Lee County
Southwest Florida

2018 Open Enrollment

Please read your attachments regarding your Summary of Benefits Coverage.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	None
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Member Coinsurance	Covered 100%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$1,500 Individual $3,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Only those preferred expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	
Routine Well Child Exams/Immunizations	Covered 100%
7 exams in the first 12 months of life, 3 exams in the second 12 months of life; 3 exams in the third 12 months of life; 1 exam per 12 months thereafter to age 18.	
Routine Gynecological Care Exams	Covered 100%
Includes routine tests and related lab fees	
Routine Mammograms	Covered 100%
One baseline mammogram for covered females age 35-39 and 1 routine mammogram per calendar year for covered females age 40 and over.	
Women's Health	Covered 100%
Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%
For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%
For all members age 50 and over.	
Routine Eye Exams	Covered 100%
1 routine exam per 12 months	
Routine Hearing Exams	Covered 100%
1 routine exam per 12 months	
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP	$10 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$25 office visit copay
Pre-Natal Maternity	Covered 100%
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;
Allergy Testing	**Covered as either PCP or specialist office visit**
Allergy Injections (Copay waived when an office visit is not made)	Covered as either PCP or specialist office visit
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**
Diagnostic Laboratory and X-ray except for Complex Imaging Services	$25 copay
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	
Diagnostic X-ray for Complex Imaging Services	$50 copay
EMERGENCY MEDICAL CARE	**PREFERRED CARE**

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Urgent Care Provider (benefit availability may vary by location)	$50 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$150 copay
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	**PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay
Outpatient Surgery	Covered 100% after $200 outpatient surgery copay
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	Covered 100%
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered same as Inpatient Hospital services.
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$25 copay
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered same as Inpatient Hospital services.
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	$25 copay
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	Covered 100% after $500 per confinement copay
Home Health Care Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%
Hospice Care - Inpatient Unlimited number of days. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year) Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.	Covered 100%
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 80 visits per calendar year.	$25 copay
Chiropractic Care Limited to 20 visits per calendar year	$25 copay
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100% (payable as any other covered expense)
Generic FDA-approved Women's Contraceptives	Covered 100%
Transplants Coverage is provided at an IOE contracted facility only.	Covered 100% after $500 per confinement copay
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	Coverage provided at 20%, all benefits and limitations apply.
FAMILY PLANNING	**PREFERRED CARE**

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Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services	Covered 100%
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.	
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered;
Tubal Ligation	Covered 100%;
PHARMACY	**PREFERRED CARE**
Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.
Mail Order	$0 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.	
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.	
Precert for growth hormones included	
Formulary Generic FDA-approved Women's Contraceptives covered 100% in network	
Prescription Drug Annual Out of Pocket Maximum	Individual Family
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-855-281-8858 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

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All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. 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 without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary.

Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

aetna : LEE COUNTY BOARD OF COUNTY COMMISSIONERS : Aetna Open Access® Aetna Select℠

Coverage for: Individual + Family | **Plan Type:** EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.HealthReformPlanSBC.com** or by calling **1-800-370-4526**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $0 / Family $0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: Individual $1,500 / Family $3,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	Not covered	None
	Specialist visit	$25 copay/visit	Not covered	None
	Preventive care / screening / immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	Copay/prescription: $10 (retail), $0 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription: $20 (retail), $40 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: $35 (retail), $70 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	$50 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $25 copay/visit	Not covered	None
	Inpatient services	$500 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$500 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	120 visits/calendar year, including up to 70 visits for private-duty nursing.
	Rehabilitation services	$25 copay/visit	Not covered	80 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$25 copay/visit	Not covered	Limited to children up to age 18 for Autism.
	Skilled nursing care	$500 copay/stay	Not covered	120 days/calendar year.
	Durable medical equipment	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$500 copay/stay for inpatient; no charge for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 separate attempts/lifetime.
- Private-duty nursing - 70- 8 hour shifts/calendar year combined with home health care.
- Routine eye care (Adult) - 1 routine eye exam/12 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? **Yes.**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-370-4526.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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Lee County BOCC
Effective Date:01-01-2018
Choice™ POS II - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	None Individual None Family	$500 Individual $1,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise	Unlimited except where otherwise
Primary Care Physician Selection	Optional	Not applicable
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $500 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	Covered 100%	Not Covered
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life; 1 exam per 12 months thereafter to age 18.	Covered 100%	30% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees; 1 exam per calendar year.	Covered 100%	Not Covered
Routine Mammograms One baseline mammogram for covered females aged 35-39 and 1 routine mammogram per calendar year for covered females age 40 and over.	Covered 100%	30% after deductible
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Eye Exams	Covered 100%	Not Covered

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1 routine exam per 12 months

Routine Hearing Exams 1 routine exam per 12 months	Covered 100%	Not Covered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay	30% after deductible
Specialist Office Visits	$35 office visit copay	30% after deductible
Pre-Natal Maternity	Covered 100%	Not Covered
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;	30% after deductible
Allergy Testing	**Covered as either PCP or specialist office visit**	30% after deductible
Allergy Injections	Covered as either PCP or specialist office visit	30% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray except for Complex Imaging Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	$35 copay	30% after deductible
Diagnostic X-ray for Complex Imaging Services	$50 copay	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$150 copay	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	100%; deductible waived
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Inpatient Maternity Coverage The newborn child will also be subject to the per confinement copay and if applicable the non-preferred calendar year deductible, separate from the mother's. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Outpatient Surgery	Covered 100% after $200 outpatient surgery copay	30% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	Covered 100%	30% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$35 copay	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered same as Inpatient Hospital services.	Covered same as Inpatient Hospital services; after deductible

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Outpatient	$35 copay	Covered same as Specialist Office visit; after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%	50% after deductible
Hospice Care - Inpatient	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%	30% after deductible
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year) Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.	Covered 100%	30% after deductible
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 80 visits per calendar year.	$35 copay	30% after deductible
Chiropractic Care Limited to 20 visits per calendar year	$35 copay	30% after deductible
Durable Medical Equipment	Covered 100%	30% after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100% (payable as any other covered expense)	30% (payable as any other covered expense) after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%	Not Covered
Transplants	Covered 100% after $500 per confinement copay Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Out of Area Dependents	Coverage provided at 20%, all non-preferred benefits and limitations apply.	

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Covered 100%	Not Covered
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		

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Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered;	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Tubal Ligation	Covered 100%;	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$0 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Injectable fertility drugs (injectable, physician charges for injections are not covered under RX, medical coverage may be limited), Diabetic supplies.

Precert for growth hormones included

Formulary Generic FDA-approved Women's Contraceptives covered 100% in network

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. 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 without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

aetna : LEE COUNTY BOARD OF COUNTY COMMISSIONERS : Aetna Choice® POS II

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, **www.HealthReformPlanSBC.com** or by calling **1-800-370-4526**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **https://www.healthcare.gov/sbc-glossary/** or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $0 / Family $0. Out–of–Network: Individual $500 / Family $1,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care; plus in-network office visits, preventive care & prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: Individual $1,500 / Family $3,000. Out–of–Network: Individual $2,000 / Family $4,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	$35 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care / screening / immunization	No charge	30% coinsurance, except gynecological exams, adult routine physicals & adult immunizations not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay/visit, deductible doesn't apply	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$50 copay/visit, deductible doesn't apply	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	Copay/prescription, deductible doesn't apply: $10 (retail), $0 (mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral & injectable fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $20 (retail), $40 (mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $35 (retail), $70 (mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Pharmacy Network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit, deductible doesn't apply	30% coinsurance	None
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible doesn't apply	$150 copay/visit, deductible doesn't apply	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	$50 copay/visit, deductible doesn't apply	30% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/stay, deductible doesn't apply	30% coinsurance after $500 copay/stay	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $35 copay/visit, deductible doesn't apply	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	$500 copay/stay, deductible doesn't apply	30% coinsurance after $500 copay/stay	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing doesn't apply to certain preventive services. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). Penalty of $500 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	$500 copay/stay, deductible doesn't apply	30% coinsurance after $500 copay/stay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	120 visits/calendar year, including up to 70 visits for private-duty nursing. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$35 copay/visit, deductible doesn't apply	30% coinsurance	80 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	$35 copay/visit, deductible doesn't apply	30% coinsurance	Limited to children up to age 18 for Autism.
	Skilled nursing care	$500 copay/stay, deductible doesn't apply	30% coinsurance after $500 copay/stay	120 days/calendar year. Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	No charge	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$500 copay/stay, deductible doesn't apply for inpatient; no charge for outpatient	30% coinsurance after $500 copay/stay for inpatient; 30% coinsurance for outpatient	Penalty of $500 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/12 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. Artificial insemination & ovulation induction: 6 separate attempts/lifetime for in-network lonly.
- Private-duty nursing - 70- 8 hour shifts/calendar year combined with home health care.
- Routine eye care (Adult) - 1 routine eye exam/12 months for in-network only.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$760**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Note: If your **plan** has a wellness program and you choose to participate, you may be able to reduce your costs.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-370-4526.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Dental Benefits Summary

	Active PPO	
	Participating	Non-participating
Annual Deductible*		
Individual	**$50**	**$50**
Family	**$100**	**$100**
Preventive Services	**100%**	**100%**
Basic Services	**80%**	**80%**
Major Services	**50%**	**50%**
Annual Benefit Maximum	**$1,500**	**$1,500**
Office Visit Copay	**N/A**	**N/A**
Orthodontic Services**	**50%**	**50%**
Orthodontic Deductible	**None**	**None**
Orthodontic Lifetime Maximum	**$1,000**	**$1,000**

***The deductible applies to: Basic & Major services only**
****Orthodontia is covered only for children (appliance must be placed prior to age 20).**

Partial List of Services	Active PPO	
Preventive	Participating	Non-participating
Oral examinations (a)	100%	100%
Cleanings (a) Adult/Child	100%	100%
Fluoride (a)	100%	100%
Sealants (permanent molars only) (a)	100%	100%
Bitewing Images (a)	100%	100%
Full mouth series Images (a)	100%	100%
Space Maintainers	100%	100%
Basic		
Root canal therapy		
Anterior teeth / Bicuspid teeth	80%	80%
Scaling and root planing (a)	80%	80%
Gingivectomy*	80%	80%
Amalgam (silver) fillings	80%	80%
Composite fillings (anterior teeth only)	80%	80%
Stainless steel crowns	80%	80%
Incision and drainage of abscess*	80%	80%
Uncomplicated extractions	80%	80%
Surgical removal of erupted tooth*	80%	80%
Surgical removal of impacted tooth (soft tissue)*	80%	80%
Major		
Inlays	50%	50%
Onlays	50%	50%
Crowns	50%	50%
Crown lengthening	50%	50%
Full & partial dentures	50%	50%
Pontics	50%	50%
Root canal therapy, molar teeth	50%	50%
Osseous surgery (a)*	50%	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%	50%
General anesthesia/intravenous sedation*	50%	50%
Denture repairs	50%	50%
Crown Build-Ups	50%	50%
Implants	50%	50%

***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Other Important Information

This Aetna Dental® Preferred Provider Organization (PPO) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Preferred Provider Organization (PPO) plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to recognized charge limits.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PPO dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals.
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:

    (a) during the first 31 days the person is eligible for this coverage, or
    (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
        (i) after the end of the 12-month period starting on the date the person became a covered person; or
        (ii) as a result of accidental injuries sustained while the person was a covered person; or
        (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.
17. Those for a crown, cast or processed restoration unless:
    (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
    (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dentals online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate.
All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental Benefits Summary

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Texas, the Dental Preferred Provider Organization (PPO) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

DAVIS VISION
EYECARE REFRAMED℠

Lee County
Southwest Florida

Low Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

IN-NETWORK BENEFITS	
Eye Examination	Every calendar year, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every calendar year, **Covered in full** For standard single-vision, lined bifocal, trifocal, or lenticular lenses after $15 copayment
Frames	Every other calendar year, **Covered in full** Any Fashion or Designer frame from Davis Vision's Collection[1] (value up to $160) OR $120 retail allowance toward any frame from provider, plus 20% off balance[2] OR $170 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations.[5]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every calendar year, Collection Contacts: **Covered in full** OR Non Collection Contacts: Standard Contacts: **Covered in full** Specialty Contacts[3]: $60 allowance with 15% off balance[2]
Contact Lenses (in lieu of eyeglasses)	Every calendar year, **Covered in full** Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $120 retail allowance toward provider supplied contact lenses, plus 15% off balance[2]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS	
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	With Davis Vision
Scratch-Resistant Coating	$0
Polycarbonate Lenses	$0
Standard Anti-Reflective (AR) Coating	$35
Standard Progressives (no-line bifocal)	$50
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$65

Lower costs and more benefits! *See the savings!*

Service	With Davis Vision
Eye Examination	$10
Lenses	
Bifocals	$15
Scratch-Resistant Coating	$0
Transitions®[4]	$65
Frame	$0
Total	$90

Employee Contributions	Monthly
Employee	$7.92
Employee plus Family	$16.68

See page 2 for more benefit information.

Call the Human Resources Department at 239-533-2245 for any questions.

For more details about the plan, just log on to the Member site at davisvision.com and enter Client Code **7600**.

[1] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.*
[2] *Additional discounts not applicable at Walmart, Sam's Club or Costco locations.*
[3] *Including, but not limited to toric, multifocal and gas permeable contact lenses.*
[4] *Transitions® is a registered trademark of Transitions Optical Inc.*
[5] *Enhanced frame allowance available at all Visionworks Locations nationwide.*

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

Davis Vision plans offer...

Value for our Members

A comprehensive benefit that ensures low out-of- pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through our network of dependent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.
- Members with a confirmed diabetes diagnosis may have a second exam within the calendar year frequency for the same $10 copayment or the same out-of-network reimbursement rate. Please consult your physician.

ADDITIONAL OPTIONS	WITH DAVIS VISION
FRAMES	
Fashion Frame (from the Davis Vision Collection)	$0
Designer Frame (from the Davis Vision Collection)	$0
Premier Frame (from the Davis Vision Collection)	$25
LENSES	
All Ranges of Prescriptions and Sizes	**$0**
Plastic Lenses	**$0**
Oversized Lenses	**$0**
Tinting of Plastic Lenses	**$0**
Scratch-Resistant Coating	**$0**
Polycarbonate Lenses	**$0**
Ultraviolet Coating	**$0**
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Standard Progressive Addition Lenses	$50
Premium Progressives Addition Lenses	$90
Ultra Progressive Addition Lenses	$140
High-Index Lenses	$55
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®, etc.)[1]	$65
Scratch Protection Plan (Single vision | Multifocal lenses)	$20 | $40

[1] Transitions® is a registered trademark of Transitions Optical, Inc.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $45 | Frame up to $70 Spectacle Lenses (per pair) up to: Single Vision $30, Bifocal $50, Trifocal $65, Lenticular $100 Elective Contacts up to $105, Visually Required Contacts up to $210

DAVIS VISION
EYECARE REFRAMED℠

Lee County
Southwest Florida

High Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

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Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

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Visionworks

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For more details about the plan, just log on to the Member site at davisvision.com and enter Client Code **7601**.

IN-NETWORK BENEFITS	
Eye Examination	Every calendar year, **Covered in full** after $10 copayment
Eyeglasses	
Spectacle Lenses	Every calendar year, **Covered in full** For standard single-vision, lined bifocal, trifocal, or lenticular lenses after $15 copayment
Frames	Every other calendar year, **Covered in full** Any Fashion, Designer or Premier frame from Davis Vision's Collection[1] (value up to $195) OR $150 retail allowance toward any frame from provider, plus 20% off balance[2] OR $200 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations.[5]
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ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS	
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	With Davis Vision
Scratch-Resistant Coating	$0
Polycarbonate Lenses	$0
Standard Anti-Reflective (AR) Coating	$0
Standard Progressives (no-line bifocal)	$0
Photochromic Lenses (i.e. Transitions®, etc.)[4]	$0

Lower costs and more benefits! *See the savings!*

Service	With Davis Vision
Eye Examination	$10
Lenses	
Bifocals	$15
Scratch-Resistant Coating	$0
Transitions®[4]	$0
Frame	$0
Total	$25

Employee Contributions	Monthly
Employee	$10.58
Employee plus Family	$22.28

See page 2 for more benefit information.

[1] *The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.*
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[3] *Including, but not limited to toric, multifocal and gas permeable contact lenses.*
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- Members with a confirmed diabetes diagnosis may have a second exam within the calendar year frequency for the same $10 copayment or the same out-of-network reimbursement rate. Please consult your physician.

ADDITIONAL OPTIONS	WITH DAVIS VISION
FRAMES	
Fashion Frame (from the Davis Vision Collection)	$0
Designer Frame (from the Davis Vision Collection)	$0
Premier Frame (from the Davis Vision Collection)	$0
LENSES	
All Ranges of Prescriptions and Sizes	**$0**
Plastic Lenses	**$0**
Oversized Lenses	**$0**
Tinting of Plastic Lenses	**$0**
Scratch-Resistant Coating	**$0**
Polycarbonate Lenses	**$0**
Ultraviolet Coating	**$0**
Standard Anti-Reflective (AR) Coating	**$0**
Premium AR Coating	**$0**
Ultra AR Coating	**$0**
Standard Progressive Addition Lenses	**$0**
Premium Progressives Addition Lenses	**$0**
Ultra Progressive Addition Lenses	**$0**
High-Index Lenses	**$0**
Polarized Lenses	**$0**
Photochromic Lenses (i.e. Transitions®, etc.)[1]	**$0**
Scratch Protection Plan (Single vision | Multifocal lenses)	$20 | $40

[1] Transitions® is a registered trademark of Transitions Optical, Inc.

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Eye Examination up to $45 | Frame up to $70 Spectacle Lenses (per pair) up to: Single Vision $30, Bifocal $50, Trifocal $65, Lenticular $100 Elective Contacts up to $105, Visually Required Contacts up to $210