



**Preferred Provider Organization (PPO)
Vision Plan**

Schedule of Benefits

If this is an ERISA plan, you have certain rights under this plan. Please contact the **policyholder** for additional information.

Prepared exclusively for:

Policyholder: Spectrum Academy Charter
Policyholder number: GP-0236514-B
Schedule of Benefits: 1A
Group policy effective date: September 1, 2023
Plan effective date: September 1, 2023
Plan issue date: August 24, 2023

Underwritten by Aetna Life Insurance Company
Based in the state of Connecticut
151 Farmington Avenue
Hartford, CT 06156
860-273-0123

Schedule of benefits

This schedule of benefits lists the **eligible vision services** and supplies, benefit frequency limits, and maximums, if any, that apply to the services you get under this plan.

How to read your schedule of benefits

- You are responsible for full payment of any vision care service you receive that is not a **covered benefit** or that exceeds your benefit frequency limit.
- This plan also has **maximum allowances** for specific in-network **covered benefits**. These are dollar amount maximums for **covered benefits**.
- This plan has **scheduled limits** for specific out-of-network **covered benefits**. These are dollar amount maximums for **covered benefits**.
- You are responsible to pay any **copayments** listed in the schedule of benefits below, if they apply.

How to contact us for help

We are here to answer your questions.

- Log in to your member website at <https://www.aetna.com/>
- Call the toll-free number on your ID card

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on your plan **copayment** or maximum benefit when the service or supply is provided, not when payment is made. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Benefit frequency limits

In-network and out-of-network combined

Vision examinations

Description	Limit
Vision examinations	Once every 12 months

Vision materials

Description	Limit
Frames	1 pair every 12 months
Lenses	1 pair every 12 months
Contact lenses	1 order every 12 months

Vision materials important note:

During each benefit frequency period, your plan will cover either **prescription** eyeglass lenses or **prescription** contact lenses.

Eligible vision services

Vision examinations

Description	In-network coverage	Out-of-network coverage
Comprehensive eye exam	\$10 copayment	\$25 scheduled limit

Vision materials

Frames

Description	In-network coverage	Out-of-network coverage
Brand names	\$0 copayment then the plan pays up to \$130 maximum allowance	\$65 scheduled limit

Standard plastic prescription lenses

Description	In-network coverage	Out-of-network coverage
Single Vision	\$10 copayment	\$20 scheduled limit
Bifocal	\$10 copayment	\$40 scheduled limit
Trifocal	\$10 copayment	\$65 scheduled limit
Lenticular	\$10 copayment	\$65 scheduled limit

Standard progressive	\$75 copayment	\$40 scheduled limit
Premium progressive	\$75 copayment then the plan pays up to \$120 maximum allowance	\$40 scheduled limit

Contact lenses

Only one of the following contact lens types may be used for the contact lenses benefit per benefit period

Conventional contact lenses	\$0 copayment then the plan pays up to \$130 maximum allowance	\$90 scheduled limit
Disposable contact lenses	\$0 copayment then the plan pays up to \$130 maximum allowance	\$104 scheduled limit

Non-conventional (medically necessary) contact lenses	\$0 copayment	\$200 scheduled limit
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Lens options

Description	In-network coverage	Out-of-network coverage
Standard polycarbonate lenses (Dependent child under 19 years of age)	\$0 copayment	\$35 scheduled limit
Scratch coating	\$0 copayment	\$15 scheduled limit