



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

**Schedule of Benefits**

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

**Prepared exclusively for:**

<b>Policyholder:</b>	Tradesmen International
<b>Group policy number:</b>	GP-100419
	<b>Control Number: 868653</b>
Schedule of Benefits	3A
<b>Group policy effective date:</b>	January 1, 2020
Plan effective date:	January 1, 2020
Plan issue date:	March 31, 2020

**Underwritten by Aetna Life Insurance Company in the state of Ohio.**

## Schedule of benefits

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This schedule of benefits lists the **eligible vision services** and supplies, Calendar Year and 12 consecutive month period frequency limits, maximums, if any, that apply to the services you get under this plan.

### How to read your schedule of benefits

- You are responsible for full payment of any vision care services you receive that are not a **covered benefit** or that exceed your Calendar Year and 12 consecutive month period frequency limit.
- This plan also has a **maximum allowance** for specific **covered benefits**. These are dollar amount maximums for **covered benefits**.

### How to contact us for help

We are here to answer your questions.

- Log onto your secure member website at [www.aetna.com](http://www.aetna.com).
- Call Member Services at the toll-free number on your ID card.

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

### General coverage provisions

This section explains the:

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

listed in this *Schedule of Benefits*.

### Copayment

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

### Scheduled limit

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

### Maximum allowance

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

### Your financial responsibility and determination of benefits provisions

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

## Plan features

Eligible vision services	In-network coverage	Out-of-network coverage
<b>Vision examination</b>		
<b>Routine eye exam</b>	\$20 copayment	\$20 scheduled limit
Maximum benefit per 12 consecutive month period	1 visit	
<b>Prescription lenses</b>		
<b>Single Vision</b>	\$20 copayment	\$15 scheduled limit
Maximum benefit per 12 consecutive month period	1 pair of lenses	
<b>Bifocal</b>	\$20 copayment	\$30 scheduled limit
Maximum benefit per 12 consecutive month period	1 pair of lenses	
<b>Trifocal</b>	\$20 copayment	\$60 scheduled limit
Maximum benefit per 12 consecutive month period	1 pair of lenses	
<b>Lenticular</b>	\$20 copayment	\$60 scheduled limit
Maximum benefit per 12 consecutive month period	1 pair of lenses	
<b>Standard progressive</b>		
\$85 copayment	\$30 scheduled limit	
Maximum benefit per 12 consecutive month period	1 pair of lenses	
<b>Premium progressive</b>		
\$85 copayment then the plan pays up a \$120 maximum allowance	\$30 scheduled limit	
Maximum benefit per 12 consecutive month period	1 pair of lenses	

<b>Frames</b>		
	<b>\$100 maximum allowance</b>	<b>\$50 scheduled limit</b>
Maximum benefit per 24 consecutive month period	1 frame	
<b>Contact Lens</b>		
<b>Conventional contact lens</b>	<b>\$105 maximum allowance</b>	<b>\$75 scheduled limit</b>
Maximum benefit per 12 consecutive month period	1 order	
<b>Disposable contact lens</b>	<b>\$105 maximum allowance</b>	<b>\$75 scheduled limit</b>
Maximum benefit per 12 consecutive month period	1 order	
<b>Medically necessary contact lens</b>	<b>\$0 copayment</b>	<b>\$200 scheduled limit</b>
Maximum benefit per 12 consecutive month period	1 order	