

Aetna VisionSM Preferred

www.aetnafeds.com

1-855-347-6899



2020

A Nationwide Vision Plan, available nationwide and overseas

IMPORTANT

- Rates: Back Cover
- Changes for 2020: Page 4
- Summary of Benefits: Page 22

Enrollment options for this plan:

- High Option - Self Only
- High Option - Self Plus One
- High Option - Self and Family
- Standard Option - Self Only
- Standard Option - Self Plus One
- Standard Option - Self and Family



Authorized for distribution by the:



**United States
Office of Personnel Management**

Healthcare and Insurance
<http://www.opm.gov/insure>

Introduction

On December 23, 2004, President George W. Bush signed the Federal Employee Dental and Vision Benefits Enhancement Act of 2004 (Public Law 108-496). The law directed the Office of Personnel Management (OPM) to establish supplemental dental and vision benefit programs to be made available to Federal employees, annuitants, and their eligible family members. In response to the legislation, OPM established the Federal Employees Dental and Vision Insurance Program (FEDVIP). OPM has contracted with dental and vision insurers to offer an array of choices to Federal employees and annuitants. Section 715 of the National Defense Authorization Act for Fiscal Year 2017 (FY 2017 NDAA), Public Law 114-38, expanded FEDVIP eligibility to certain TRICARE-eligible individuals.

This brochure describes the benefits of Aetna Vision under Aetna Life Insurance Company's contract OPM01-FEDVIP-01AP-2 with OPM, as authorized by the FEDVIP law. The address for our administrative office is:

Aetna Vision
Federal Plans
PO Box 550
Blue Bell, PA 19422-0550
1-855-347-6899
www.aetnafeds.com

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your benefits. You and your family members do not have a right to benefits that were available before January 1, 2020, unless those benefits are also shown in this brochure.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One, you and your designated family member are entitled to these benefits. If you are enrolled in Self and Family coverage, each of your eligible family members is also entitled to these benefits, if they are also listed on the coverage.

OPM negotiates benefits and rates with each carrier annually. Rates are shown at the end of this brochure.

Aetna is responsible for the selection of in-network providers in your area. Contact us 1-855-347-6899 for the names of participating providers or to request a provider directory. You may also request or view the most current directory via our website at www.aetnafeds.com. Continued participation of any specific provider cannot be guaranteed. Thus, you should choose your plan based on the benefits provided and not on a specific provider's participation. When you phone for an appointment, please remember to verify that the provider is currently in-network. If your provider is not currently participating in the provider network, you can nominate him or her to join. Please print off a nomination form from our website at www.aetnafeds.com or call us and we will have a form sent to you. Bring the form to your provider and ask him or her to complete it if he or she is interested in participating in our network. You cannot change plans, outside of open season, because of changes to the provider network.

Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If you require the services of a specialist and one is not available in your area, please contact us for assistance.

This Aetna Vision Plan and all other FEDVIP plans are not a part of the Federal Employees Health Benefits (FEHB) Program.

Discrimination is Against the Law

Aetna complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Aetna does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Table of Contents

Introduction	1
Table of Contents	1
FEDVIP Program Highlights	3
A Choice of Plans and Options	3
Enroll Through BENEFEDS	3
Dual Enrollment	3
Coverage Effective Date	3
Pre-Tax Salary Deduction for Employees	3
Annual Enrollment Opportunity	3
Continued Group Coverage After Retirement	3
How We Have Changed For 2020	4
Section 1 Eligibility	5
Federal Employees	5
Federal Annuitants	5
Survivor Annuitants	5
Compensationers	5
Family Members	5
Not Eligible	6
Section 2 Enrollment	7
Enroll Through BENEFEDS	7
Enrollment Types	7
Dual Enrollment	7
Opportunities to Enroll or Change Enrollment	7
.....	8
When Coverage Stops	9
Continuation of Coverage	9
FSAFEDS/High Deductible Health Plans and FEDVIP	9
Section 3 How You Obtain Care	11
Identification Cards/Enrollment Confirmation	11
Plan Providers	11
In-Network	11
Out-of-Network	11
Pre-Authorization	11
FEHB First Payor	11
Coordination of Benefits	12
Limited Access Areas	12
Section 4 Your Cost for Covered Services	13
Co-payment	13
In-Network Services	13
Out-of-Network Services	13
Section 5 Vision Services and Supplies	14
Diagnostic	14
Eyewear	14
Contact Lenses	15
Section 6 International Services and Supplies	16
Section 7 General Exclusions – Things We Do Not Cover	17

Section 8 Claims Filing and Disputed Claims Processes.....	18
How to File a Claim for Covered Services	18
Deadline for Filing Your Claim.....	18
Disputed Claims Process.....	18
Section 9 Definitions of Terms We Use in This Brochure	20
Stop Health Care Fraud!	21
Summary of Benefits	22
Rate Information	26

FEDVIP Program Highlights

A Choice of Plans and Options	You can select from several nationwide, and in some areas, regional dental Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) plans, and high and standard coverage options. You can also select from several nationwide vision plans. You may enroll in a dental plan or a vision plan, or both. Some TRICARE beneficiaries may not be eligible to enroll in both. Visit www.opm.gov/dental or www.opm.gov/vision for more information.
Enroll Through BENEFEDS	You enroll online at www.BENEFEDS.com . Please see Section 2, Enrollment, for more information.
Dual Enrollment	If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.
Coverage Effective Date	If you sign up for a dental and/or vision plan during the 2019 Open Season, your coverage will begin on January 1, 2020. Premium deductions will start with the first full pay period beginning on/after January 1, 2020. You may use your benefits as soon as your enrollment is confirmed.
Pre-Tax Salary Deduction for Employees	Employees automatically pay premiums through payroll deductions using pre-tax dollars. Annuitants automatically pay premiums through annuity deductions using post-tax dollars. TRICARE enrollees automatically pay premiums through payroll deduction or automatic bank withdrawal (ABW) using post-tax dollars.
Annual Enrollment Opportunity	Each year, an Open Season will be held, during which you may enroll or change your dental and/or vision plan enrollment. This year, Open Season runs from November 11, 2019 through midnight EST December 9, 2019. You do not need to re-enroll each Open Season unless you wish to change plans or plan options; your coverage will continue from the previous year. In addition to the annual Open Season, there are certain events that allow you to make specific types of enrollment changes throughout the year. Please see Section 2, Enrollment, for more information.
Continued Group Coverage After Retirement	Your enrollment or your eligibility to enroll may continue after retirement. You do not need to be enrolled in FEDVIP for any length of time to continue enrollment into retirement. Your family members may also be able to continue enrollment after your death. Please see Section 1, Eligibility, for more information.

How We Have Changed For 2020

Changes to the High Option include:

- Your rates for 2020 have increased.
- There are no changes to your plan for 2020.

Changes to the Standard Option include:

- Your rates for 2020 have increased.
- There are no changes to your plan for 2020.

Section 1 Eligibility

Federal Employees

If you are a Federal or U.S. Postal Service employee, you are eligible to enroll in FEDVIP, if you are eligible for the Federal Employees Health Benefits (FEHB) Program or the Health Insurance Marketplace (Exchange) and your position is not excluded by law or regulation. Enrollment in the FEHB Program or a Health Insurance Marketplace (Exchange) plan is not required.

Federal Annuitants

You are eligible to enroll if you:

- retired on an immediate annuity under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or another retirement system for employees of the Federal Government;
- retired for disability under CSRS, FERS, or another retirement system for employees of the Federal Government.

Your FEDVIP enrollment will continue into retirement, if you retire on an immediate annuity or for disability under CSRS, FERS or another retirement system for employees of the Government, regardless of the length of time you had FEDVIP coverage as an employee. There is no requirement to have coverage for 5 years of service prior to retirement in order to continue coverage into retirement, as there is with the FEHB Program.

Your FEDVIP coverage will end if you retire on a Minimum Retirement Age (MRA) + 10 retirement and postpone receipt of your annuity. You may enroll in FEDVIP again when you begin to receive your annuity.

Survivor Annuitants

If you are a survivor of a deceased Federal/U.S. Postal Service employee or annuitant and you are receiving an annuity, you may enroll or continue the existing enrollment.

Compensationers

A compensationer is someone receiving monthly compensation from the Department of Labor's Office of Workers' Compensation Programs (OWCP) due to an on-the-job injury/illness who is determined by the Secretary of Labor to be unable to return to duty. You are eligible to enroll in FEDVIP or continue FEDVIP enrollment into compensation status.

Newly eligible employees

FEDVIP has expanded eligibility to include certain TRICARE eligible individuals. The TRICARE Retiree Dental Program (TRDP) will no longer be available after December 31, 2018. Those who were previously eligible for the TRDP are now eligible to enroll in FEDVIP.

Family Members

Except with respect to TRICARE-eligible individuals, family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. FEDVIP rules and FEHB rules for family member eligibility are **NOT** the same. For more information on family member eligibility visit the website at www.opm.gov/healthcare-insurance/dental-vision/ or contact your employing agency or retirement system.

With respect to TRICARE-eligible individuals, family members include your spouse, unremarried widow, unremarried widower, unmarried child, an unremarried former spouse who meets the U.S Department of Defense's 20-20-20 or 20-20-15 eligibility requirements, and certain unmarried persons placed in your legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.

Not Eligible

The following persons are not eligible to enroll in FEDVIP, regardless of FEHB eligibility or receipt of an annuity or portion of an annuity:

- Deferred annuitants
- Former spouses of employees or annuitants. **Note:** Former spouses of TRICARE-eligible individuals may enroll in a FEDVIP vision plan.
- FEHB Temporary Continuation of Coverage (TCC) enrollees
- Anyone receiving an insurable interest annuity who is not also an eligible family member
- Active duty uniformed service members. **Note:** If you are an active duty uniformed service member, your dental and vision coverage will be provided by TRICARE. Your family members will still be eligible to enroll in the TRICARE Dental Plan (TDP).

Section 2 Enrollment

Enroll Through BENEFEDS

You must use BENEFEDS to enroll or change enrollment in a FEDVIP plan. BENEFEDS is a secure enrollment website (www.BENEFEDS.com) sponsored by OPM. If you do not have access to a computer, call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680 to enroll or change your enrollment.

If you are currently enrolled in a FEDVIP vision plan and want to switch to Aetna Vision, you must change enrollment through BENEFEDS. If you do not want to change plans or options, your enrollment will continue automatically as it was for 2019. Please note: your plans' premiums may change for 2020.

Note: You cannot enroll or change enrollment in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, PostalEase, EBIS, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

Enrollment Types

Self Only: A Self Only enrollment covers only you as the enrolled employee or annuitant. You may choose a Self Only enrollment even though you have a family; however, your family members will not be covered under FEDVIP.

Self Plus One: A Self Plus One enrollment covers you as the enrolled employee or annuitant plus one eligible family member whom you specify. You may choose a Self Plus One enrollment even though you have additional eligible family members, but the additional family members will not be covered under FEDVIP.

Self and Family: A Self and Family enrollment covers you as the enrolled employee or annuitant and all of your eligible family members. You must list all eligible family members when enrolling.

Dual Enrollment

If you or one of your family members is enrolled in or covered by one FEDVIP plan, that person cannot be enrolled in or covered as a family member by another FEDVIP plan offering the same type of coverage; i.e., you (or covered family members) cannot be covered by two FEDVIP dental plans or two FEDVIP vision plans.

Opportunities to Enroll or Change Enrollment

Open Season

If you are an eligible employee, annuitant, or TRICARE-eligible individual, you may enroll in a dental and/or vision plan during the November 11, through midnight EST December 9, 2019, Open Season. Coverage is effective January 1, 2020.

During future annual Open Seasons, you may enroll in a plan, or change or cancel your dental and/or vision coverage. The effective date of these Open Season enrollments and changes will be set by OPM.

If you want to continue your current enrollment, do nothing. Your enrollment carries over from year to year, unless you change it.

New hire/Newly eligible

You may enroll within 60 days after you become eligible as:

- a new employee;
- a previously ineligible employee who transferred to a covered position;
- a survivor annuitant if not already covered under FEDVIP; or
- an employee returning to service following a break in service of at least 31 days.
- a TRICARE-eligible individual

Your enrollment will be effective the first day of the pay period following the one in which BENEFEDS receives and confirms your enrollment.

Qualifying Life Event

A qualifying life event (QLE) is an event that allows you to enroll, or if you are already enrolled, allows you to change your enrollment outside of an Open Season.

The following chart lists the QLEs and the enrollment actions you may take:

Qualifying Life Event	From Not Enrolled to Enrolled	Increase Enrollment Type	Decrease Enrollment Type	Cancel	Change from One Plan to Another
Marriage	Yes	Yes	No	No	Yes
Acquiring an eligible family member (non-spouse)	No	Yes	No	No	No
Losing a covered family member	No	No	Yes	No	No
Losing other dental/vision coverage (eligible or covered person)	Yes	Yes	No	No	No
Moving out of regional plan's service area	No	No	No	No	Yes
Going on active military duty, non-pay status (enrollee or spouse)	No	No	No	Yes	No
Returning to pay status from active military duty (enrollee or spouse)	Yes	No	No	No	No
Returning to pay status from Leave without pay	Yes (if enrollment cancelled during LWOP)	No	No	No	Yes (if enrollment cancelled during LWOP)
Annuity/compensation restored	Yes	Yes	Yes	No	No
Transferring to an eligible position*	No	No	No	Yes	No

*Position must be in a Federal agency that provides dental and/or vision coverage with 50 percent or more employer-paid premium.

The timeframe for requesting a QLE change is from 31 days before to 60 days after the event. There are two exceptions:

- There is no time limit for a change based on moving from a regional plan's service area; and
- You cannot request a new enrollment based on a QLE before the QLE occurs, except for enrollment because of a loss of dental or vision insurance. You must make the change no later than 60 days after the event.

Generally, enrollments and enrollment changes made based on a QLE are effective on the first day of the pay period following the one in which BENEFEDS receives and confirms the enrollment or change. BENEFEDS will send you confirmation of your new coverage effective date.

Once you enroll in a plan, your 60-day window for that type of plan ends, even if 60 calendar days have not yet elapsed. That means once you have enrolled in either a dental or a vision plan, you cannot change or cancel that particular enrollment until the next Open Season, unless you experience a QLE that allows such a change or cancellation.

Canceling an enrollment

You may cancel your enrollment only during the annual Open Season. An eligible family member's coverage also ends upon the effective date of the cancellation.

Your cancellation is effective at the end of the day before the date OPM sets as the Open Season effective date.

When Coverage Stops

Coverage ends for active and retired Federal, U.S. Postal employees, and TRICARE-eligible individuals when you:

- no longer meet the definition of an eligible employee, annuitant, or TRICARE-eligible individual;
- as a Retired Reservist you begin active duty;
- as sponsor or primary enrollee leaves active duty
- begin a period of non-pay status or pay that is insufficient to have your FEDVIP premiums withheld and you do not make direct premium payments to BENEFEDS;
- are making direct premium payments to BENEFEDS and you stop making the payments;
- cancel the enrollment during Open Season;
- a Retired Reservist begins active duty; or
- the sponsor or primary enrollee leaves active duty.

Coverage for a family member ends when:

- you as the enrollee lose coverage; or
- the family member no longer meets the definition of an eligible family member.

Continuation of Coverage

Under FEDVIP, there is no 31-day extension of coverage. The following are also NOT available under FEDVIP plans:

- Temporary Continuation of Coverage (TCC);
- spouse equity coverage; or
- right to convert to an individual policy (conversion policy).

FSAFEDS/High Deductible Health Plans and FEDVIP

If you are planning to enroll in an FSAFEDS Health Care Flexible Spending Account (HCFSA) or Limited Expense Health Care Flexible Spending Account (LEX HCFSA), you should consider how coverage under a FEDVIP plan will affect your annual expenses, and thus the amount that you should allot to an FSAFEDS account. Please note that insurance premiums are not eligible expenses for either type of FSA.

If you have an HCFSA or LEX HCFSA FSAFEDS account and you haven't exhausted your funds by December 31st of the plan year, FSAFEDS can automatically carry over up to \$500 of unspent funds into another health care or limited expense account for the subsequent year. To be eligible for carryover, you must be employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31. You must also actively reenroll in a health care or limited expense account during the NEXT Open Season to be carryover eligible. Your reenrollment must be for at least the minimum of \$100. If you do not reenroll, or if you are not employed by an agency that participates in FSAFEDS and actively making allotments from your pay through December 31st, your funds will not be carried over.

Because of the tax benefits an FSA provides, the IRS requires that you forfeit any money for which you did not incur an eligible expense and file a claim in the time period permitted. This is known as the "Use-it-or-Lose-it" rule. Carefully consider the amount you will elect.

For a health care or limited expense account, each participant must contribute a minimum of \$100 to a maximum of \$2,650.

Current FSAFEDS participants must re-enroll to participate next year. See www.fsafeds.com or call 1-877-FSAFEDS (372-3337) or TTY: 1-866-353-8058. **Note: FSAFEDS is not open to retired employees, or to TRICARE eligible individuals.**

If you enroll or are enrolled in a high deductible health plan with a health savings account (HSA) or health reimbursement arrangement (HRA), you may use your HSA or HRA to pay for qualified dental/vision costs not covered by your FEHB and FEDVIP plans.

Using your FSA pre-tax dollars for your eye care and eyewear needs is a great way to get more out of your benefit dollar. And Aetna will submit your eligible FSAFEDS out-of-pocket expenses electronically, so you don't have to.

Using your FSAFEDS account for your eye care and eyewear expenses is simple:

- Visit your provider for your routine eye examination and eyewear
- Pay any out-of-pocket expenses
- Aetna will submit your expenses for reimbursement for you.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation

We will send you an identification (ID) card when you initially enroll. If you enroll in Self, Self Plus One or Self and Family, you will receive two ID Cards listed in the subscribers name. You should carry your ID Card with you at all times. You can print a temporary ID card online or call customer service to verify your eligibility in the plan.

It is important to bring your FEHB identification card to every vision appointment because most FEHB plans offer some level of vision benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Plan Providers

We list plan providers in the provider directory, which is updated nightly. The provider directory is on our website www.aetnafeds.com. It is your responsibility to ensure that the provider chosen is an active participant in the program at the time you receive services. The Aetna Vision Preferred network is specific to routine vision care and is different from the network for the Aetna medical plan.

In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.

In-Network

We negotiate rates with vision care providers and other health care providers to help save you money. Aetna Vision Preferred in-network providers are contracted through EyeMed Vision Care. When scheduling an appointment, you should identify yourself as a member of the FEDVIP Aetna Vision Preferred plan. The provider is then responsible for verifying eligibility by contacting Aetna Vision Preferred either by telephone or via the web. We refer to these providers as “In-Network providers”. If you use in-network providers to obtain covered care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance.

Out-of-Network

You may obtain care from any licensed eye care provider. If the provider you use is not part of our network, benefits will be considered out-of-network. Because these providers are out of our network, we will reimburse you up to the maximum reimbursement amount allowed by the plan. You are responsible to pay the out-of-network provider and then submit a claim to receive your reimbursement.

Pre-Authorization

Pre-authorization is not required.

FEHB First Payor

When you visit a provider who participates with both, your FEHB plan and your FEDVIP plan, the FEHB plan will pay benefits first. The FEDVIP plan allowance will be the prevailing charge in these cases. You are responsible for the difference between the FEHB and FEDVIP benefit payments and the FEDVIP plan allowance. We are responsible for facilitating the process with the primary FEHB payor.

It is important to bring your FEDVIP and FEHB identification cards to every vision appointment because most FEHB plans offer some level of vision benefits separate from your FEDVIP coverage. Presenting both identification cards can ensure that you receive the maximum allowable benefit under each Program.

Coordination of Benefits

IF	THEN
You have medical coverage through FEHB and Aetna's FEDVIP vision plan	Present your FEHB ID card at the time of service as the FEHB plan will pay benefits first
You have vision coverage through a non-FEHB plan and Aetna Vision coverage under FEDVIP (covered through a spouse)	Aetna Vision is the primary payor and your non-FEHB plan is secondary
If your covered dependent child has coverage through a non-FEHB plan and Aetna Vision coverage under FEDVIP.	The parent's plan whose birthday occurs first in the calendar year (1. Month, 2. Date) is primary. If the months and dates are the same for both parents, the primary payor is the plan that has provided coverage the longest.

Limited Access Areas

If you live in an area with limited access to a network provider and you receive covered services from an out-of-network provider, we will pay the same benefit level as if you utilized the services of an in-network provider. You are responsible for any difference between the amount billed and our payment. Call us 1-855-347-6899, if you are having problems locating a provider in your area.

Plan Allowance: The maximum benefit payment for services provided in areas not meeting the access standards are shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	Standard Option	High Option
	We Pay	We Pay
Exam	Up to \$40	Up to \$40
Single Vision Lenses	Up to \$40	Up to \$40
Bifocal Lenses	Up to \$60	Up to \$60
Trifocal Lenses	Up to \$80	Up to \$80
Lenticular Lenses	Up to \$80	Up to \$80
Contact Lenses	Up to \$112	Up to \$120
Medically Necessary Contact Lenses	Up to \$200	Up to \$200
Frames	Up to \$70	Up to \$90

Section 4 Your Cost for Covered Services

This is what you pay out-of-pocket for covered care:

Co-payment

A co-payment is a fixed amount of money you pay to the provider when you receive services.

Example: In the Aetna Vision High Option plan, you pay a \$0 co-pay for an exam.

In-Network Services

When you visit an Aetna Vision network doctor, your eye exam and prescription glasses or contacts are covered after any co-payments. You will also receive 20% off any out-of-pocket costs over your frame allowance and a savings of 15% on any balance over your conventional contact allowance.

Out-of-Network Services

If you choose to visit a non-participating provider, you will be reimbursed according to the following fee schedule allowances shown in the chart below. You are responsible for charges billed over the amounts shown.

Services/Materials	Standard Option	High Option
	We Pay	We Pay
Exam	Up to \$40	Up to \$40
Single Vision Lenses	Up to \$40	Up to \$40
Bifocal Lenses	Up to \$60	Up to \$60
Trifocal Lenses	Up to \$80	Up to \$80
Lenticular Lenses	Up to \$80	Up to \$80
Contact lenses	Up to \$112	Up to \$120
Medically Necessary Contact Lenses	Up to \$200	Up to \$200
Frames	Up to \$70	Up to \$90

Please see Section 3, How You Obtain Care, for more information.

Section 5 Vision Services and Supplies

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted protocols.

- Both the High and Standard vision options include out-of-network benefit coverage. The out-of-network benefit structure is listed under the Summary of Benefits section.

Benefit Description		You Pay*	
Diagnostic		High Option	Standard Option
<p>Eye examination - covered in full (once every calendar year).</p> <p>Aetna doctors provide a comprehensive exam that focuses on your eyes and overall wellness.</p>		Nothing	Nothing
Eyewear		High Option	Standard Option
You may choose prescription eyeglass lenses or contacts.			
<p>Lenses: covered in full (once every calendar year)</p> <p>Standard Plastic single vision, lined bifocal, lined trifocal, and lenticular lenses</p>		Nothing	\$10
Lens Options (covered in addition to base lens)			
Standard Polycarbonate lenses (shatter-resistant)		Nothing	Nothing
Standard Scratch resistant coating		Nothing	Nothing
Standard Anti-reflective coatings		\$20	\$45 fixed discount**
UV Protection and Tint (Solid or Gradient)		Nothing	\$15 fixed discount**
Photochromic lenses- lenses are clear indoors and darken outside		\$75 fixed discount**	\$75 fixed discount**
Standard progressive lenses		Nothing	\$75
Premium progressive lenses Tiers 1-3		\$40-65	\$95-120
Other premium progressive lenses		80% of charge less \$120 allowance + \$20 copay	80% of charge less \$120 allowance + \$75 copay
<p>Frames -</p> <p>Any frame available at the provider location</p>		<p>Nothing for frames up to the \$230 plan allowance</p> <p>Frame Greater than \$230: pay any amount after a 20% discount</p> <p>Covered once every calendar year</p>	<p>Nothing for frames up to the \$140 plan allowance</p> <p>Frame Greater than \$140: pay any amount after a 20% discount</p> <p>Covered once every calendar year</p>

Benefit Description	You Pay*	
	High Option	Standard Option
Contact Lenses		
Contact Lens Care covered (once per calendar year)		
Standard Contact Lens Fit & Follow-up	\$40 fixed discount**	\$40 fixed discount**
Premium Contact Lens Fit & Follow-up	90% of retail price	90% of retail price
Conventional/Disposable contact lenses	Nothing for Contact Lenses up to the \$150 plan allowance	Nothing for Contact Lenses up to the \$140 plan allowance
You may choose prescription eyeglass lenses or contacts once every calendar year	You will receive a 15% discount off the cost over \$150 for conventional contact lenses	You will receive a 15% discount off the cost over \$140 for conventional contact lenses
Medically necessary contact lenses	Nothing	Nothing

* Please refer to Section 4, Your Cost for Covered Services, for the nationwide reimbursement schedule and Section 6, International Services and Supplies, for the international reimbursement schedule.

**The amount shown is the negotiated discounted price you will pay the provider. Discounts may not be available in all states at all in-network providers. To see a list of providers who do honor discounts, go to www.aetnafeds.com/vision or directly to www.aetnavision.com, select Find a Provider, and if you see “May not accept all additional plan discounts” you should contact the provider to confirm.

Extra Discounts and Savings

The following extra discounts and savings are only available from network doctors.

Prescription glasses

- Minimum savings of 20% on all non-covered lens options.
- Up to 40% discount off additional pairs of prescription glasses and sunglasses.

Retinal imaging (also known as fundus photography) -

When available at a participating provider's office, members will pay no more than \$39 for this service.

Laser vision correction

Members will receive a discount of 15% off retail or 5% off promotional prices. In addition, featured LasikPlus providers offer special member prices from \$695* - \$1,895 per eye plus a free LASIK exam. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600.

Replacement Contact Lens Program: Receive significant savings on replacement contact lens after your plan allowance has been exhausted by ordering online. Visit www.aetnavision.com for details.

* Nearsighted better than -2 and astigmatism better than -1.

Section 6 International Services and Supplies

International Claims Payment

Aetna Vision is a nationwide vision plan and therefore does not have network doctors overseas. To obtain services, visit any international eye care provider and you will be reimbursed out-of-network schedule:

Services/Materials	Standard Option	High Option
	We Pay	We Pay
Exam	Up to \$40	Up to \$40
Single Vision Lenses	Up to \$40	Up to \$40
Bifocal Lenses	Up to \$60	Up to \$60
Trifocal Lenses	Up to \$80	Up to \$80
Lenticular Lenses	Up to \$80	Up to \$80
Contact lenses	Up to \$112	Up to \$120
Medically Necessary Contact Lenses	Up to \$200	Up to \$200
Frames	Up to \$70	Up to \$90

Finding an International Provider

Visit the international eye care provider of your choice.

Filing International Claims

You may obtain an out-of-network claim form for reimbursement by visiting our website, www.aetnafeds.com or calling our customer service at 1-855-347-6899. Please keep a copy of the information and mail the originals to:

- Aetna Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111

Customer Service Website and Phone Numbers

You may look up information on our plan or ask a question at www.aetnafeds.com. (Our toll-free number will not work overseas).

International Rates

Please refer to the Rate Information section, to view the rates. Premiums for our international members are the same as our nationwide members.

Section 7 General Exclusions – Things We Do Not Cover

The following services and materials are not covered:

- Any charges in excess of the benefit, dollar, or supply limits stated in this brochure;
- Any exams given during your stay in a hospital or other facility for medical care;
- Drugs or medicines;
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Vision services or supplies which do not meet professionally accepted standards;
- Duplicate or spare eyeglasses or lenses or frames for them;
- Replacement of lost, stolen or broken **prescription** lenses or frames;
- Special supplies such as nonprescription sunglasses and subnormal vision aids;
- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services and materials which are rendered prior to your effective date;
- Services and materials incurred after the termination date of your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Services or materials provided as a result of intentionally self-inflicted injury or illness;
- Services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Special lens designs or coatings other than those described in this brochure;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption.
- Discounts not applicable to certain brand name Vision Materials for which the manufacturer imposes a no-discount practice.
- Benefits may not be combined with any discount or promotional offering unless otherwise noted in an offer.

Section 8 Claims Filing and Disputed Claims Processes

How to File a Claim for Covered Services

When you visit a network doctor, you do not complete any paperwork or claim forms. Aetna Vision doctors verify your eligibility, plan coverage and obtain authorization from Aetna Vision.

If you decide not to see an Aetna Vision doctor, you are required to pay the provider in full at the time of your appointment and submit a claim for reimbursement up to the amount allowed by the plan.

You may obtain an out-of-network claim form for reimbursement by visiting our website, www.aetnafeds.com or calling our customer service at 1-855-347-6899. Please keep a copy of the information and mail the originals to:

- Aetna Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111

Deadline for Filing Your Claim

Out-of-network claims must be submitted to Aetna Vision within 15 months of the date of service for reimbursement.

Disputed Claims Process

Follow this disputed claims process if you disagree with our decision on your claim or request for services. **The FEDVIP law does not provide a role for OPM to review disputed claims.**

1. Ask us in writing to reconsider our initial decision. You must:

- a) Write to us within 15 months from the date of our decision; and
- b) Send your request to us at: Aetna Vision, Attention: Appeal Resolution Team, 4000 Luxottica Place, Mason, OH 45040; and

Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and include copies of documents that support your claim, and explanation of benefits (EOB) forms. This is your first level appeal.

2. We have 30 days from the date we receive your request to:

- a) Pay the claim (or, if applicable, arrange for the vision provider to give you the care); or
- b) Write to you and maintain our denial – go to step 3; or
- c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

3. If the dispute is not resolved through the reconsideration process, and the reason for the denial was based on medical necessity or for experimental or investigational reasons, you have the right to file a second level appeal. That appeal must be submitted within 60 days following the receipt of our first level denial.

4. If you do not agree with our final decision, and the amount of your claim is more than

\$300 and the plan denied your claim because it did not consider the treatment a medical necessity, you may request an independent third party, mutually agreed upon by us and OPM, review the decision. You have 30 days from the date you received our final decision to request a third party review.

The decision of the independent third party is binding and is the final review of your claim. This decision is not subject to judicial review.

Section 9 Definitions of Terms We Use in This Brochure

Annuitants	Federal retirees (who retired on an immediate annuity), and survivors (of those who retired on an immediate annuity or died in service) receiving an annuity. This also includes those receiving compensation from the Department of Labor's Office of Workers' Compensation Programs, who are called compensationers. Annuitants are sometimes called retirees.
BENEFEDS	The enrollment and premium administration system for FEDVIP.
Benefits	Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.
Enrollee	The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.
FEDVIP	Federal Employees Dental and Vision Insurance Program.
Plan Allowance	The maximum benefit payment for services received. Please refer to Section 4, Your Cost for Covered Services, for the maximum benefit payment for services received in limited access areas or out-of-network and Section 6, International Services and Supplies, for services received outside the United States or Puerto Rico.
Pre-Authorization	This is the procedure used by the plan to pre-approve services and the amount that the plan will cover.
Sponsor	Generally, a sponsor means the individual who is eligible for medical or dental benefits under 10 U.S.C. chapter 55 based on his or her direct affiliation with the uniformed services (including military members of the National Guard and Reserves).
TEI certifying family member	Under circumstances where a sponsor is not an enrollee, a TEI family member may accept responsibility to self-certify as an enrollee and enroll TEI family members
TRICARE-eligible individual (TEI) family member	TEI family members include a sponsor's spouse, unremarried widow, unremarried widower, unmarried child, and certain unmarried persons placed in a sponsor's legal custody by a court. Children include legally adopted children, stepchildren, and pre-adoptive children. Children and dependent unmarried persons must be under age 21 if they are not a student, under age 23 if they are a full-time student, or incapable of self-support because of a mental or physical incapacity.
We/Us	Aetna Vision
You	Enrollee or eligible family member.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Dental and Vision Insurance Program premium.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your providers, plan, BENEFEDS, or OPM.
- Let only the appropriate providers review your clinical record or recommend services.
- Avoid using providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review your explanation of benefits (EOBs) statements, which is available online at www.aetnavision.com.
- Do not ask your provider to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at [1-855-347-6899](tel:1-855-347-6899) and explain the situation.
- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self-support).

If you have any questions about the eligibility of a dependent, please contact BENEFEDS.

Be sure to review Section 1, Eligibility, of this brochure, prior to submitting your enrollment or obtaining benefits.

Fraud or intentional misrepresentation of material fact is prohibited under the plan. You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEDVIP benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the plan, or enroll in the plan when you are no longer eligible.

Summary of Benefits

- **Do not rely on this chart alone.** This page summarizes specific expenses we cover; for more detail, please review the individual sections of this brochure.
- If you want to enroll or change your enrollment in this plan, please visit www.BENEFEDS.com or call 1-877-888-FEDS (1-877-888-3337), TTY number 1-877-889-5680.

High Option Benefits	You Pay	
	In-Network	Out-of-Network
Eye Exam –a comprehensive exam that focuses on your eyes and overall wellness.	Nothing	Reimbursed up to \$40
Prescription Eyewear – Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.		
Lenses – Standard Plastic single vision, lined bifocal, lined trifocal and lenticular lenses.	Nothing	Reimbursed up to: Single vision \$40 Lined bifocal \$60 Lined trifocal \$80 Lenticular \$80
Lens options, including:		
• Standard Polycarbonate lenses (shatter resistant)	Nothing	Reimbursed up to \$5
• Standard Scratch resistant coating	Nothing	Reimbursed up to \$5
• Standard Anti-reflective coating	\$20	Reimbursed up to \$5
• Tints	Nothing	Reimbursed up to \$5
• UV protection	Nothing	Reimbursed up to \$5
• Photochromic Lenses - lenses are clear indoors and darken outside	\$75 fixed discount*	Not covered
Standard progressive lenses	Nothing	Reimbursed up to \$60
• Premium progressive lenses Tiers 1-3	\$40-\$65	Reimbursed up to \$60
• Other premium progressive lenses	80% of charge less \$120 allowance + \$20 copay	Reimbursed up to \$60
Contact Lenses Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.		
Conventional contact lenses –	Any amount over \$150 plan allowance after a 15% discount	Reimbursed up to \$120
Disposable contact lenses	Any amount over \$150 plan allowance	Reimbursed up to \$120
Medically necessary contact lenses	Nothing	Reimbursed up to \$200

High Option Benefits - continued on next page

High Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
<p>Frame - Once every calendar year. Any frame available at the provider location</p> <p>Nothing for frames up to the \$230 plan allowance</p> <p>Frame Greater than \$230:</p> <p>pay any amount after a 20% discount</p>		Reimbursed up to \$90
<p>Extra Discounts and Savings</p> <p>Prescription glasses</p> <ul style="list-style-type: none"> • Minimum 20% savings on all non-covered lens options • Up to 40% discount off additional pairs of prescription glasses and sunglasses; Up to 20% off non-prescription sunglasses <p>Retinal imaging (also known as fundus photography) - When available at a participating provider's office, members will pay no more than \$39 for this service.</p> <p>Laser vision correction</p> <p>Members will receive a discount of 15% off retail or 5% off promotional prices. In addition, Featured LasikPlus Providers offer special member prices from \$695* - \$1,895 per eye plus a free LASIK exam. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600.</p> <p>Replacement Contact Lens Program: Receive significant savings on replacement contact lens after your plan allowance has been exhausted by ordering online. Visit www.aetnavision.com for details.</p>	Available	Not available
Standard Option Benefits	In-Network	Out-of-Network
Eye Exam - a comprehensive exam that focuses on your eyes and overall wellness.	Nothing	Reimbursed up to \$40
Prescription Eyewear - Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.		
Lenses - Standard Plastic single vision, lined bifocal, lined trifocal and lenticular lenses	\$10	<p>Reimbursed up to:</p> <p>Single Vision - \$40</p> <p>Lined bifocal - \$60</p> <p>Lined trifocal - \$80</p> <p>Lenticular - \$80</p>

Standard Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
Lens options, including:		
• Standard Polycarbonate lenses (shatter-resistant)	Nothing	Reimbursed up to \$5
• Standard Scratch-resistant coating	Nothing	Reimbursed up to \$5
• Standard progressive lenses	\$75	Reimbursed up to \$60
• Premium progressive lenses Tiers 1-3	\$95-120	Reimbursed up to \$60
• Standard Anti-reflective coating	\$45 fixed discount*	Not covered
• Photochromic Lenses - lenses are clear indoors and darken outside	\$75 fixed discount*	Not covered
• Other premium progressive lenses	80% of charge less \$120 allowance + \$75 copay	Reimbursed up to \$60
Contact Lenses Choose eyeglass lenses or contact lenses every calendar year. You cannot use both benefits within the same calendar year.		
Conventional contact lenses	Any amount over \$140 plan allowance after a 15% discount	Reimbursed up to \$112
Disposable contact lenses	Any amount over \$140 plan allowance	Reimbursed up to \$112
Medically necessary contact lenses	Nothing	Reimbursed up to \$200
Frame - Once every calendar year. Any frame available at the provider location	Nothing for frames up to the \$140 plan allowance Frame Greater than \$140: pay any amount after a 20% discount	Reimbursed up to \$70
Extra Discounts and Savings Prescription glasses • Minimum 20% savings on all non-covered lens options • Up to 40% discount off additional pairs of prescription glasses and sunglasses; Up to 20% off non-prescription sunglasses Retinal imaging (also known as fundus photography) - When available at a participating provider's office, members will pay no more than \$39 for this service. Laser vision correction	Available	Not Available

Standard Option Benefits - continued on next page

Standard Option Benefits (cont.)	You Pay	
	In-Network	Out-of-Network
<p>Members will receive a discount of 15% off retail or 5% off promotional prices. In addition, Featured LasikPlus Providers offer special member prices from \$695* - \$1,895 per eye plus a free LASIK exam. The LASIK discount is only available from U.S. Laser Network by calling 1-800-422-6600.</p> <p>Replacement Contact Lens Program: Receive significant savings on replacement contact lens after your plan allowance has been exhausted by ordering online. Visit www.aetnavision.com for details.</p>	Available	Not Available

*The amount shown is the negotiated discounted price you will pay the provider. Discounts may not be available in all states at all in-network providers. To see a list of providers who do honor discounts, go to www.aetnavision.com, select Find a Provider, and if you see "May not accept all additional plan discounts" you should contact the provider to confirm.

Rate Information

These rates apply nationwide and internationally.

High - Bi-Weekly			High - Monthly		
Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
\$5.77	\$11.53	\$17.29	\$12.50	\$24.98	\$37.46

Standard - Bi-Weekly			Standard - Monthly		
Self Only	Self Plus One	Self and Family	Self Only	Self Plus One	Self and Family
\$3.18	\$6.36	\$9.55	\$6.89	\$13.78	\$20.69