For certain types of services and supplies, you will be responsible for any copayment shown in this *Schedule of Benefits*. The plan will pay for covered expenses, up to the maximums shown. You are responsible for any expenses incurred over the maximum limits outlined in this *Schedule of Benefits*. You may be billed for any copayment or coinsurance amounts, or any non-covered expenses that you incur.

Schedule of Benefits

(GR-9N S-01-001-01)

Employer: **Millard Public Schools**

Group Policy Number: **GP-737381**

Issue Date: April 20, 2016
Effective Date: January 1, 2016
Schedule: 2A
Cert Base: 2

For: Aetna Vision Preferred

Schedule of Aetna Vision Preferred Benefits *(GR-9N-S-24-015-01 NE)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Eye Exam	$10 per visit copay	100% per visit
Maximum Benefit per Routine Eye Exam	Unlimited	$35
Maximum number of Routine Eye Exams per 12 months	1	1

Schedule of Aetna Vision Preferred Benefits *(GR-9N-S-24-020-01 NE)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Eyewear Lenses		
Single Vision lenses (2 lenses)	$25 copay	100%
Maximum Benefit for single vision lenses once per 12 months	Unlimited	$25
Bifocal Vision lenses (2 lenses)	$25 copay	100%
Maximum Benefit for bifocal vision lenses once per 12 months	Unlimited	$40
Trifocal Vision lenses (2 lenses)	$25 copay	100%
Maximum Benefit for trifocal vision lenses once per 12 months	Unlimited	$55
Lenticular Vision lenses (2 lenses)	$25 copay	100%
Maximum Benefit for lenticular vision lenses once per 12 months	Unlimited	$55
Standard Progressive (2 lenses)	*	100%
Maximum Benefit for Standard Progressive vision lenses once per 12 months	*	$40
***Please refer to the plan design summary provided by your employer for any discount arrangements that may apply.**		
Premium Progressive (2 lenses)	*	100%
Maximum Benefit for Premium Progressive vision lenses once per 12 months	*	$40
***Please refer to the plan design summary provided by your employer for any discount arrangements that may apply.**		

Contact Lenses		
Conventional (2 lenses)	100%	100%
Maximum Benefit for conventional lenses once per 12 months	$130	$104
Disposable contacts (per set)	100%	100%
Maximum Benefit for disposable lenses once per 12 months	$130	$104
Contact lenses needed 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.	100%	100%
Maximum Benefit for contact lenses per lifetime	Unlimited	$210

Schedule of Aetna Vision Preferred Benefits *(GR-9N-S-24-025-01 NE)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Lenses Options		
Standard Polycarbonate Lenses (for covered dependent children under 19 years of age) (one set)	100%	100%
Maximum Benefit for Standard Polycarbonate lenses (for covered dependent children) once per 12 months	Unlimited	$5
Standard Plastic Scratch Coating	100%	100%
Maximum Benefit for Standard Plastic Scratch Coating per 12 months	Unlimited	$5

Schedule of Aetna Vision Preferred Benefits *(GR-9N-S-24-030-01 NE)*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Eyewear - Frames	100%	100%
Maximum Benefit for one set of frames per 24 months	$130	$65

Expense Provisions *(GR-9N S-09-05 01)*

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

The insurance described in this *Schedule of Benefits* will be provided under Aetna Life Insurance Company's policy form GR-29N.

Keep This Schedule of Benefits With Your Booklet-Certificate.

Copayment Provisions *(GR-9N S-09-05 01)*

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

General *(GR-9N S-28-01 01)*

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet-Certificate and should be kept with your Booklet-Certificate form GR-9N. Coverage is underwritten by Aetna Life Insurance Company.