

**[SECTION XXVIII]**  
**CARECONNECT INSURANCE COMPANY, INC.**  
**Gold EPO 30/50 Tradition SCHEDULE OF BENEFITS**  
**Low Rx**

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>• <b>Individual</b></li> <li>• <b>Family</b></li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p>[Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year]</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$1,000 \$2,000</p> <p>\$3,000 \$6,000</p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>Non-Participating Provider services are not Covered except as required for emergency care.</p>	
<p><b>OFFICE VISITS</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$30 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>\$50 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<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 Women*</li> <li>• [Vasectomy</li> </ul>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>\$30 Copayment (PCP)/ \$50 Copayment (Specialist)</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>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"> <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>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>	
<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	\$200 Copayment	\$200 Copayment.	See Benefit For Description
Urgent Care Center	\$50 Copayment	Non-Participating Provider Services Are	See Benefit For

		Not Covered and You Pay the Full Cost	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	\$50 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>	10% Coinsurance after Deductible  10% Coinsurance after Deductible <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 <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	\$30 Copayment  \$50 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	10% Coinsurance after Deductible <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)	10% Coinsurance after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary			See Benefit For

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>	\$50 Copayment  \$50 Copayment  10% Coinsurance after Deductible per admission  <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	Description
Chemotherapy <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$30 Copayment  \$50 Copayment  \$50 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
Chiropractic Services	\$50 Copayment <b>Preauthorization Required</b>	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 (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Diagnostic Testing <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	10% Coinsurance after Deductible  10% Coinsurance after Deductible  10% Coinsurance after Deductible <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 <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>	\$30 Copayment  \$50 Copayment  \$50 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 t  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)	\$50 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	\$30 Copayment <b>Preauthorization Required</b>	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)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

	Services; Surgery; Laboratory & Diagnostic Procedures) <b>Preauthorization Required</b>		
<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>\$30 Copayment</p> <p>\$50 Copayment</p> <p>\$50 Copayment</p> <p>\$30 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
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Laboratory Facility or Specialist Office</li> </ul>	<p>10% Coinsurance after Deductible</p> <p>10% 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>	See Benefit For Description

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	10% Coinsurance after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
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 Facilities</li> </ul>	Included as part of the PCP office visit Cost-Sharing  Included as part of the PCP office visit Cost-Sharing  \$30 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 not Covered and You pay the full cost	See benefit for description
Maternity & Newborn Care <ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Inpatient Hospital Services and Birthing Center</li> <li>Physician and Midwife Services for Delivery</li> <li>Breast Pump</li> <li>Postnatal Care</li> </ul>	Covered in full  10% Coinsurance after Deductible per admission  10% Coinsurance after Deductible  Covered in Full  Covered in Full  <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  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description  One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early  Covered for duration of breast feeding



Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible <b>Preauthorization Required</b>	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
Diagnostic Radiology Services <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>	10% Coinsurance after Deductible  10% Coinsurance after Deductible  10% Coinsurance after Deductible	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
Therapeutic Radiology Services <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>	\$50 Copayment  \$50 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
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$50 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, Plan Year combined therapies. Speech and

			Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$50 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> <li>Office Surgery</li> </ul>	10% Coinsurance after Deductible per admission  10% Coinsurance after Deductible  10% Coinsurance after Deductible  10% Coinsurance after Deductible  <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	See Benefit For Description  All transplants must be performed at designated Facilities
Telemedicine Program	Covered In Full	See Benefit For Description	See Benefit For Description
<b>ADDITIONAL SERVICES,</b>	<b>Participating Provider Member</b>	<b>Non-Participating Provider Member</b>	<b>Limits</b>

<b>EQUIPMENT &amp; DEVICES</b>	<b>Responsibility for Cost-Sharing</b>	<b>Responsibility for Cost-Sharing</b>	
ABA Treatment for Autism Spectrum Disorder	\$30 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	\$30 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>	\$30 Copayment  \$30 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	10% Coinsurance after Deductible <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	10% Coinsurance after Deductible <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	10% Coinsurance after Deductible <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> </ul>	10% Coinsurance after Deductible per	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	210 Days per Plan Year

<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	admission  \$30 Copayment  <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Five (5) Visits for Family Bereavement Counseling
Medical Supplies	10% 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"> <li>External</li> <li>Internal</li> </ul>	10% Coinsurance after Deductible  10% Coinsurance after Deductible <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 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)	10% Coinsurance after Deductible 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	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	10% Coinsurance after Deductible <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	10% Coinsurance after Deductible per	Non-Participating Provider services are	60 days per Plan

(Physical, Speech and Occupational Therapy)	admission  <b>Preauthorization required</b>	not Covered and You pay the full cost	Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	10% Coinsurance after Deductible 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)	10% Coinsurance after Deductible 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)  • Office Visits	\$30 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)	10% Coinsurance after Deductible per admission <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Outpatient Substance Use Services</p> <ul style="list-style-type: none"> <li>Office Visits</li> <li>All other outpatient substance abuse services</li> </ul>	<p>\$30 Copayment</p> <p>10% Coinsurance after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Unlimited</p>
<p><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.</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p><b>Retail Pharmacy</b></p>			
<p>30 Day Supply</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p>	<p>\$10 Copayment</p> <p>\$50 Copayment</p> <p>50% Coinsurance max to \$250</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>Up to a 90 Day Supply For</p>			<p>See Benefit For</p>

Maintenance Drugs Tier 1	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Description
Tier 2	\$150 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$750	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	\$25 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$125 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$625	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$10 Copayment	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>

<p><b>Pediatric Dental Care</b></p> <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>	<p>\$30 Copayment</p> <p>\$30 Copayment</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p><b>Orthodontics &amp; Major Dental Require Preauthorization</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>One (1) Dental Exam &amp; Cleaning Per six (6)-Month Period</p>
<p><b>Pediatric Vision Care</b></p> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses &amp; Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$30 Copayment</p> <p>10% Coinsurance after Deductible</p> <p>10% 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 &amp; Frames in a 12-Month Period</p>