

[SECTION XXVII]

CARECONNECT INSURANCE COMPANY, INC.
 NON-STD Silver CSR 200-250% FPL EPO Tradition SCHEDULE OF BENEFITS
 HIGH Rx

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Prescription Drug Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$4,000</p> <p>\$8,000</p> <p>\$100</p> <p>\$300</p> <p>\$6,000</p> <p>\$12,000</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>Non-Participating Provider services are not Covered except as required for emergency care.</p>	
<p>OFFICE VISITS</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$40 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and 	<p>Covered in full</p>	<p>Non-Participating Provider Services Are</p>	<p>See Benefit For</p>

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Immunizations*		Not Covered and You Pay the Full Cost	Description
<ul style="list-style-type: none"> Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Adult Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Vasectomy 	\$40 Copayment (PCP)/\$60 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Bone Density Testing* 	Covered in full		

<ul style="list-style-type: none"> • Screening for Prostate Cancer • All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	<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 & 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>	
EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment	\$150 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$150 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment waived if Hospital admission	\$350 Copayment	\$350 Copayment	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
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	\$60 Copayment Preauthorization Required	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"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$60 Copayment \$60 Copayment Preauthorization Required	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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	\$40 Copayment \$60 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	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$350 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all	20% Coinsurance after Deductible	Non-Participating Provider Services Are	See Benefit For

settings)	Preauthorization Required	Not Covered and You Pay the Full Cost	Description
Autologous Blood Banking	20% Coinsurance after Deductible	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"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services 	\$40 Copayment \$40 Copayment 20% Coinsurance after Deductible per admission Preauthorization Required	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
Chemotherapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 Copayment Preauthorization Required	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
Chiropractic Services	\$60 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Clinical Trials	Use Cost Sharing for Appropriate Service	Non-Participating Provider Services Are	See Benefit For

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	(Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	Not Covered and You Pay the Full Cost	Description
Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 Copayment Preauthorization Required	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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 Copayment Preauthorization Require	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)	\$40 Copayment Preauthorization Required	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 Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Infusion Therapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy 	\$40 Copayment \$60 Copayment \$60 Copayment \$40 Copayment Preauthorization Required	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	See Benefit For Description Home infusion counts towards home health care visit limits
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"> • Performed in a PCP Office 	\$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"> Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services 	<p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>Preauthorization Required</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>Medications Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed in Outpatient Facilities 	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the Specialist office visit Cost-Sharing</p> <p>\$40 Copayment after Deductible</p> <p>Preauthorization Required</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>Maternity & Newborn Care</p> <ul style="list-style-type: none"> Prenatal Care 	<p>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care 	<p>20% Coinsurance after Deductible per admission</p> <p>\$100 Copayment</p> <p>Covered in full</p> <p>Covered in full</p> <p>Preauthorization Required</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>One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
Outpatient Hospital Surgery Facility Charge	<p>\$350 Copayment</p> <p>Preauthorization Required</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services 	<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>	See Benefit For Description

<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	<p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>Preauthorization Required</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 Speech Therapy)</p>	<p>\$40 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>60 visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p>	<p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist</p>	<p>See Benefit For Description</p>
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p> <ul style="list-style-type: none"> Inpatient Hospital 	<p>\$100 Copayment per admission</p>	<p>Non-Participating Provider Services Are</p>	<p>See Benefit For Description</p> <p>All transplants must be performed at designated</p>

<p>Surgery</p> <ul style="list-style-type: none"> • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	<p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$100 Copayment Preauthorization Required</p>	<p>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>Facilities</p>
<p>Telemedicine Program</p>	<p>Covered In Full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>ADDITIONAL SERVICES, EQUIPMENT & DEVICES</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>ABA Treatment for Autism Spectrum Disorder</p>	<p>\$40 Copayment Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Assistive Communication Devices for Autism Spectrum Disorder</p>	<p>\$40 Copayment Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

<p>Diabetic Equipment, Supplies & Self-Management Education</p> <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education 	<p>\$40 Copayment</p> <p>\$40 Copayment</p> <p>Preauthorization Required</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>Durable Medical Equipment & Braces</p>	<p>20% Coinsurance after Deductible</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>External Hearing Aids</p>	<p>20% Coinsurance after Deductible</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Single Purchase Once Every three (3) Years</p>
<p>Cochlear Implants</p>	<p>20% Coinsurance after Deductible</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One (1) Per Ear Per Time Covered</p>
<p>Hospice Care</p> <ul style="list-style-type: none"> • Inpatient • Outpatient 	<p>20% Coinsurance after Deductible per admission</p> <p>\$40 copayment</p> <p>Preauthorization Required</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>210 Days per Plan Year</p> <p>Five (5) Visits for Family Bereavement Counseling</p>

Medical Supplies	20% Coinsurance after Deductible	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"> External Internal 	20% Coinsurance after Deductible 20% Coinsurance after Deductible Preauthorization Required	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
INPATIENT SERVICES & FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	20% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost.	See Benefit For Description
Observation Stay	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility	20% Coinsurance after Deductible	Non-Participating Provider Services Are	200 Days Per

(Includes Cardiac & Pulmonary Rehabilitation)	Preauthorization Required	Not Covered and You Pay the Full Cost	Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	20% Coinsurance after Deductible per admission Preauthorization Required	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)	20% Coinsurance after Deductible per admission Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 Days Per Plan Year
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	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 Hospital)	20% Coinsurance after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Substance Use Services	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited

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PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
*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.			
Retail Pharmacy			
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 Not Covered and You Pay the Full Cost	
Tier 3	\$225 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
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 Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse, not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse, not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse
PEDIATRIC DENTAL & VISION CARE	Participating Provider Member Responsibility for Cost-Sharing Provider	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			One (1) Dental Exam & Cleaning Per six (6)-Month Period
<ul style="list-style-type: none"> • Preventive Dental Care 	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Routine Dental Care 	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Major Dental Care (Oral Surgery, Endodontics, Periodontics & 	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

<p>Prosthodontics</p> <ul style="list-style-type: none"> • Orthodontics 	<p>20% Coinsurance after Deductible</p> <p>Orthodontics & Major Dental Require Preauthorization</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
<p>Pediatric Vision Care</p> <ul style="list-style-type: none"> • Exams • Lenses & Frames • Contact Lenses 	<p>\$40 Copayment</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</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>One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses & Frames in a 12-Month Period</p>