Preferred Provider Organization (PPO)
Vision Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	City of Phoenix
Contract number:	MSA-0109698
Schedule of Benefits:	2A
Plan effective date:	January 1, 2026
Plan issue date:	November 6, 2025

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

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 exceed your benefit frequency limit.
- This plan has **maximum allowance**s for specific in network **covered benefits**. These are dollar amount maximums for **covered benefits**.
- This plan has **scheduled limit**s 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 http://www.aetna.com.
- Call Member Services at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits in use. Keep it with your booklet.

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.

Plan features

Benefit frequency limits

In-network and out-of-network combined

Vision examinations

Description	Limit
Vision examinations	Once every **Calendar Year**

Vision materials

Description	Limit
Frames	1 pair every **Calendar Year**
Lenses	1 pair every **Calendar Year**
Contact lenses	1 order every **Calendar Year**

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	$25 **copayment**	$0 **scheduled limit**

Vision materials

Frames

Description	In-network coverage	Out-of-network coverage
Eyeglass frame	$0 **copayment** then the plan pays up to $30 **maximum allowance**	$0 **scheduled limit**

Standard plastic prescription lenses

Description	In-network coverage	Out-of-network coverage
Single Vision	$20 **copayment**	$0 **scheduled limit**
Bifocal	$30 **copayment**	$0 **scheduled limit**
Trifocal	$40 **copayment**	$0 **scheduled limit**
Lenticular	$40 **copayment**	$0 **scheduled limit**

Standard progressive	$95 **copayment**	$0 **scheduled limit**
Premium progressive	$95 **copayment** then the plan pays up to $120 **maximum allowance**	$0 **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 $75 **maximum allowance**	$0 **scheduled limit**
Disposable contact lenses	$0 **copayment** then the plan pays up to $75 **maximum allowance**	$0 **scheduled limit**
Description	**In-network coverage**	**Out-of-network coverage**
Non-conventional (medically necessary) contact lenses	$0 **copayment**	$0 **scheduled limit**