

SECTION XV

Vision Care

{Drafting Note: use Section XV for Essential Plans 1, 2, 200-250 (e.g., those whose income is above 138% through 250% FPL)}

Please refer to the Schedule of Benefits section of this [Contract; Policy] for day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage.}

A. Vision Care.

We Cover emergency, preventive and routine vision care.

B. Vision Examinations.

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time [in any 12-month period; per Plan Year, per calendar year], unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Prescribed Lenses and Frames.

We Cover standard prescription lenses or contact lenses one (1) time [in any 12-month period; per Plan Year, per calendar year], unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. [If You choose non-standard lenses, We will pay the amount that We would have paid for standard lenses and You will be responsible for the difference in cost between the standard lenses and the non-standard lenses.] [The difference in cost does not apply toward Your Out-of-Pocket Limit.]

We also Cover standard frames adequate to hold lenses one (1) time [in any 12-month period; per Plan Year; per calendar year], unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame. The difference in cost does not apply

toward Your Out-of-Pocket Limit.

[D. How to Access Vision Services.

If You need to find a Participating Provider or change Your Provider, please call [XXX; the number on Your ID card] or visit Our website at [XXX].]