

[SECTION XXVIII]  
**CARECONNECT INSURANCE COMPANY, INC.**  
**Gold EPO 40/60 Tradition SCHEDULE OF BENEFITS**  
**High Rx**

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Deductible</b> <ul style="list-style-type: none"> <li>• <b>Individual</b></li>   <li>• <b>Family</b></li> </ul> <b>Prescription Drug Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> [Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year]	None  None  \$100 \$300  \$7,150 \$14,300	Non-Participating Provider services are not Covered except as required for emergency care.	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>

Primary Care Office Visits (or Home Visits)	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Specialist Office Visits (or Home Visits)	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> <li>Adult Annual Physical Examinations*</li> <li>Adult Immunizations*</li> <li>Routine Gynecological Services/Well Woman Exams*</li> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> <li>[Sterilization Procedures for</li> </ul>	<p>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]</p>	<p>See Benefit For Description</p>

<p>Women*</p> <ul style="list-style-type: none"> <li>• [Vasectomy</li> <li>• Bone Density Testing*</li> <li>• Screening for Prostate Cancer</li> <li>• All other preventive services required by USPSTF and HRSA.</li> <li>• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</li> </ul>	<p>\$40 Copayment (PCP)/\$60 Copayment (Specialist)</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures &amp; Diagnostic Testing)</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
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<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	\$100 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$100 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment waived if Hospital admission	25% Coinsurance	25% Coinsurance	See Benefit For Description
Urgent Care Center	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	\$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$60 Copayment  \$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Allergy Testing & Treatment		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Ambulatory Surgical Center Facility Fee	\$300 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	\$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	\$300 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>\$1,500 Copayment per admission <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
Chemotherapy <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$60 Copayment</p> <p>\$60 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
Chiropractic Services	<p>\$60 Copayment <b>Preauthorization Required</b></p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Clinical Trials	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures) <b>Preauthorization Required</b></p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description

Specialist Office <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	\$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Dialysis <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Center or Specialist Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$40 Copayment  \$60 Copayment  \$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description  Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per Plan Year combined therapies
Home Health Care	\$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year

<p>Infertility Services</p>	<p>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures) <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li>   <li>• Performed in Specialist Office</li>   <li>• Performed as Outpatient Hospital Services</li>   <li>• Home Infusion Therapy</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>\$40 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>    <p>Home infusion counts towards home health care visit limits</p>

Inpatient Medical Visits	Covered in full per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Laboratory Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$60 Copayment  \$60 Copayment  \$60 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Medications Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed in Outpatient</li> </ul>	Included as part of the PCP office visit Cost-Sharing  Included as part of the PCP office visit Cost-Sharing  \$40 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are	See benefit for description



<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p> <p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$60 Copayment</p> <p>\$60 Copayment</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or</p>	<p>\$60 Copayment</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>60 visits per condition, per Plan Year</p>

Speech Therapy)			combined therapies. Speech and physical therapy are only Covered following a Hospital stay or Surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) <ul style="list-style-type: none"> <li>• Inpatient Hospital Surgery</li> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> </ul>	Covered in full per admission  Covered in full  Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are	See Benefit For Description  All transplants must be performed at designated Facilities

<ul style="list-style-type: none"> <li>Office Surgery</li> </ul>	Covered in full <b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	
Telemedicine Program	Covered In Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder	\$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	\$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> <li>Diabetic Equipment, Supplies and Insulin (30-Day Supply)</li> <li>Diabetic Education</li> </ul>	\$40 Copayment  \$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Durable Medical Equipment & Braces	\$300 Copayment <b>Preauthorization Required for Items Above \$500</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

External Hearing Aids	\$300 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Single Purchase Once Every three (3) Years
Cochlear Implants	\$300 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul>	\$1,500 Copayment per admission  \$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	210 Days per Plan Year  Five (5) Visits for Family Bereavement Counseling
Medical Supplies	\$300 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul>	\$300 Copayment  \$300 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements  Unlimited See Benefit For Description
<b>INPATIENT SERVICES &amp; FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$1,500 Copayment per admission <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost.	See Benefit For Description

Observation Stay	\$300 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$1,500 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	200 Days Per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	\$1,500 Copayment per admission <b>Preauthorization Required.</b>	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$1,500 Copayment per admission <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 Days Per Plan Year
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1,500 Copayment per admission <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a	\$1,500 Copayment per admission <b>Preauthorization Required. However, Preauthorization is Not</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Hospital)	<b>Required for Emergency Admissions or for Participating OASAS-certified Facilities.</b>		
Outpatient Substance Use Services	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited
<b>PRESCRIPTION DRUGS</b> *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 and obtained at a participating pharmacy.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30 Day Supply Tier 1	\$15 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$35 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$75 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	\$45 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$105 Copayment after Deductible	Non-Participating Provider Services Are	

Tier 3	\$225 Copayment after Deductible	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<b>Mail Order Pharmacy</b>			
Up to a 90 Day Supply Tier 1	\$38 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$88 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$188 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$15 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse

<b>PEDIATRIC DENTAL &amp; VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics &amp; Periodontics)</li> <li>• Orthodontics</li> </ul>	\$40 Copayment  \$40 Copayment  \$300 Copayment  \$300 Copayment  <b>Orthodontics &amp; Major Dental Require Preauthorization</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Dental Exam & Cleaning Per six (6)-Month Period
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses &amp; Frames</li> <li>• Contact Lenses</li> </ul>	\$40 Copayment  25% Coinsurance  25% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses & Frames in a 12-Month Period