### Summary of Benefits for Rice University

**Effective Date:** 07-01-2018  
**Frequency:** 12/12/24  
**Plan External Plan ID:** 9918533144  
**Line Value:** 343

#### Exam
Use your Exam coverage once every calendar year.

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine/Comprehensive Eye Exam</td>
<td>$20 Copay</td>
<td>$20 Reimbursement</td>
</tr>
<tr>
<td>Standard Contact lens Fit/Follow up</td>
<td>Member pays discounted fee of $40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Premium Contact Lens Fit/Follow-Up</td>
<td>Member pays 90% of retail</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

#### Eyeglass Lenses / Lens options
Use your Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision lenses</td>
<td>$20 Copay</td>
<td>$15 Reimbursement</td>
</tr>
<tr>
<td>Bifocal Vision lenses</td>
<td>$20 Copay</td>
<td>$30 Reimbursement</td>
</tr>
<tr>
<td>Trifocal Vision lenses</td>
<td>$20 Copay</td>
<td>$60 Reimbursement</td>
</tr>
<tr>
<td>Lenticular Vision lenses</td>
<td>$20 Copay</td>
<td>$60 Reimbursement</td>
</tr>
<tr>
<td>Standard Progressive Vision lenses</td>
<td>$85 Copay</td>
<td>$30 Reimbursement</td>
</tr>
<tr>
<td>Premium Progressive Vision lenses</td>
<td>20% Discount off retail minus $120 plan allowance plus $85 Copay = member out-of-pocket</td>
<td>$30 Reimbursement</td>
</tr>
<tr>
<td>UV Treatment</td>
<td>Member pays discounted fee of $15</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>Member pays discounted fee of $15</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>Member pays discounted fee of $15</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Polycarbonate lenses - Adult</td>
<td>Member pays discounted fee of $40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Polycarbonate lenses - Children to age 19</td>
<td>Member pays discounted fee of $40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>Member pays discounted fee of $45</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Photochromic/Transitions plastic</td>
<td>Member pays 80% of Retail</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Polarized</td>
<td>Member pays 80% of Retail</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

#### Contact Lenses
Use your Contact Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional contact lenses</td>
<td>$105 Allowance**</td>
<td>$75 Reimbursement</td>
</tr>
<tr>
<td>Disposable contact lenses</td>
<td>$105 Allowance</td>
<td>$75 Reimbursement</td>
</tr>
<tr>
<td>Medically necessary contact lenses</td>
<td>$0 Copay</td>
<td>$200 Reimbursement</td>
</tr>
</tbody>
</table>

#### Frames
Use your Frame coverage once every 2 calendar years.

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Frame available, including frames for prescription sunglasses</td>
<td>$100 Allowance</td>
<td>$50 Reimbursement</td>
</tr>
</tbody>
</table>

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**Financial well-being**  
**Intelligent solutions**

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[Visit www.aetnavision.com]
Discounts
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.

<table>
<thead>
<tr>
<th></th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances** have been exhausted.</td>
<td>Up to a 40% Discount</td>
<td>No Discount</td>
</tr>
<tr>
<td>Non-covered items such as cleaning cloths and contact lens solution1</td>
<td>20% Discount</td>
<td>No Discount</td>
</tr>
<tr>
<td>Lasik Laser vision correction or PRK from U.S. Laser Network® only. Call 1-800-422-6600</td>
<td>15% discount off retail or 5% discount off the promotional price</td>
<td>No Discount</td>
</tr>
<tr>
<td>Retinal Imaging2</td>
<td>Member pays a discounted fee up to $39</td>
<td>No Discount</td>
</tr>
<tr>
<td>Replacement contact lenses</td>
<td>Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit <a href="http://www.aetnavision.com">www.aetnavision.com</a> for details</td>
<td>No Discount</td>
</tr>
</tbody>
</table>

Partial list of exclusions and limitations
Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

1Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.
2You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @ 877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.
3**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.
4Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.
5Non covered discounts may not be available in all states.
6Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
7Retinal imaging available at participating locations. Contact your eyecare provider to verify if available.

Key Definitions
Copayment - The fixed amount paid by the member under the plan. Providers should collect all copayments
Allowance - Dollar amount to be applied toward the cost of materials or a service
Reimbursement - Dollar amount to be paid to the member from Aetna up to the providers' billed charge
Out-of-Pocket - The amount the member must pay after benefits have been applied
Discount - Percentage off the providers billed charge or retail cost
Standard Polycarbonate - 1.5 mm center thickness with spherical curves
Standard Scratch-Resistant Coating - Front-side factory scratch coat
Standard Progressive Lens - Multi-focal design that produce a gradual change in focus without lines or junctions
Conventional Contact Lens - Lenses intended for ongoing, daily-wear use; rigid-gas-permeable lenses are included
Disposable Contact Lens - Lenses that are designed and labeled to be replaced at specified time intervals (e.g., daily, weekly, monthly)
Medically Necessary Contact Lenses - To correct visual acuity to 20/40 or better if such correction is not possible with conventional lenses; or if aphakic lenses are prescribed after cataract surgery.

Providers participating in the Aetna Vision network are contracted through EyeMed Vision Care, LLC. EyeMed and Aetna are independent contractors and not employees or agents of each other. Participating vision providers are credentialed by and subject to the credentialing requirements of EyeMed. Aetna does not provide medical/vision care or treatment and is not responsible for outcomes. Aetna does not guarantee access to vision care services or access to specific vision care providers and provider network composition is subject to change without notice.

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

Coverage is not provided for the following:
- Special vision procedures, such as orthoptics, vision therapy, or vision training.
- Vision services that are covered in whole or in part; 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.
- 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.
- For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- Replacement of lost, stolen or broken prescription lenses or frames.
- Any exams given during a stay in a hospital or other facility for medical care.
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