Affinity Health Plan

Essential Plan 2018 Schedule of Benefits

	ESSENTIAL PLAN 1	ESSENTIAL PLAN 1 AI/AN	ESSENTIAL PLAN 1 (DV)	ESSENTIAL PLAN 1 AI/AN (DV)	ESSENTIAL PLAN 2	ESSENTIAL PLAN 2 AI/AN	ESSENTIAL PLAN 2 (DV)	ESSENTIAL PLAN 2 AI/AN (DV)	ESSENTIAL PLAN 3	ESSENTIAL PLAN 4
COST-SHARING										
Deductible • Individual	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Out-of-Pocket Limit • Individual	$2,000	$0	$2,000	$0	$200	$0	$200	$0	$200	$0
OFFICE VISITS										
Primary Care Office Visits (or Home Visits)	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Specialist Office Visits (or Home Visits)	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
PREVENTIVE CARE										
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Adult Immunizations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Mammography Screenings and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Sterilization Procedures for Women*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Vasectomy	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Bone Density Testing*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• Screening for Prostate Cancer Performed in PCP Office										
Performed in PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Performed in Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
EMERGENCY CARE										
Pre-Hospital Emergency Medical Services (Ambulance Services)	$75	$0	$75	$0	$0	$0	$0	$0	$0	$0
Non-Emergency Ambulance Services **Preauthorization Required**	$75	$0	$75	$0	$0	$0	$0	$0	$0	$0
Emergency Department [Copayment / Coinsurance waived if Hospital admission]	$75	$0	$75	$0	$0	$0	$0	$0	$0	$0
Urgent Care Center	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
PROFESSIONAL SERVICES and OUTPATIENT CARE										
Advanced Imaging Services										
• Performed in a Freestanding Radiology Facility or Office Setting	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed in a specialist office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services **Preauthorization Required**	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Allergy Testing and Treatment										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in a Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Ambulatory Surgical Center Facility Fee	$50	$0	$50	$0	$0	$0	$0	$0	$0	$0
Anesthesia Services (all settings) **Preauthorization Required**	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Autologous Blood Banking **Preauthorization Required**	5% coinsurance	Covered in full	5% coinsurance	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Cardiac and Pulmonary Rehabilitation										
• Performed in a Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed as Inpatient Hospital Services **Preauthorization Required**	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing	Included as part of inpatient Hospital service cost-sharing
Chemotherapy										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in a Specialist Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services **Preauthorization Required (preauthorizaion not required for injectables and infusions)**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0

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Chiropractic Services **Preauthorization Required**	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Clinical Trials **Preauthorization Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service
Diagnostic Testing										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in a Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Dialysis										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in a Freestanding Center or Specialist Office Setting	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services **Preauthorization required with first encounter and after 12 visits**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$15 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$15 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$0 60 visits per condition, per plan year combined therapies	$0 20 visits per therapy per Plan Year	$0 20 visits per therapy per Plan Year
Home Health Care 40 visits Per Plan Year **Preauthorization required**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)
Infusion Therapy										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in Specialist Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Home Infusion Therapy (Home infusion counts toward home health care visit limits) **Preauthorization required for first encounter and beyond 6 encounters**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Inpatient Medical Visits **Preauthorization Required**	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission
Laboratory Procedures										
• Performed in a PCP Office	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
• Performed in a Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed in a Freestanding Laboratory Facility or Specialist Office	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Maternity and Newborn Care										
• Prenatal Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
• Inpatient Hospital Services	$150 Per Admission	$0	$150 Per Admission	$0	$0	$0	$0	$0	$0	$0
• Physician and Midwife Services for Delivery	$50	$0	$50	$0	$0	$0	$0	$0	$0	$0
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
• Postnatal Care **Preauthorization required** at initial visit then at 36 weeks	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing

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Outpatient Hospital Surgery Facility Charge **Preauthorization Required for hospital (not for freestanding)**	$50	$0	$50	$0	$0	$0	$0	$0	$0	$0
Preadmission Testing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prescription Drugs Adminstered in Office (or Out Paitent facility • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 $25 $25	 $0 $0 $0	 $15 $25 $25	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 $25 $25	 $0 $0 $0	 $15 $25 $25	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization Required**	 $15 $15 $15	 $0 $0 $0	 $15 $15 $15	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$15 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$15 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0 20 visits per therapy per Plan Year	$0 20 visits per therapy per Plan Year
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Preauthorization Required**	$25	$0	$25	$0	$0	$0	$0	$0	$0	$0
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) **All transplants must be performed at designated Facilities** • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization Required**	$50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office	$0 $0 $0 $0	$50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0	$0 $0 $0 $0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES										
ABA Treatment for Autism Spectrum Disorder **Preauthorization Required**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization Required**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education **Preauthorization required for insulin pump**	 $15 $15	 $0 $0	 $15 $15	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0
Durable Medical Equipment and Braces **Preauthorization required for DME items greater than cost of $500 (NY Medicare rate/current fee schedule)**	5% cost-sharing	$0	5% cost-sharing	$0	$0	$0	$0	$0	$0	$0
External Hearing Aids (Single purchase one every three (3) years) **Preauthorization required**	5% cost-sharing	$0	5% cost-sharing	$0	$0	$0	$0	$0	$0	$0
Cochlear Implants (One (1) per ear per time Covered) **Preauthorization required**	5% cost-sharing	$0	5% cost-sharing	$0	$0	$0	$0	$0	$0	$0
Hospice Care • Inpatient • Outpatient 210 days per Plan Year **Preauthorization required**	 $150 $15	 $0 $0	 $150 $15	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0	 $0 $0
Medical Supplies **Preauthorization required for greater than cost of $500**	5% coinsurance	$0	5% coinsurance	$0	$0	$0	$0	$0	$0	$0
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements • Internal **Preauthorization required for greater than cost of $500**	5% coinsurance Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	5% coinsurance Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing

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INPATIENT SERVICES and FACILITIES										
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$75	$0	$75	$0	$0	$0	$0	$0	$0	$0
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility **Preauthorization required**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies **Preauthorization required**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies **Preauthorization required**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES										
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) **Preauthorization required**	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$150	$0	$150	$0	$0	$0	$0	$0	$0	$0
Outpatient Substance Use Services Up to 20 visits per Plan Year may be used for family counseling	$15	$0	$15	$0	$0	$0	$0	$0	$0	$0
PRESCRIPTION DRUGS										
*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF										
Retail Pharmacy										
30-day supply Tier 1 Tier 2 Tier 3	$6 $15 $30	$0 $0 $0	$6 $15 $30	$0 $0 $0	$1 $3 $3	$0 $0 $0	$1 $3 $3	$0 $0 $0	$1 $3 $3	$0 $0 $0
If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.										
Mail Order Pharmacy										
Up to a 90-day supply for Maintenance Drugs (2.5x copay) Tier 1 Tier 2 Tier 3	$15 $37.50 $75	$0 $0 $0	$15 $37.50 $75	$0 $0 $0	$2.50 $7.50 $7.50	$0 $0 $0	$2.50 $7.50 $7.50	$0 $0 $0	$2.50 $7.50 $7.50	$0 $0 $0
NON-PRESCRIPTION DRUGS										
(only include for Essential Plans 3 & 4)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$0.50	$0

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WELLNESS BENEFITS										
Gym Reimbursement	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period
Sign-up for Affinity Member Portal and access Wellness newsletter	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card	$20 Gift Card
Complete annual physical with PCP and complete gaps in care identified for you throughout the calendar year.	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards	Up to $100 in Gift Cards
DENTAL and VISION CARE										
Dental Care										
• Preventive Dental Care	N/A	N/A	$15	$0	N/A	N/A	$0	$0	$0	$0
• Routine Dental Care	N/A	N/A	$15	$0	N/A	N/A	$0	$0	$0	$0
• Major Dental (Endodontics, Periodontics and Prosthodontics	N/A	N/A	$15	$0	N/A	N/A	$0	$0	$0	$0
One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals **Orthodontics and major dental require Preauthorization**										
Vision Care										
• Exams	N/A	N/A	$15	$0	N/A	N/A	$0	$0	$0	$0
• Lenses and Frames	N/A	N/A	10% Coinsurance	$0	N/A	N/A	$0	$0	$0	$0
• Contact Lenses	N/A	N/A	10% Coinsurance	$0	N/A	N/A	$0	$0	$0	$0
One (1) exam per 12-month period One (1) prescribed lenses and frames per Plan Year **Contact lenses require Preauthorization**										