Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$250	$250	$500
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum ("OOPM")	$7,800	$7,800	$15,600

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" heading in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	$5 per visit		✓
Cancer chemotherapy drugs and adjuncts	20% Coinsurance		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	20% Coinsurance		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	$250 per trip	✓	✓
Nonemergency ambulance and psychiatric transport van Services	$250 per trip	✓	✓

Behavioral health treatment for autism spectrum disorder

Description of Behavioral Health Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered Services	$35 per day		✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	20% Coinsurance		✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	20% Coinsurance up to a $2,000 benefit limit per Accumulation Period	✓	✓
Retail-grade breast pumps	No charge		✓
Hospital-grade breast pumps	No charge		✓

Emergency and Urgent Care visits

Description of Emergency and Urgent Care Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency Department visits	$250 per visit	✓	✓
Urgent Care visits	$35 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the Emergency Department, the Emergency Department visits Cost Share above does not apply. Instead, the Services you received in the Emergency Department, including any observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital inpatient care" in this "Cost Share Summary." The Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Female sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other female sterilization procedures	No charge		✓
Male sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	$335 per procedure	✓	✓
All other male sterilization procedures	$55 per visit		✓
Termination of pregnancy	$55 per procedure	✓	✓

Fertility Services

Diagnosis and treatment of infertility

Description of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Services for the diagnosis and treatment of infertility	Not covered		

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Services for artificial insemination	Not covered		

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Assisted reproductive technology ("ART") Services such as invitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT")	Not covered		

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to smoking cessation	No charge		✓
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$35 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	$55 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (100 visits per Accumulation Period)	$30 per visit		✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		✓

Hospital inpatient care

Description of Hospital Inpatient Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient hospital stays	$600 per day up to a maximum of $3,000 per admission	✓	✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	$600 per day up to a maximum of $3,000 per admission	✓	✓
Individual mental health evaluation and treatment	$35 per visit		✓
Group mental health treatment	$17 per visit		✓
Partial hospitalization	$35 per day		✓
Other intensive psychiatric treatment programs	$35 per day		✓
Residential mental health treatment Services	$600 per day up to a maximum of $3,000 per admission	✓	✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$35 per visit		✓
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$55 per visit		✓
Group appointments that are not described elsewhere in this "Cost Share Summary"	$17 per visit		✓
Acupuncture Services	$35 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	$250 per procedure	✓	✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	$55 per encounter		✓
Nuclear medicine	$55 per encounter		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	$35 per encounter		✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	$55 per encounter		✓

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Radiation therapy	20% Coinsurance		✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on the generic tier (Tier 1) not described elsewhere in this "Cost Share Summary"	$15 for up to a 30-day supply	$30 for up to a 100-day supply		✓
Items on the brand tier (Tier 2) not described elsewhere in this "Cost Share Summary"	$40 for up to a 30-day supply	$80 for up to a 100-day supply		✓
Items on the specialty tier (Tier 4) not described elsewhere in this "Cost Share Summary"	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
All other items on the generic tier (Tier 1) as described in this *EOC*	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the brand tier (Tier 2) as described in this *EOC*	$40 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the specialty tier (Tier 4) as described in this *EOC*	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on the generic tier (Tier 1)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the brand tier (Tier 2)	$40 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the specialty tier (Tier 4)	20% Coinsurance (not to exceed $200) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the generic tier (Tier 1)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the brand tier (Tier 2)	$40 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Non-oral anticancer drugs on the specialty tier (Tier 4)	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Diabetes supplies and amino acid–modified products

Description of Diabetes Supplies and Amino Acid-Modified Products	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 30-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$15 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the “Most items” table above. For insulin pumps, refer to the “Durable Medical Equipment (“DME”) for home use” table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Female condoms • Spermicide • Sponges	No charge for up to a 30-day supply	Not available		✓
The following hormonal contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Female condoms • Spermicide • Sponges	No charge for up to a 30-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms and cervical caps	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 30-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on the generic tier (Tier 1) prescribed to treat infertility or in connection with covered artificial insemination Services	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed to treat infertility or in connection with covered artificial insemination Services	Not covered	Not covered		
Drugs on the generic tier (Tier 1) prescribed in connection with covered assisted reproductive technology ("ART") Services	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed in connection with covered assisted reproductive technology ("ART") Services	Not covered	Not covered		
Drugs on the generic tier (Tier 1) prescribed for sexual dysfunction disorders	$15 for up to a 30-day supply	$30 for up to a 100-day supply		✓
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed for sexual dysfunction disorders	$40 for up to a 30-day supply	$80 for up to a 100-day supply		✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$335 per procedure	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$55 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
First postpartum follow-up consultation and exam	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection (“STI”) tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Internally implanted prosthetic and orthotic devices as described in this *EOC*	No charge	✓	✓
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$35 per visit		✓
Group outpatient physical, occupational, and speech therapy	$17 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$35 per day		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	$300 per day up to a maximum of $1,500 per admission	✓	✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	$600 per day up to a maximum of $3,000 per admission	✓	✓

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual substance use disorder evaluation and treatment	$35 per visit		✓
Group substance use disorder treatment	$5 per visit		✓
Intensive outpatient and day-treatment programs	$35 per day		✓
Residential substance use disorder treatment	$600 per day up to a maximum of $3,000 per admission	✓	✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$55 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$35 per visit		✓

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$55 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$35 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Specialty contact lenses (other than aniridia and aphakia lenses) that will provide a significant improvement in vision not obtainable with eyeglass lenses: either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 12-month period	No charge		✓
One complete pair of eyeglasses in any 12-month period, or contact lenses as described in this *EOC*, in any 12-month period	No charge		✓
One low vision device (including fitting and dispensing) per Accumulation Period	No charge		✓