HEALTH CARE]
[All Other Lenses (one set)]	<p>[\$10-\$100 copay after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>	<p>[\$10-\$100 deductible after the calendar year deductible then the plan pays 50% - 100%]</p> <p>[50%-100% after the calendar year deductible]</p> <p>[No deductible applies]</p> <p>[Not Covered]</p>
[Maximum Benefit for one set of other lenses per calendar year]	[\$25-Unlimited]	[\$10-Unlimited]	[\$10-Unlimited]

Your Aetna Vision [Expense Insurance] [Plan]

It is important that you have the information and useful resources to help you get the most out of your **Aetna** vision [expense insurance] [plan]. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access services, including procedures you need to follow;
- What services and supplies are covered and what limits may apply;
- What services and supplies are not covered by the plan;
- How you share the cost of your covered services and supplies; and
- **1** [Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.]

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all vision care expenses are covered under the plan. Exclusions and limitations apply to certain services, supplies and expenses. Refer to the **2** [*What the Plan Covers, Exclusions and Schedule of Benefits*] sections to determine what expenses are covered, excluded or limited.

[Important Notes:

Unless otherwise indicated, “you” refers to you and your covered dependents.

Your vision plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are medically necessary.

This Booklet-Certificate applies to coverage only and does not restrict your ability to receive vision care services that are not or might not be covered benefits under this vision expense insurance plan.

Store this Booklet-Certificate in a safe place for future reference.]

[About the [Basic][Comprehensive] Vision [Expense Insurance] [Plan]

[Using the Plan

[The Basic Vision Expense Insurance [plan] will pay for **covered expenses**, up to the maximums shown in the *Schedule of Benefits*.]

- You can directly access **physicians** and other vision care providers of your choice for covered vision services and supplies under the plan.
- You may have to pay the provider or facility full charges and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the provider. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.
- **1** [You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.]

Cost Sharing

[Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.]

- **2** [You must satisfy any **deductibles** before the plan begins to pay benefits. After you satisfy any applicable **deductible**,] [Y] [y]ou will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.]
- **3** [Your **coinsurance** will be based on the **recognized charge**. If the vision care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.]
- **4** [Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to your *Schedule of Benefits* for specific dollar limits that apply to your plan and for information on what expenses do not apply.]
- The plan will pay for **covered expenses**, up to the maximums shown in the [*What the Plan Covers* or *Schedule of Benefits* sections]. You are responsible for any expenses incurred over the maximum limits outlined in the [*What the Plan Covers* or *Schedule of Benefits*] sections.

[About the [Limited] [Comprehensive][PPO] Vision [Expense Insurance] [Plan]

[This **Aetna** limited-benefit vision care insurance plan is designed to cover a limited range of vision services and supplies. It does not provide benefits covering expenses incurred for all vision care.]

1 [This Aetna [comprehensive][PPO] vision care insurance plan is designed to cover a wide range of vision services and supplies. Benefits are payable for each **covered person** as shown in the *Schedule of Benefits* for expenses incurred while this insurance is in force.]

2 [This plan provides access to covered benefits through a network of vision care providers. These **[network] physicians** and other vision care professionals have contracted with **Aetna** or an affiliate to provide vision care services and supplies to **Aetna** plan members at a fee called the **negotiated charge**.

3 [Your **deductibles, copayments, and coinsurance** will usually be lower when you use participating **network providers** and facilities.]

[You also have the choice to access licensed providers outside the network for covered benefits. **Deductibles and coinsurance** are usually higher when you utilize **out-of-network providers**. **Out-of-network providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan.]

4[Some services and supplies may only be covered through **network providers**. Refer to the *Covered Benefit* section and the *Schedule of Benefits* to determine if any services are limited to network coverage only.]

To better understand the choices that you have with your plan, please carefully review the following information. Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you.

[Availability of Providers

Aetna cannot guarantee the availability or continued network participation of a particular **provider**. Either **Aetna** or any **network provider** may terminate the **provider** contract.]

[Ongoing Reviews

Aetna conducts ongoing reviews of those services and supplies which are recommended or provided by vision professionals to determine whether such services and supplies are covered benefits under this Booklet-Certificate. If **Aetna** determines that the recommended services or supplies are not covered benefits, you will be notified. You may appeal such determinations by contacting **Aetna** to seek a review of the determination. Please refer to the *Claim Procedures/Complaints and Appeals* section of this Booklet-Certificate.]

[How Your Plan Works

Accessing Network Providers and Benefits

- You may select a **network** vision care **provider** from the **Aetna Network Provider Directory** or by logging on to **Aetna's** website at [www.aetna.com.] You can search **Aetna's** online **directory**, [DocFind], for names and locations of **physicians** and other vision care **providers** and facilities. You can change your vision care **provider** at any time.
- If a service you need is covered under the plan but not available from a **network provider**, please contact Member Services at the toll-free number on your ID card for assistance.
- You will not have to submit claims for services and supplies received from **network providers**. Your **network provider** will take care of claim submission. **Aetna** will directly pay the **network provider** less any cost sharing required by you. You will be responsible for **deductibles**, **coinsurance** and **copayments**, if any.]
- **5**[You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible**, **copayment**, **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.]

Cost Sharing For [Network] Benefits

[Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*].

- **6**[You will need to satisfy any applicable **deductibles** before the plan will begin to pay benefits.]
- **7**[For certain types of services and supplies, you will be responsible for any **copayment** shown in the *Schedule of Benefits*.]
- **8**[After you satisfy any applicable **deductible**, you will be responsible for your **coinsurance** for **covered expenses** that you incur. Your **coinsurance** is based on the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for that covered service or supply. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.]
- **9**[Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Schedule of Benefits* for the specific **maximum out-of-pocket limit**, amounts that apply to your plan.]

- The plan will pay for **covered expenses**, up to the maximums shown in the [*What the Plan Covers* or *Schedule of Benefits*] sections. You are responsible for any expenses incurred over the maximum limits outlined in the [*What the Plan Covers* or *Schedule of Benefits*] sections.
- You may be billed for any **deductible, copayment** or **coinsurance** amounts, or any non-covered expenses that you incur.]

[Accessing [Out-of-Network] Providers and Benefits

You have the choice to directly access **physicians** or other vision care providers that do not participate with the **Aetna** provider network. You will still have coverage when you access **out-of-network providers** for covered benefits. You may have more out-of-pocket expenses.

- You select a provider for covered benefits.
- You may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to the provider. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.
- If your provider charges more than the **recognized charge**, you will be responsible for any expenses incurred above the **recognized charge**. The **recognized charge** is the maximum amount **Aetna** will pay for a **covered expense** from a provider.
- **1**[You will receive notification of what the plan has paid toward your medical expenses. It will indicate any amounts you owe towards your **deductible** and **coinsurance** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.]

Cost Sharing for [Out-of-Network] Benefits

[Important Note:

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.]

- **2**[You must satisfy any **deductibles** before the plan begins to pay benefits.]
- **3**[After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **maximum out-of-pocket limit** applicable to your plan.]
- **4**[Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.]
- **5**[Once you satisfy the **maximum out-of-pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year. Certain designated out-of-pocket expenses may not apply to the **maximum out-of-pocket limit**. Refer to the *Common Terms* section for information on what expenses do not apply. Refer to the *Schedule of Benefits* for specific dollar limits that apply to your plan.]
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefits* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or the *Schedule of Benefits* sections.]

[Basic][Limited][Comprehensive][PPO] Vision [Expense Insurance] [Plan]

What the Plan Covers

This plan covers charges for certain vision care exams [1and supplies] described in this section. The plan limits coverage to a maximum benefit amount per [2calendar year] [benefit period.] Refer to your [Schedule of Benefits] to determine the maximum benefits that apply to your plan, if any. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum listed in the [Schedule of Benefits].

3[Vision Exams

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- Routine eye exam: A complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.]
- [Comprehensive eye exam: A complete eye exam used to diagnose or detect existing conditions of the eye and vision system. This exam includes refraction and glaucoma testing. A comprehensive eye exam includes a contact lens exam.]
- [Contact lens exam: A contact lens exam performed for the sole purpose of fitting contact lenses.]

Benefits are payable up to the benefit maximum listed on your [Schedule of Benefits]. Refer to the [Schedule of Benefits] for frequency limits and maximums on exams.]

4[Limitations

All **covered expenses** are subject to the vision expense exclusions in this Booklet-Certificate and are subject to the **deductible(s)**, **copayments** or **coinsurance** listed in the *Schedule of Benefits*, if any.

Coverage is subject to the exclusions listed in the *Exclusions* section of this Booklet-Certificate.]

[Vision Supplies

Covered expenses include charges for prescription lenses and frames,¹ or prescription contact lenses] up to the Benefit Maximum, per benefit period listed in the *Schedule of Benefits*.

[Prescription Lenses

[**Covered expenses** include **prescription** lenses prescribed for the first time and new lenses required due to a change in **prescription** up to the benefit maximum, listed in the *Schedule of Benefits*.

[Charges for **prescription** contact lenses will be covered] [in an amount equal to the sum of:

- The amount that would be covered for single vision lenses; and
- The amount that would be covered for frames, as shown in the *Schedule of Benefits*.]

[Benefits are payable up to the benefit maximum, per benefit period, listed in the *Schedule of Benefits*.]

²[**Covered expenses** also include

- Aphakic lenses prescribed after cataract surgery; and
- Contact lenses required to correct visual acuity to 20/40 or better in the better eye if such correction cannot be made with conventional lenses;
- **Standard progressive lenses**; and
- **Premium progressive lenses**.

[Benefits for these lenses are payable up to the Benefit Maximums, per benefit period, listed in the *Schedule of Benefits*. You are responsible for any cost-sharing amounts listed in the *Schedule of Benefits*.]

³[Frames

Covered expenses include expenses for frames if the lenses for them are covered under this section.

Eyeglass frames are covered when purchased with **prescription** lenses up to the benefit maximum, per benefit period, listed in the *Schedule of Benefits*.]

⁴[Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before you coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in **prescription**.

Coverage is subject to the benefit maximums described above and in the *Schedule of Benefits*.]

[1 Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**. The plan must meet these tests:

- It is carried out in a **hospital; psychiatric hospital** or **residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.]

[Partial Disability Employment Program

A period of part-time work at your **own occupation** or a **reasonable occupation** that is not expected to result in your return to full-time work. This may also be a period of part-time or full-time work at other than a **reasonable occupation**. **Aetna** must review the program and approve it in writing.

A **partial disability employment program** will cease to be an approved **partial disability employment program** on the earliest to occur of:

- The date you are able to perform the **material duties** of your **own occupation** or work at any other **reasonable occupation**;
- The date you begin an **Approved Rehabilitation Program**; or
- The date **Aetna** withdraws, in writing, its approval of the program.]

[Passenger Restraint

This is a restraint that is:

- An unaltered seat belt or lap and shoulder restraint installed by the manufacturer of the **motor vehicle**; or
- A seat belt or lap and shoulder restraint:
 - Provided by the manufacturer of the **motor vehicle**; and
 - Installed by an authorized **motor vehicle** dealer; and
- Any child restraint device that is properly secured in the **motor vehicle** and meets the definition of the law of the state in which the **motor vehicle** is licensed and registered.]

[2 Pharmacy

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.]

[3Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law, is considered a "**physician**" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition; and
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, drug abuse, a **mental disorder**, or a **serious mental illness**.
- A **physician** is not you or related to you.

For the purposes of Short Term Disability and Long Term Disability coverage, regular care of a **physician** means you are attended by a **physician** who:

- Is not you or related to you;
- Is practicing within the scope of his or her license;
- Has the medical training and clinical expertise suitable to treat your disabling condition;
- Specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- Whose treatment is:
 - Consistent with the diagnosis of the disabling condition;
 - According to guidelines established by medical, research and rehabilitative organizations; and
 - Administered as often as needed.]

[4Precertification, Precertify

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.]

[Predisability Earnings

[The amount of salary or wages you were receiving from an employer participating in this Plan on the Month & Day that precedes the date a period of disability started, calculated on a monthly basis. If not employed on the preceding Month & Day, it is the monthly amount of salary or wages you were receiving from an employer participating in this Plan on your date of hire.

Your predisability earnings will be figured from the rule below that applies to you.

- 1) If you are paid on an annual salaried basis, your monthly salary is [1/12th of your annual salary.] [your annual salary divided by the number of months you were scheduled to work (excluding summer break).]
- 2) If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate less shift differential multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.
- 3) If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 173 hours per month.

Included in salary or wages are:

- Monthly average of commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of awards and bonuses paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of differential pay paid [over the last three months of actual employment or such shorter period if actual employment was for fewer than three months][during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12-60 months, if not employed throughout all of the last two full calendar years)].
- Monthly average of overtime pay based on the average number of overtime hours worked [over the last three months of actual employment or such shorter period if actual employment was for fewer than 3 months [during the last two full calendar years before a period of disability started (or during the months you were employed, up to 12 months, if not employed throughout all of the last two full calendar years), but not more than 10 hours].
- The amount of net tips you report to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form) averaged over the last three full months of actual employment or such shorter period if actual employment was for fewer than three full months.

- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[This is one-twelfth of the amount of salary or wages you received from an employer participating in this plan for the last two full calendar years before a period of disability started. If you were not employed for all of the last two full calendar years, it will be the average monthly salary or wages for the last 12 months before the period of disability started. If you were not employed for all of the last 12 months, it will be the average monthly salary or wages for the months employed.]

Included in salary or wages are:

- Commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw.
- Awards and bonuses.
- Differential pay.
- Overtime pay based on the average number of overtime hours worked, but not more than 10 hours.
- Net tips reported to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form).
- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[For purposes of the following definition, the determination period is the [Month & Day through Month & Day that precedes the date your disability started.]

- [one month or week equivalent period ending on the Month & Day that precedes the date your disability started.]
- [last one monthly or weekly equivalent pay period ending on the Month & Day that precedes the date your disability started.]

Predisability Earnings is the monthly average of the amount of salary or wages you received from an employer participating in this plan for the determination period. If you were not employed during all of the determination period, it will be the average monthly salary or wages for the last one month or equivalent weeks before the period of disability started. If you were not employed for all of the last one month or equivalent weeks, it will be the average monthly salary or wages for the months employed.]

Included in salary or wages are:

- Commissions, renewal commissions, overwriting renewal commissions, contingent commissions, draw.
- Awards and bonuses.
- Differential pay.

- Overtime pay based on the average number of overtime hours worked, but not more than 10 hours.
- Net tips reported to your Employer on Internal Revenue Service Form 4070, Employee's Report of Tips to Employer (or its successor form).
- Contributions you make through a salary reduction agreement with your Employer to any of the following:
 - An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
 - An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
 - An executive nonqualified deferred compensation agreement.
- Taxable cost of group term life and disability insurance.]

[This is one twelfth of the amount of ["Medicare Wages"] [Wages, tips, other compensation] reported by your employer on Internal Revenue Service Form W-2, Wage and Tax Statement, for the last full calendar year before a period of disability started. If you were not employed for all of the last two full calendar years, it will be the average monthly income for the last 12 before the period of disability started. If you were not employed for all of the last 12 months, it will be the average monthly income for the months you were employed.]

Added to your W-2 salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

[The following is for sole proprietor, partners, members of a limited liability company taxable as a partnership under the Federal income tax laws, or shareholders in an S-Corporation.]

[This is one-twelfth of the amount of salary or wages reported as "net earnings from self-employment" for Federal income tax purposes from your Employer for the last two full tax years before a period of disability started (as shown on Internal Revenue Service Schedule K-1, Form 1065, or its successor form). If you were not employed for all of the last two full tax years, it will be the average net earnings from self-employment for the last 12 months before the period of disability started. If you were not employed for all of the last 12 months, it will be the average net earnings from self-employment for the months employed.]

Included in salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

[The following applies to employees with an ownership interest in the employer participating in this plan such as sole proprietor, partners, members of a limited liability company taxable as a partnership under the Federal income tax laws, or shareholders in an S-Corporation.]

This is one-twelfth of your salary or wages determined by adding the following amounts as reported on the applicable Internal Revenue Service Schedule K-1, Schedule C, Form W-2, or S-Corporation Federal income tax return or any successor form or schedule, for the last two full tax years before a period of disability started]

- Your ordinary income (loss) from trade or business activities.
- Your guaranteed payments, if you are a partner.
- Net earnings from self-employment.
- Your compensation (as an officer), salary, or wages, if you are an S-Corporation shareholder.

If you did not have ownership interest for all of the last two full tax years, it will be your average earnings for the number of months, up to 12, that you were a sole proprietor, partner, member of a limited liability company, or an S-Corporation shareholder.

Included in salary or wages are contributions you make through a salary reduction agreement with your Employer to any of the following:

- An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.
- An IRC 401(k), 403(b), or 457 deferred compensation arrangement.
- An executive nonqualified deferred compensation agreement.]

Salary or wages do not include:

- § [Commissions, Awards and Bonuses, Overtime Pay, Shift Differential Pay, Tips.
- § Commissions, awards, and bonuses received during the calendar year in which your disability started.
- § Overtime pay in excess of 10 hours.
- § Payments under any stock option plan or similar equity program.
- § Payments made for unused paid time off.
- § Sign-on bonuses or any other payment made upon acceptance of employment with the Employer.
- § Any non-cash compensation.
- § Severance.
- § Salary continuation payments or benefits.
- § Lump sum vacation payments.
- § Transfer or relocation payments.
- § Travel and entertainment expenses.
- § Tuition reimbursement.
- § Any stay or retention bonus.
- § Any bonus which is paid pursuant to a deferral agreement or program.
- § Taxable cost of group term life or disability insurance.
- § Dividends, capital gains, and returns of capital
- § Fringe benefits.
- § Contributions made by your employer to any deferred compensation arrangement or pension plan.
- § Extra compensation such as payments for revenue sharing, housing allowances, stipends, relocation incentives or buyouts of unused vacations, professional fees, non qualified income.]

[A retroactive change in your rate of earnings will not result in a retroactive change in benefits/coverage.

In no event will a change in your salary or wages be considered if it occurs:

- On or after the date a period of disability started
- On or after the determination period
- Between separate disabilities which are considered one disability under the *If You Become Disabled Again* section.]

[Preexisting Condition

A **preexisting condition** is an **illness** or **injury** for which, during the 180 day period immediately prior to your enrollment date:

- Medical treatment, services, or supplies were received or **prescription drugs** or medicines were taken.
- or medical advice, diagnosis, care, or treatment was recommended or received.

The **preexisting condition** limitation does not apply to

- A newborn enrolled within 31 days of birth;
- A child who is adopted or placed for adoption before attaining 18 years of age if the child becomes covered under creditable coverage within 31 days of birth, adoption, or placement of adoption;
- Genetic information will not be treated as a preexisting condition in the absence of a diagnosis of the condition related to that information.
- Pregnancy will not be treated as a **preexisting condition**.]

[5Premium Progressive Lenses

These are multi-focal lenses that produce a gradual change in focus without lines or junctions and are the manufacturer's highest technology lenses.]

[Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.]

[6Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the **pharmacy**.]

[7Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.]

[8Primary Care Dentist (PCD)

This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Dentists** in the **directory**;
- Supervises, coordinates and provides initial care and basic dental services to a person;
- Initiates **referrals** for **specialist dentist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **primary care dentist**.

If you do not choose a **PCD**, **Aetna** will have the right to make a selection for you. You will be notified of the selection.]

[9Primary Care Physician (PCP)

This is the **network provider** who:

- Is selected by a person from the list of **Primary Care Physicians** in the **directory**;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician;
- Initiates **referrals** for **specialist** care and maintains continuity of patient care; and
- Is shown on **Aetna's** records as the person's **PCP**.]

[10Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.]

[11] **Psychiatric Physician**

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, drug abuse, **mental disorders**, or **serious mental illnesses**.]

Exclusions That Apply to Vision Care Insurance Coverage

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician**. The plan covers only those services and supplies that are included in the [1*What the Plan Covers*] section. Charges made for the following are **not** covered. In addition, some services are specifically limited or excluded. This section describes expenses that are **not** covered or subject to special limitations.

2[These vision exclusions are in addition to the exclusions listed under your medical coverage.]

3[Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet-Certificate.]

3[Any exams given during your **stay** in a **hospital** or other facility for medical care.]

3[An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.]

3[Drugs or medicines.]

3[Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.]

3[For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.]

3[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.]

Prescription or over-the-counter drugs or medicines.

3[Special vision procedures, such as orthoptics, vision therapy or vision training.]

3[Vision services or supplies which do not meet professionally accepted standards.]

3[Anti-reflective coatings.]

3[Tinting of eyeglass lenses.]

3[Duplicate or spare eyeglasses or lenses or frames for them.]

3[Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.]

3[Replacement of lost, stolen or broken **prescription** lenses or frames.]

3[Special supplies such as nonprescription sunglasses and subnormal vision aids.]

3[Vision services that are covered in whole or in part:

- [**4**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.]

DRAFTER'S NOTE: THE FOLLOWING EXCLUSION APPLIES TO SRC VISION PLANS ONLY.

3Any vision care supply.]

1 [Self-injectable Drug(s)]

Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.]

[Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.]

[Service Area

This is the geographic area, as determined by **Aetna**, in which **network providers** for this plan are located.]

2 [Severe Mental Illnesses

This means the following organic-based **severe mental illnesses** as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of **Mental Disorders**":

- Bipolar disorder.
- Major depressive disorder.
- Obsessive-compulsive disorder.
- Panic disorder.
- Paranoia and other psychotic disorders.
- Pervasive developmental disorder (Autism).
- Schizo-affective disorder.
- Schizophrenia.

Treatment is generally provided by; or under the direction of; a **behavioral health provider** such as a **psychiatric physician**; a psychologist; or a psychiatric social worker.]

3 [Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
 - Professional nursing care by an **R.N.**, or by an **L.P.N.** directed by a full-time **R.N.**; and
 - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders** or **severe mental illnesses**.

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[00000]

- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
 - It is licensed or approved under state or local law.
 - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **Skilled Nursing Facility** under Medicare or as an institution accredited by:
 - The Joint Commission on Accreditation of Health Care Organizations;
 - The Bureau of **Hospitals** of the American Osteopathic Association; or
 - The Commission on the Accreditation of Rehabilitative Facilities

Skilled Nursing Facilities also include Rehabilitation **Hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

Skilled Nursing Facility does not include:

- Institutions which provide only:
 - Minimal care;
 - **Custodial care** services;
 - Ambulatory; or
 - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, drug abuse, **mental disorders** or **severe mental illnesses**.]

[Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.]

[Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.]

[Specialist Dentist

Any **dentist** who, by virtue of advanced training is board eligible or certified by a Specialty Board as being qualified to practice in a special field of dentistry.]

[Specialty Care

Health care services or supplies that require the services of a **specialist**.]

[Specialty Care Drugs

Prescription drugs include **injectable**, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the **specialty care drug** list.]

[Specialty Pharmacy Network

A network of pharmacies designated to fill **1 [self-injectable drug prescriptions] [specialty care drugs]**.]

[Stay

A full-time inpatient confinement for which a **room and board** charge is made.]

[4 Standard Progressive Lenses

These are multi-focal lenses that produce a gradual change in focus without lines or junctions but are not the manufacturer's highest technology lenses.]

[5 Step Therapy

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at www.Aetna.com/formulary.]

[Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your insured dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.]

[Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets facility licensing standards as ambulatory surgical facility.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.

GR-9N

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[--]

[00000]

- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
 - **Physicians** who practice surgery in an area **hospital**; and
 - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- **Physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.]



[Aetna VisionSM Preferred]
Enrollment/Change Request
Aetna Life Insurance Company

Aetna Life Insurance Company
 151 Farmington Avenue
 Hartford, CT 06156

Instructions: Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Employer Group Information (To Be Completed by Employer)	Control	Suffix	Account	Plan Number
Employer Name – Full Name of Business or Organization				
Employer Address (Street, City, State, ZIP Code) – Primary Location of Business or Organization				

A. Type of Activity – Employee Completes Sections A – E. Please Print Clearly.

Enrollment – Check one. <input type="checkbox"/> New Enrollee/Subscriber Effective Date: _____ Date of Hire: _____ <input type="checkbox"/> Rehire/Reinstatement Date of Rehire/Reinstatement _____	Change – Check all that apply. <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____ <input type="checkbox"/> Control/Suffix/Acct/Plan: _____ Date of Event: _____ Reason: _____	Remove or Terminate – Check all that apply. <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Employee Withdrawal/Termination <input type="checkbox"/> Cancel Coverage Effective Date: _____ Reason: _____	Continuation of Coverage, i.e., COBRA, State <i>Not all options are available. Contact Employer for available options.</i> Coverage for: <input type="checkbox"/> Employee <input type="checkbox"/> Dependents Length of Continuation (months): <input type="checkbox"/> 18 <input type="checkbox"/> 36 <input type="checkbox"/> Other _____ <input type="checkbox"/> 29 – Attach disability determination from the Social Security Administration Date of Loss of Coverage: _____ Date of Qualifying Event: _____ Continuation of Coverage Expiration Date: _____
--	---	---	--

B. Employee Information

Social Security Number	Last Name, First Name, M.I.	Home Telephone	Work Telephone
Employee Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Home Address	Apt. No.	City, State
Subscriber Primary Language (other than English) Primer Idioma del suscriptor (que no sea el Ingles) What is your primary Language? ¿Cuál es su primer idioma?		Subscriber Disability Do you have a disability which affects your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate the nature of your disability.	
		ZIP Code	

C. Product Information

[Aetna VisionSM Preferred]
 [Aetna VisionSM Preferred may not be available in all states.]

D. Individuals Covered - List individuals for whom you are enrolling or adding/changing/removing coverage.

Check this box if you are refusing coverage for your dependents. * Provide details for "Yes*" responses below.

(A)dd (C)hange (R)emove	1. Employee Name - Last, First, M.I.	Relationship Code Self	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>
		Handicapped N/A	Student N/A
(A)dd (C)hange (R)emove	2. Spouse Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)	Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>
		Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>

Continued on Page 2

D. Individuals Covered – (continued) List individuals for whom you are enrolling or adding/changing/removing coverage.

* Provide details for "Yes" responses below. Attach sheet to list additional children.

(A)dd (C)hange (R)emove	3. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
(A)dd (C)hange (R)emove	4. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
(A)dd (C)hange (R)emove	5. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>
(A)dd (C)hange (R)emove	6. Child Name - Last, First, M.I. (Explain difference in last name in Special Remarks.)			Relationship Code	Sex (M/F)
Birthdate (MM/DD/YYYY)	Social Security Number (if dependent has no SSN, write "None")	Other Vision Coverage Yes* <input type="checkbox"/>	Currently Covered by Medicare Yes* <input type="checkbox"/>	Handicapped Yes <input type="checkbox"/>	Student Yes <input type="checkbox"/>

1. If "Yes" to Other Vision Coverage and/or Currently Covered by Medicare above, provide effective dates, name & policy number of insurance carrier, vision plan or other source & your Member Identification Number.

2. Does any dependent listed above live at a different address than the employee? Yes No If "Yes," who & what address?

Special Remarks:

E. Race/Ethnicity - Optional (This information is designed for the purpose of data collection & will not be used for determining eligibility, rating or claim payment.)

Employee 1.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 4.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Spouse 2.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 5.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____
Child 3.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____	Child 6.	<input type="checkbox"/> White – 01 <input type="checkbox"/> African American or Black – 02 <input type="checkbox"/> Hispanic or Latino – 03 <input type="checkbox"/> Asian – 04 <input type="checkbox"/> Other – 05 _____

Conditions of Enrollment

Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in an [Aetna VisionSM Preferred] plan, coverage is underwritten by Aetna Life Insurance Company (referred to as "Aetna") and that certain claims adjudication and other administrative services are provided by First American Administrators, Inc. (an affiliate of EyeMed Vision Care, LLC) and/or its affiliates.
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, optometrist, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand I am entitled to a copy of this authorization upon request and that a photocopy is as valid as the original.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery[®], all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Arkansas and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Massachusetts Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Attention Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

By checking this box you agree to use [Aetna Navigator[®]], Aetna's member self-service website for all future printed materials and understand you may choose to receive paper documents in the future.

Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and belief. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Employee Enrollment/Change Request form.

<i>Employee Signature - Required</i>	<i>Date (Month/Day/Year)</i>	<i>Employee E-mail Address (optional)</i>
X		

Employer Verification (To Be Completed by Employer)

<i>Employer Signature - Required</i>	<i>Title</i>	<i>Date (Month/Day/Year)</i>
X		

Instructions

Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

Employee – Complete Sections A – E. Additional dependent and/or other information may be provided on a separate sheet. All attachments must be signed and dated.

Section A – Type of Activity:

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

Section B – Employee Information:

- Complete **all** information in order for your Enrollment/Change Request to be processed.

Section C – Product Information.

Section D – Individuals Covered:

- Add/Change/Remove – Use “A”, “C”, or “R” to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual.
 - *Relationship Code* – Use **ONLY**: H=Husband, W=Wife, S=Son, D=Daughter, Y=Sponsored Male, X=Sponsored Female. **If the dependent is NOT your spouse or a biological or legally adopted child, please indicate relationship to employee in Special Remarks.**
- If you or your dependent(s) have **Other Vision Coverage** and/or are **Currently Covered by Medicare**, check the “Yes” box(es) and provide beginning & ending effective dates, name & policy number of insurance carrier, vision plan or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If a dependent is Handicapped & financially dependent, check “Yes” & provide proof of handicapped status from the attending physician.
- If a dependent is a Student, check “Yes”. Refer to your Summary Coverage for plan definitions. Aetna may request that you provide proof from the educational institution.

Section E – Race/Ethnicity (Optional): Check the appropriate Race/Ethnicity code for each individual. If your Race/Ethnicity is “Other,” print the Race/Ethnicity for each individual in the space provided.

Conditions of Enrollment/Misrepresentation – Employee Signature: Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

<i>SERFF Tracking Number:</i>	<i>AENX-126560200</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Aetna Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>45271</i>
<i>Company Tracking Number:</i>	<i>GH AR0262701F01</i>		
<i>TOI:</i>	<i>H20G Group Health - Vision</i>	<i>Sub-TOI:</i>	<i>H20G.000 Health - Vision</i>
<i>Product Name:</i>	<i>2010 Vision</i>		
<i>Project Name/Number:</i>	<i>2010 Vision/GH AR0262701F01</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: AR - READABILITY CERTIFICATION.PDF	Approved-Closed	04/02/2010

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: not applicable Comments:	Approved-Closed	04/02/2010

	Item Status:	Status Date:
Satisfied - Item: Cover Letter, Attachment A Comments: Attachments: Cover Letter.PDF Attachment A.PDF	Approved-Closed	04/02/2010

	Item Status:	Status Date:
Satisfied - Item: Sample Plan designs Comments: Attachment: Sample Plan designs.PDF	Approved-Closed	04/02/2010

	Item Status:	Status Date:
Satisfied - Item: AR - NAIC TRANSMITTAL DOCUMENT, AR - NAIC FORM	Approved-Closed	04/02/2010

SERFF Tracking Number: AENX-126560200 State: Arkansas
 Filing Company: Aetna Life Insurance Company State Tracking Number: 45271
 Company Tracking Number: GH AR0262701F01
 TOI: H20G Group Health - Vision Sub-TOI: H20G.000 Health - Vision
 Product Name: 2010 Vision
 Project Name/Number: 2010 Vision/GH AR0262701F01

FILING ATTACHMENT

Comments:

Attachments:

AR - NAIC TRANSMITTAL DOCUMENT.PDF
 AR - NAIC FORM FILING ATTACHMENT.PDF

	Item Status:	Status Date:
Satisfied - Item: EOVS - AL GE EGR9N022005 V002, EOVS - AL GE EGR9N022015 V002, EOVS - AL GE EGR9N022020 V002, EOVS - AL GE EGR9N022025 V002, EOVS - AL GE EGR9N024005 V002, EOVS - AL GE EGR9N024010 V002, EOVS - AL GE EGR9N028000 V002, EOVS - AL GE EGR9N028030 V002, EOVS - AL , ...	Approved-Closed	04/02/2010

Comments:

explanation of variable

Attachments:

EOVS - AL GE EGR9N022005 V002.PDF
 EOVS - AL GE EGR9N022015 V002.PDF
 EOVS - AL GE EGR9N022020 V002.PDF
 EOVS - AL GE EGR9N022025 V002.PDF
 EOVS - AL GE EGR9N024005 V002.PDF
 EOVS - AL GE EGR9N024010 V002.PDF
 EOVS - AL GE EGR9N028000 V002.PDF
 EOVS - AL GE EGR9N028030 V002.PDF
 EOVS - AL GE EGR9N034000 V003.PDF
 EOVS - AL GE EGR9N034080 V005.PDF
 EOVS - AL GE EGR9N034095 V005.PDF
 EOVS - AL GE EGR9N024000 V001.PDF
 EOVS - AL GE EGR9N022000 V001.PDF
 EOVS - AL GE EGR9NS024000 V002.PDF

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Aetna Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GR-9N S-24-005 02	0
GR-9N S-24-015 02	0
GR-9N S-24-020 01	0
GR-9N S-24-030 01	0
GR-9N S-24-025 01	0
GR-9N 22-005 02	0
GR-9N 22-015 02	46.4
GR-9N 22-020 02	41.5
GR-9N 22-025 02	48.8
GR-9N 24-005 02	40.7
GR-9N 24-010 02	40.1
GR-9N 34-080 05	41.5
GR-9N 28-030 002	47.8
GR-9N 34-095 005	41.2
GR-68610 912-09)	0

STATE OF ARKANSAS
READABILITY CERTIFICATION

Form Number	Score
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Signed: John W Ciesielski

Name: John Ciesielski

Title: Product and Regulatory Approvals Manager

Date: March 26, 2010



John W. Ciesielski
Product & Regulatory Approvals
Law and Regulatory Affairs
151 Farmington Ave, RW61
Hartford, CT 06156
(845) 279-1282
Fax: (860) 952-2065
Email: Ciesielskijw@aetna.com

March 26, 2010

Insurance Commissioner Julie Benafield Bowman
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: Aetna Life Insurance Company
NAIC No. 001-60054
Vision Expense Coverage
Booklet-Certificate Form GR-9N 22-005 05 et al
Enrollment/Change Request Form GR-68610 (12-09)

Dear Commissioner Benafield:

The forms listed on the Attachment A are being submitted for your Department's review and approval on a general use basis. The subject forms are new and do not replace any form(s) previously approved by your Department.

We intend to use the subject GR-9N form segments with Booklet-Certificate form GR-9N that was approved by your Department on June 23, 2006 and in conjunction with wraparound style master policy form GR-29N that was approved by your Department on June 23, 2006.

The enclosed forms describe revisions to Aetna's Vision Expense Coverage product which can be sold to customers as a Basic Vision Expense Benefit, a [Limited] Comprehensive Vision Expense Benefit or a [Limited] Comprehensive PPO Vision Expense Benefit. The product has been re-designed to meet market needs by providing our customers with greater plan design flexibility and more benefit options, such as:

- The addition of copayments and deductibles to allow for a wider array of cost-sharing options.
- An expanded listing of covered services and supplies.
- The addition of an optional Lasik Surgery benefit.

We are also including some sample plan designs to assist your Department with understanding the new plan features. You will note that the benefits are limited, but it is important that we mention that benefit amounts for both network and out-of-network benefits are based on the negotiated rate for network based providers. It should also be mentioned that this benefit structure is in line with industry standards for vision plans.

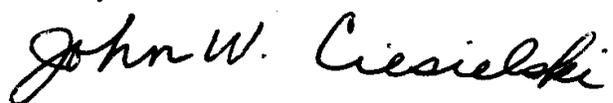
Upon issue, the coverage described may be offered on a standalone basis or may be included with other products approved by your Department for booklet-certificate form GR-9N.

Variability, as indicated by bracketed material on the forms, is required so that only the appropriate language may be reflected on the forms. Upon issuance of these documents, the placement of textual material may vary to avoid gaps that would otherwise be created by the deletion of bracketed material. Provisions may appear in sequence other than that shown. [Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the group policy, may vary as the sense demands.](#) Detailed Explanations of Variability for the forms have been included.

We request approval of this letter, the enclosed forms and any attachments.

If you have any questions, please feel free to contact me at the phone number, fax number or e-mail address shown above.

Sincerely,

A handwritten signature in black ink that reads "John W. Ciesielski". The signature is written in a cursive style with a large initial 'J' and 'C'.

John W. Ciesielski, Manager
Product & Regulatory Approvals

Enclosures

**2010 Vision Expense Coverage Enhancements
ATTACHMENT A**

Schedule of Benefits:

Schedule of Benefits Section S-24:

GR-9N S-24-005 02	GR-9N S-24-015 02	GR-9N S-24-020 01
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GR-9N S-24-025 01	GR-9N S-24-030 01
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Certificate:

Certificate Section 22:

GR-9N 22-005 02	GR-9N 22-015 02	GR-9N 22-020 02
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GR-9N
22-025
02

Certificate Section 24:

GR-9N 24-005 02	GR-9N 24-010 02
-----------------------	-----------------------

Certificate Section 28:

GR-9N
28-030
02

Certificate Section 34:

GR-9N 34-080 05	GR-9N 34-095 05
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General Comments - EOV only:

GR-9N
S-24-000
02

GR-9N
22-000
01

GR-9N
24-000
01

GR-9N
28-000
02

GR-9N
34-000
03

Sample Vision Plans

	Voluntary - Low Option		Voluntary - Medium Option		Voluntary - High Option	
Vision Care Services	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Exam	(Once Every 12 Months)		(Once Every 12 Months)		(Once Every 12 Months)	
Exam	\$25 Copay	\$11	\$10 Copay	\$21	Paid-in-Full	\$28
Standard Contact Lens Fit & Follow-Up:	Up to \$40	\$0	Up to \$40	\$0	Up to \$40	\$0
Frames	(Once Every 24 Months)		(Once Every 24 Months)		(Once Every 12 Months)	
Any available frame at provider location	\$100 Allowance	\$50	\$120 Allowance	\$60	\$140 Allowance	\$70
Standard Plastic Lenses	(Once Every 12 Months)		(Once Every 12 Months)		(Once Every 12 Months)	
Single Vision	\$25 Copay	\$7	\$10 Copay	\$18	Paid-in-Full	\$25
Bifocal	\$25 Copay	\$21	\$10 Copay	\$32	Paid-in-Full	\$39
Trifocal	\$25 Copay	\$46	\$10 Copay	\$56	Paid-in-Full	\$63
Lenticular	\$25 Copay	\$46	\$10 Copay	\$56	Paid-in-Full	\$63
Standard Progressive Lens**	\$90	\$21	\$75	\$32	\$90	\$39
Premium Progressive Lens**	\$90	\$21	\$75	\$32	\$90	\$39
Lens Options:						
UV Treatment	\$15	\$0	\$15	\$0	\$15	\$0
Tint (Solid and Gradient)	\$15	\$0	\$15	\$0	\$15	\$0
Standard Plastic Scratch Coating	\$15	\$0	\$0	\$11	\$0	\$11
Standard Polycarbonate - Adults	\$40	\$0	\$40	\$0	\$40	\$0
Standard Polycarbonate - Kids under 19	\$40	\$0	\$0	\$28	\$0	\$28
Standard Anti-Reflective Coating	\$45	\$0	\$45	\$0	\$45	\$0
Contact Lenses	(Once Every 12 Months)		(Once Every 12 Months)		(Once Every 12 Months)	
(Contact lens allowance includes materials only)						
Conventional	\$100 allowance	\$80	\$135 allowance	\$108	\$155 allowance	\$124
Disposable	\$100 allowance	\$80	\$135 allowance	\$108	\$155 allowance	\$124
Medically Necessary	Paid-in-Full	\$200	Paid-in-Full	\$200	Paid-in-Full	\$200

*All out of network amounts are based on the benefit maximum per item/supply/service. \$0 refers to not covered out of network.

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
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2.	Department Use Only	
	State Tracking ID	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Aetna Life Insurance Company 151 Farmington Avenue Hartford CT 06156	CT		001	60054	06-6033492	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
John Ciesielski 151 Farmington Avenue, Mail Stop RW61 Hartford CT 06156	860-279-1282	860-952-2069	CiesielskiJW@Aetna.com

5. Requested Filing Mode	<input type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	GH AR0262701F01
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7. <input type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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8. Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H20G Group Health - Vision
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10. Product Coding Matrix Filing Code	H20G.000 Health - Vision
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11. Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input checked="" type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____ <input type="checkbox"/> RATES <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	Filing Submission Date	March 26, 2010
13.	Filing Fee (If required)	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
14.	Date of Domiciliary Approval	January 6, 2010
15.	Filing Description:	
<p>The enclosed forms describe revisions to Aetna's Vision Expense Coverage product which can be sold to customers as a Basic Vision Expense Benefit, a [Limited] Comprehensive Vision Expense Benefit or a [Limited] Comprehensive PPO Vision Expense Benefit. The product has been re-designed to meet market needs by providing our customers with greater plan design flexibility and more benefit options, such as:</p> <ul style="list-style-type: none"> · The addition of copayments and deductibles to allow for a wider array of cost-sharing options. · An expanded listing of covered services and supplies. · The addition of an optional Lasik Surgery benefit. 		

16.	Certification (If required)	
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>John Ciesielski</u> Title <u>Product and Regulatory Approvals Manager</u></p> <p>Signature <u>John W Ciesielski</u> Date <u>March 26, 2010</u></p>		

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	GH AR0262701F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	[Basic] [Comprehensive] Vision Expense Insurance Plan	GR-9N S-24-005 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02	Schedule of Vision Exams and Other Services	GR-9N S-24-015 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03	Schedule of Vision Eyewear - Lenses	GR-9N S-24-020 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04	Schedule of Vision Eyewear - Frames	GR-9N S-24-030 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05	Schedule of Vision Lens Options	GR-9N S-24-025 01	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06	Your Aetna Vision [Expense Insurance] [Plan]	GR-9N 22-005 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07	About the [Basic][Comprehensive] Vision [Expense Insurance] [Plan]	GR-9N 22-015 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08	[About the [Limited] [Comprehensive][PPO] Vision [Expense Insurance] [Plan]	GR-9N 22-020 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09	[Accessing [Out-of-Network] Providers and Benefits	GR-9N 22-025 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10	What the Plan Covers	GR-9N 24-005 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
11	Vision Supplies. Prescription Lenses. Frames. Benefits for Vision Care Supplies After Your Coverage Terminates	GR-9N 24-010 02	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number	GH AR0262701F01	
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
12	Glossary Letter P	GR-9N 34-080 05	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
13	Exclusions that Apply to Vision Care Insurance Coverage	GR-9N 28-030 002	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
14	Glossary Letter S	GR-9N 34-095 005	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
15	Enrollment Form	GR-68610 912-09)	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

Aetna Life Insurance Company
Your Aetna Vision [Expense Insurance] [Plan]
Explanation of Variability
GR-9N
22-005
02

Your Aetna Vision [Expense Insurance] [Plan]

1. In the sixth bulleted item, the phrase starting with “Other important information...”, any item(s) on the list will reflect sections applicable to the policyholders plan.
2. The section references may be changed to reflect the section(s) applicable to the policyholder’s plan.
3. The Important Notes may be changed to reflect the policyholders plan.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
22-015
02

General Comments

This subsection 22-015 will be included when the vision plan is a Basic or Major Medical style plan. The appropriate term will be included to reflect the coverage (e.g. Basic or Comprehensive Vision) selected by the policyholder and this will be reflected throughout the text.

About the [Basic] [Comprehensive] Vision [Expense Insurance] [Plan]

Using the Plan

In the introductory statement, the language addressing benefit maximums may be removed if there are no benefit maximums under a policyholder's plan of benefits.

1. The third bulleted item may be omitted or moved to the "Cost Sharing", "Schedule of Benefits", or other section where it may be more appropriate. If all communications are handled electronically and not through the mail, the third sentence of this item will be revised accordingly.

Cost Sharing

The Important Note will be included as a standard; it may be omitted at the election of the policyholder.

2. Under the first bulleted item:
 - The first sentence and the beginning of the second sentence will be included if the plan has a deductible(s).
 - The second half of the second sentence will be included if the plan includes member coinsurance responsibility.
 - The third sentence will be included when the policyholder's plan includes a maximum on the member's coinsurance or out-of-pocket expenses.
3. The second bulleted item may be omitted.
4. The third bulleted item will be included when the policyholder's plan includes a maximum on the member's coinsurance or out-of-pocket expenses. When included, the reimbursement of expenses at 100% may apply for the remainder of that calendar year or for that year and the year following.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
22-020
02

General Comments

Section 22-020 will be included when the vision plan has a PPO benefit structure.

The appropriate term (e.g., Limited, Comprehensive and/or PPO) will be included to reflect the coverage selected by the policyholder and it will be reflected throughout the text.

About the [Limited] [Comprehensive][PPO] Vision [Expense Insurance] [Plan]

1. The second paragraph will be included for PPO plans.
2. The third paragraph will be included for network based plans. (PPO plans).
3. The fourth paragraph may be omitted.
4. The sixth bulleted item will be included for plans that only cover services and supplies in-network or cover some services and supplies in-network only.

Availability of Providers

This section may be omitted or moved to the General Provisions Section.

Ongoing Reviews

This section may be omitted if the plan does not conduct reviews.

How Your Plan Works

This section will be included when the plan is a PPO plan. This section will be omitted when this type of coverage is not provided in a plan of benefits.

Accessing Network Providers and Benefits

5. The fourth bulleted item may be omitted or moved to the “Cost Sharing”, “Schedule of Benefits”, or other section where it may be more appropriate. If all communications are handled electronically and not through the mail, the third sentence of this item will be revised accordingly.

Cost Sharing for [Network] Benefits

6. The first bulleted item will be included if the plan has a deductible(s).
7. The second bulleted item will be included if the plan has network copayments. The term “copayment” may be changed to “copay”.
8. Under the third bulleted item: The first sentence and the beginning of the second sentence will be included if the plan has a deductible(s).
9. The second half of the second sentence will be include if the plan includes member coinsurance responsibility.

Aetna Life Insurance Company

Explanation of Variability

GR-9N

22-020

02

10. The third sentence will be included when the policyholder's plan includes a maximum on the member's coinsurance or out-of-pocket expenses.

11. The fourth bulleted item will be included when the policyholder's plan includes a maximum on the member's coinsurance or out-of-pocket expenses. When included, the reimbursement of expenses at 100% may apply for the remainder of that calendar year or for that year and the year following.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
22-025
02

General Comments

Section 22-025 will be included when out-of-network PPO coverage is provided in a plan of benefits.

The appropriate section references will be included.

Accessing Out-of-Network Providers and Benefits

1. The fourth bulleted item may be omitted or moved to the “Cost Sharing” or the “Schedule of Benefits” section where it may be more appropriate.
 - The appropriate cost sharing term(s) will be included.

Cost Sharing for Out-of-Network Benefits

The Important Note will be included as a standard; it may be omitted at the election of the policyholder.

2. The first bulleted item will be included if the plan has a deductible(s).
3. In the second bulleted item, the first phrase will be included when the policyholder’s plan has a deductible.
4. The third bulleted item will be included when the plan has coinsurance.
5. The fourth bulleted item will be included when the plan has a coinsurance limit or maximum out-of-pocket limit.

Aetna Life Insurance Company
[Basic][Limited][Comprehensive][PPO] Vision [Expense Insurance][Plan]
Explanation of Variability
GR-9N
24-005
02

General Comments

Section 24 will be included when the vision plan is part of the medical plan or purchased as a stand alone plan.

The appropriate plan reference (e.g., Basic, Limited, Comprehensive or PPO) will be included.

Reference to “Expense Insurance” may be omitted.

Reference to “Plan” may be changed to “Coverage”.

What The Plan Covers

1. The phrase “and supplies” will be included when the plan covers vision care supplies. It will be omitted when only exams are covered.
2. In accordance with the policyholder’s plan, either “calendar year” or “benefit period” will be included.

Vision Exams

3. The section on Vision Exams will be included when the plan covers eye exams. It may be omitted if exams are covered under the medical plan, and only vision supplies are covered in this section. The second and/or third bulleted items will be included or omitted in accordance with the policyholder’s plan.

Limitations

4. The Limitations will be included in accordance with the policyholder’s plan.
 - The appropriate cost sharing terms will be included in accordance with the policyholder’s plan.
 - The appropriate section reference will be included.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
24-010
02

Vision Supplies

1. In the first sentence, the phrase “or prescription lenses” may be omitted.

Prescription Lenses

In the first paragraph, the statement regarding coverage of new lenses due to a change in prescription may be included if applicable to the policyholder’s plan of benefits.

The second paragraph regarding contact lens charges will be included when coverage is part of a policyholder’s plan.

The section starting with “in an amount equal to...” may be omitted. If this section applies, it will include the items and frequency limits applicable under the policyholder’s plan.

The section starting with “A vision examination may result in ...” may be included when coverage is part of a policyholder’s plan.

2. The provisions for aphakic, contact, standard and premium progressive lenses may be included when such coverage is elected by the policyholder, or if these benefits are not otherwise provided under the medical plan.

Frames

3. The section on frames will be included when part of the policyholder’s plan.

Benefits for Vision Care Supplies After Your Coverage Terminates

4. This section will be included when the policyholder’s plan provides an extension. The time frames may be increased.

Aetna Life Insurance Company
Exclusions
Explanation of Variability
GR-9N
28-000
02

General Comments

These general comments apply to the entire section. If no other variables are specified, only these general comments apply.

This section will be included if a policyholder's plan includes Basic, Limited or Comprehensive Vision Expense Insurance.

Any bracketed exclusion may be removed in its entirety if not applicable to the policyholder's plan of benefits. Any exclusion applicable to a specific coverage may be repeated in the coverage sections at the end of the coverage description to assist readers to better understand the applicable covered expense(s).

Brackets within the exclusion indicate the exclusion may be modified in accordance with the policyholder's plan. For example, certain parts of the exclusion or services or supplies may be omitted if covered under the policyholder's plan of benefits.

Reference to "Booklet-Certificate" may be changed to "Certificate" or "Certificate of Coverage".

Reference to "Schedule of Benefits" may be changed to "Summary of Benefits", "Schedule of Coverage", or "Summary of Coverage".

Reference to "policyholder" and/or "employer" may be changed to "association", "plan sponsor", "contract holder", "participating employer", or "member group".

Reference to "medical" may be changed to "health".

Aetna Life Insurance Company
Exclusions that Apply to Vision Care Insurance Coverage
Explanation of Variability
GR-9N
28-030
02

Note

The exclusions in this section 28-030 may be moved to the medical exclusions list when Aetna medical coverage is also purchased.

Throughout this section, each bracketed exclusion may be omitted, or specific services or supplies mentioned within the exclusion may be omitted if the policyholder has elected to provide coverage.

Exclusions That Apply to Vision Care Insurance Coverage

References to specific sections of the Policy and Booklet-Certificate will be revised to reflect any changes to the names of those sections, and to list other sections should it be appropriate.

1. The reference to “What the Plan Covers” may be changes to another section applicable to the policyholder’s plan.
2. The statement “These vision exclusions are in addition to the exclusions listed under your medical coverage” will print if the policyholder has purchased medical coverage.
3. Any of the exclusions listed may be included or omitted in accordance with the policyholder’s plan.
4. The phrase “under any other part of this plan” may be omitted for a standalone vision plan.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
34-000
03

General Comments

These general comments apply to the entire section. If no other variables are specified, only these general comments apply.

A particular definition will appear in this Glossary for the Booklet-Certificate only when that term is applicable to the plan of benefits purchased by the policyholder. Therefore, any definition may be included.

All bracketed phrases, terms, may be omitted as applicable to a particular policyholder's plan.

If a term is approved with multiple options, for example (e.g. "formulary" changed to "preferred drug list"), then that defined term will be integrated under the appropriate alphabetical listing within this glossary. For the example given, it would mean that the drug guide definition would move from "F" to "P" within the issued documents

Reference to "Booklet-Certificate" may be changed to "Certificate" or "Certificate of Coverage".

Reference to "dependents" will be omitted if the plan does not include such coverage.

Reference to "calendar year" or "policy year" are interchangeable, or may be changed to "plan year", "contract year", "policy term", "contract term", "365 consecutive day period" or "12 consecutive month period".

Reference to "illness" may be changed to "disease".

Reference to "employee" may be changed to "subscriber", "enrollee", "member", or "you".

Reference to "policyholder" and/or "employer" may be changed to "association", "plan sponsor", "contract holder", "participating employer", or "member group".

Reference to "network" may be changed to "in-network", "participating" or "preferred" or it may be omitted if the plan does not have a network.

Reference to "out-of-network" may be changed to "non-participating", "non-preferred" or "non-network" or it may be omitted if the plan is not a network based plan.

Reference to "medical" may be changed to "health".

Aetna Life Insurance Company
Explanation of Variability
GR-9N
34-080
05

Glossary Letter ‘P’

General

Each defined term will be included as appropriate and applicable to the policyholder’s plan of benefits.

Predisability Earnings: These are examples of how Predisability Earnings may be defined by a policyholder. Any of the six definitions of Predisability Earnings shown may be included in a group policyholder's plan, as appropriate. Within each such definition, terminology may be included, omitted or modified to agree with the specifics of the policyholder's plan design (compensation terms applicable to covered persons; any special payroll, industry or occupation-specific method or schedule for paying employees; special types of employees.) For example, "monthly" may be changed to "weekly"; "bonuses" may be changed to "performance incentive bonuses", time frames may be increased or decreased; and items appearing on any list may be included, omitted or modified to reflect the policyholder's needs and plan design.

Other definitions:

1. The definition of Partial Confinement Treatment will include the appropriate combination of services and categories of covered expenses applicable to the policyholder’s plan. The reference to “severe” mental illness may be change to “serious” or “biologically based.”
2. The definition of Pharmacy will include reference to the types of pharmacies included under a policyholder’s plan of benefits. The appropriate term(s) will be used in accordance with the policyholders’ plan.
3. Under the definition of Physician, the fifth bulleted item of the second paragraph will include the appropriate combination of services and categories of covered expenses applicable to the policyholder’s plan. The reference to “severe” mental illness may be change to “serious” or “biologically based.”
4. Either the term “precertification” or “precertify” will be used in accordance with the policyholder’s plan.
5. The Premium Progressive lenses definition will be included if the plan has vision coverage, and the policyholder elects to provide coverage for these lenses under the plan.
6. Under the definition of Prescription, either the defined term “prescriber” will be used, or the definition of prescriber will be incorporated into this definition.
7. Under the definition of Prescription Drug, the term “injectable” may or may not be included.

Aetna Life Insurance Company

Explanation of Variability

GR-9N

34-080

05

8. Under the definition of Primary Care Dentist, the term “network” may be changed to another term, (e.g., participating). In the second bulleted item the words “initial care and basic” may or may not be included.
9. Under the definition of Primary Care Physician, the term “network” may be changed to another term, (e.g., participating).
10. Under the definition of Psychiatric Hospital, the first bulleted item will include the appropriate combination of services and categories of covered expenses applicable to the policyholder’s plan. The reference to “severe” mental illness may be change to “serious” or “biologically based.”
11. Under the definition of Psychiatric Physician, the second bulleted item will include the appropriate combination of services and categories of covered expenses applicable to the policyholder’s plan. The reference to “severe” mental illness may be change to “serious” or “biologically based.”

Aetna Life Insurance Company
Glossary
Explanation of Variability
GR-9N
34-095
05

Glossary Letter ‘S’

General

The defined terms on this form will be included as appropriate for a policyholder’s plan of benefits.

1. In the definition of self injectables, the word “self” may be omitted.
2. In the definition of severe mental illness the word “severe” may be changed to “organic-based” “serious”, or “biologically-based”. The term “mental illness” may be changed to “mental disorder”.
3. In the definition of skilled nursing facility, this may be changed to “convalescent facility”. The eighth bulleted item in this definition may or may not be included.
4. The definition of Standard Progressive Lenses will be included if the plan has vision coverage, and the policyholder elects to provide coverage for these lenses under the plan.
5. In the definition of step therapy, “www.Aetna.com/formulary” is the current site name of Aetna’s online preferred drug guide. This will be revised to reflect the appropriate site name if it changes.

Aetna Life Insurance Company
Vision Care Expense Insurance
Explanation of Variability
GR-9N
24-000
01

General Comments

These general comments apply to the entire section. If no other variables are specified, only these general comments apply.

The appropriate plan reference (e.g., Basic, Limited, Comprehensive, PPO) will be used based on the plan elected by the policyholder.

The following terms may be omitted or revised as indicated:

- “expense insurance” will be omitted when “plan” is used and visa versa;
- “insurance” and “plan” may be changed to “coverage” or other term of similar meaning;
- “Booklet-Certificate” may be changed to “Certificate” or “Certificate of Coverage”;
- “Schedule of Benefits” may be changed to “Summary of Benefits”, “Schedule of Coverage”, or “Summary of Coverage”.

References to specific sections of the policy and the Booklet-Certificate will be revised to reflect any changes to the names of those sections, and to list other sections should it be appropriate.

The benefits shown will correspond to the particular coverage provided by the policyholder’s plan of insurance, and will vary, depending on plan design. Variability is required so that only the appropriate information for the plan elected by the policyholder will be shown.

Connective words and phrases which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of coverage may vary as sense may demand. Such connective wording will not be ambiguous or deceptive.

The placement of material may vary to avoid gaps and to allow the contractual documents to be system-produced. Information in the Schedule of Benefits may be moved to the Booklet-Certificate.

Aetna Life Insurance Company
Vision Care Expense Insurance
Explanation of Variability
GR-9N
22-000
01

General Comments

These general comments apply to the entire section. If no other variables are specified, only these general comments apply.

The appropriate plan reference (e.g., Basic, Limited, Comprehensive, PPO) will be used based on the plan elected by the policyholder.

The following terms may be omitted or revised as indicated:

- “expense insurance” will be omitted when “plan” is used and visa versa;
- “insurance” and “plan” may be changed to “coverage” of other term of similar meaning;
- “recognized charge” may be changed to “recognized amount”; “reasonable charge”; “reasonable and customary charge; or other term of similar meaning;
- “copayment” may be changed to “copay”;
- “maximum out-of-pocket limit” may be changed to “coinsurance limit”; “payment limit”; or other term of similar meaning;
- “Booklet-Certificate” may be changed to “Certificate” or “Certificate of Coverage”;
- “Schedule of Benefits” may be changed to “Summary of Benefits”, “Schedule of Coverage”, or “Summary of Coverage”.

“Member Services”, “www.aetna.com” and “DocFind” (Aetna’s on-line provider directory), are variable throughout the document as department names and website addresses etc. change over time. The appropriate name will be included if changed.

References to specific sections of the policy and the Booklet-Certificate will be revised to reflect any changes to the names of those sections, and to list other sections should it be appropriate.

The benefits shown will correspond to the particular coverage provided by the policyholder’s plan of insurance, and will vary, depending on plan design. Variability is required so that only the appropriate information for the plan elected by the policyholder will be shown.

Connective words and phrases which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of coverage may vary as sense may demand. Such connective wording will not be ambiguous or deceptive.

The placement of material may vary to avoid gaps and to allow the contractual documents to be system-produced. Information in the Schedule of Benefits may be moved to the Booklet-Certificate.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
S-24-000
02

General Comments

These general comments apply to the entire section. If no other variables are specified, only these general comments apply.

This section will be included if a policyholder's plan includes Basic, Limited or Comprehensive Vision Expense Insurance. The appropriate plan reference (e.g., Basic, Limited, Comprehensive) will be used based on the plan elected by the policyholder. The structure allows the plan design to contain different cost-sharing and benefit limits based on the type of service or supply.

The fields in the upper right "header" are variable and illustrative. When included they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.

Connective words and phrases which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of coverage may vary as sense may demand. Such connective wording will not be ambiguous or deceptive.

References to "Schedule of Benefits" may be changed to "Summary of Benefits", "Schedule of Coverage" or "Summary of Coverage".

The placement of material may vary to avoid gaps and to allow the contractual documents to be system-produced. Information in the Schedule of Benefits may be moved to the Booklet-Certificate.

Vision coverage can apply on a plan year, calendar year or, 12 to 24 month period basis as elected by the policyholder.

If the policy holder elects different benefit levels for dependent children, diabetic and post-cataract patients, the benefit level selected by the policyholder will show on the Schedules of Benefits. However, separate benefit options will only be included to provide dependent children, diabetic and post-cataract patients with a better benefit. If the policyholder does not elect separate benefits for these individuals, references to "adult" may be omitted.

If dependents are not covered under the policyholder's plan, all provisions that are specific to dependent coverage will be omitted.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
S-24-000
02

Comments Regarding Benefits

The benefits shown will correspond to the particular coverage provided by the policyholder's plan of insurance, and will vary, depending on plan design. Variability is required so that only the appropriate information for the plan elected by the policyholder will be shown. Any cost-sharing restrictions (e.g., coinsurance differential between network and out-of-network expenses) will be applied in accordance with applicable state law.

When the policyholder elects coverage with a network component, all three columns will be used. The third column reflects the coverage level that would apply in any instance where a covered person is located in an area where they do not have access to network providers and when the Aetna network does not include any/does not include an adequate number of specific providers, (e.g., ophthalmologists), within a broader category of providers, (e.g., physicians).

When the benefit amounts are combined for in-network, out-of-network and other health care coverage, all benefit amounts may appear only in the first column. When such benefit amounts are applied independently to in-network, out-of-network or other health care coverage all benefit amounts shown in the first column will be omitted.

References to copayments and deductibles and all corresponding copayment and deductible provisions may be omitted when a policyholder's plan does not include these cost sharing features. When included as part of a policyholder's plan, the plan may contain either an individual or individual and family deductible. Copayment and deductible amounts will vary within the ranges shown in accordance with the policyholder's plan.

The calendar year deductible may be waived for any expense. When waived, "No deductible applies" will be included for that expense.

Per visit copayments and deductibles may be included. When a per visit copayment is included, a per visit deductible may also be included. When a per visit deductible is included, a per visit copayment may also be included. When included, the amounts will vary within the ranges shown, and will reflect the policyholder's plan design. A calendar year deductible may apply when a per visit copayment or deductible applies.

The coinsurance percentage will be completed to reflect the percentage selected by the policyholder. The plan coinsurance will vary between the ranges shown. The calendar year deductible may be included.

"Not covered" will be included when an expense is not covered out-of-network.

Benefit maximums may be applied. When a maximum does not apply, the maximum benefit line will be omitted. When included, any dollar amounts or durations will vary within the ranges shown, and will reflect the benefit maximum selected by the policyholder.