



Aetna Life Insurance Company

151 Farmington Ave
Hartford, CT 06156

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

Schedule of Benefits

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

Prepared exclusively for:

Policyholder: Baxter Credit Union
Policyholder number: GP-0232282
Schedule of Benefits: 1A
Group policy effective date: January 1, 2024
Plan effective date: January 1, 2024
Plan issue date: November 19, 2025
Plan revision effective date: January 1, 2026

Issued by Aetna Life Insurance Company in the state of Illinois

Schedule of benefits

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

How to read your schedule of benefits

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

How to contact us for help

We are here to answer your questions.

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

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

Your financial responsibility and determination of benefits provisions

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

Plan features

Benefit frequency limits

In-network and out-of-network combined

Vision examinations

Description	Limit
Vision examinations	Once every 12 months

Vision materials

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

Vision materials important note:

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

Eligible vision services

Vision examinations

Description	In-network coverage	Out-of-network coverage
Comprehensive eye exam	\$0 copayment	\$32 scheduled limit

Vision materials

Frames

Description	In-network coverage	Out-of-network coverage
Eyeglass frame	\$0 copayment then the plan pays up to \$150 maximum allowance	\$75 scheduled limit

Standard plastic prescription lenses

Description	In-network coverage	Out-of-network coverage
Single Vision	\$10 copayment	\$25 scheduled limit
Bifocal	\$10 copayment	\$40 scheduled limit
Trifocal	\$10 copayment	\$64 scheduled limit
Lenticular	\$10 copayment	\$64 scheduled limit

Standard progressive	\$75 copayment	\$40 scheduled limit
Premium progressive Tier 1	\$95 copayment	\$40 scheduled limit
Premium progressive Tier 2	\$105 copayment	\$40 scheduled limit
Premium progressive Tier 3	\$120 copayment	\$40 scheduled limit
Premium progressive Tier 4	\$75 copayment then the plan pays up to \$120 maximum allowance	\$40 scheduled limit

Contact lenses

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

Description	In-network coverage	Out-of-network coverage
Conventional contact lenses	\$0 copayment then the plan pays up to \$150 maximum allowance	\$120 scheduled limit
Disposable contact lenses	\$0 copayment then the plan pays up to \$150 maximum allowance	\$120 scheduled limit
Description	In-network coverage	Out-of-network coverage
Non-conventional (medically necessary) contact lenses	\$0 copayment	\$200 scheduled limit

Lens options

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