



PLAN DOCUMENT

Vision Benefit Plan Information	
Plan ID	2907510959
Plan Version ID	2907510959
Effective Date	1/1/2023
Plan Description	C1 PPO Comprehensive
Customization Level	Level 1
Product Segment	Global Health Care
Market Segment	All Segments
Product Type	Benefit Plan
Product Family	Vision
Product	Vision Benefit Plan
Base Child Indicator	Base

Plan Option			
Vision Plan Type	Vision Plan Type	Vision Plan Type	C1 PPO Comprehensive
		Pediatric Vision Coverage under age 19	Not Covered
Vision Benefit Period	Vision Benefit Period	Benefit Period	Calendar Year
		Frequency (Exam/Lens/Contact Lens/Frame)	12/12/12/12
Eye Exam	Eye Exam	Eye Exam Cost Share In-Network (IN)	Eye Exam Copay In-Network (IN)
		Eye Exam Copay In-Network (IN)	\$20
		Eye Exam Coinsurance In-Network (IN)	100%
		Eye Exam Cost Share Out of Network (OON)	Eye Exam Reimbursement Out of Network (OON)
		Eye Exam Reimbursement Out of Network (OON)	\$45
Optional Exam Enhancements	Optional Exam Enhancements	Retinal Screening	Not Covered
		Contact Lenses Professional Services	Not Included

Plan Option			
Material Coverage - Lenses	Material Coverage - Lenses	Lenses Cost Share In-Network (IN)	Lenses Copay In-Network (IN)
		Lenses Copay In-Network (IN)	\$20
		Lenses Coinsurance In-Network (IN)	100%
		Lenses Cost Share Out of Network (OON)	Lenses Reimbursement Out of Network (OON)
		Lenses Reimbursement Out of Network (OON)	32/55/65/80
		Lens Enhancement Options	Not Covered
Material Coverage - Contact Lenses	Material Coverage - Contact Lenses	Contact Lenses Reimbursement In-Network (IN)	\$300
		Contact Lenses Therapeutic Reimbursement In-Network (IN) Coverage	Covered in Full
		Contact Lenses Reimbursement Out of Network (OON)	\$192
		Contact Lenses Therapeutic Reimbursement Out of Network (OON)	\$210
Material Coverage - Frames	Material Coverage - Frames	Frame Retail Reimbursement In-Network (IN)	\$300
		Frame Retail Reimbursement Out of Network (OON)	\$130

Benefit Option	
Low Vision Coverage	Not Covered
Safety Eyewear Coverage	Not Covered