

**[SECTION XXVIII]  
CARECONNECT INSURANCE COMPANY, INC.  
VALUE SILVER SCHEDULE OF BENEFITS**

<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><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$2,500 \$5,000</p> <p>\$7,100 \$14,200</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>\$35 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>\$65 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p><b>PREVENTIVE CARE</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>
<ul style="list-style-type: none"> <li>• Well Child Visits and Immunizations*</li> <li>• Adult Annual Physical Examinations*</li> </ul>	<p>Covered in full</p> <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>See Benefit For Description</p>

<ul style="list-style-type: none"> <li>• Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• [Sterilization Procedures for Women*</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
<ul style="list-style-type: none"> <li>• [Vasectomy</li> </ul>	\$20 Copayment (PCP)/\$30 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• Screening for Prostate Cancer</li> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>• All other preventive services required by USPSTF and HRSA.</li> </ul>	Covered in full	Non-Participating Provider Services Are	

<ul style="list-style-type: none"> <li>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</li> </ul>	Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Not Covered and You Pay the Full Cost	
<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	\$250 Copayment after Deductible	\$250 Copayment after Deductible	See Benefit For Description
Urgent Care Center	\$75 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	\$65 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</li> </ul>	\$100 Copayment	Non-Participating Provider Services Are	See Benefit For Description

<p>Freestanding Radiology Facility or Office Setting</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$100 Copayment</p> <p><b>Preauthorization Required</b></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>Allergy Testing &amp; Treatment</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>\$35 Copayment</p> <p>\$65 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>See Benefit For Description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>20% Coinsurance after deductible</p> <p><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>Anesthesia Services (all settings)</p>	<p>20% Coinsurance after deductible</p> <p><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>Autologous Blood Banking</p>	<p>20% Coinsurance after deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Cardiac &amp; Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	<p>\$35 Copayment</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>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p>\$65 Copayment</p> <p>20% Coinsurance after deductible per admission</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>Chemotherapy</p> <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>	<p>\$35 Copayment</p> <p>\$65 Copayment</p> <p>20% Coinsurance after deductible</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>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Chiropractic Services</p>	<p>\$65 Copayment</p> <p><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>Clinical Trials</p>	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

	Procedures) <b>Preauthorization Required</b>		
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>	\$75 Copayment  \$75 Copayment  \$75 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 <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>	\$35 Copayment  \$65 Copayment  20% 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  Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year

	<b>Preauthorization Required</b>		
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$65 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	\$35 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 Services; 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
Infusion Therapy <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>	\$35 Copayment   \$65 Copayment  20% Coinsurance after deductible  \$35 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  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	20% Coinsurance after deductible 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>	\$75 Copayment  \$75 Copayment  \$75 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 Facilities</li> </ul>	Included as part of the PCP office visit Cost-Sharing  Included as part of the PCP office visit Cost-Sharing  \$35 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

<p>Maternity &amp; Newborn Care</p> <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>	<p>Covered in full</p> <p>20% Coinsurance after deductible per admission</p> <p>20% Coinsurance after deductible</p> <p>Covered in Full</p> <p>Covered in Full</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>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>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>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>20% Coinsurance after deductible</p> <p><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>Preadmission Testing</p>	<p>20% Coinsurance after deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<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> </ul>	<p>\$75 Copayment</p> <p>\$75 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>See Benefit For Description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	\$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
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>	\$75 Copayment  \$75 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)	\$65 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. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$65 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)			See Benefit For Description
<ul style="list-style-type: none"> <li>Inpatient Hospital Surgery</li> </ul>	20% Coinsurance after deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	All transplants must be performed at designated Facilities
<ul style="list-style-type: none"> <li>Outpatient Hospital Surgery</li> </ul>	20% Coinsurance after deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Surgery Performed at an Ambulatory Surgical Center</li> </ul>	20% Coinsurance after deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Office Surgery</li> </ul>	20% Coinsurance after deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are 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	\$35 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	\$35 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			See Benefit For

& Self-Management Education			Description
<ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-Day Supply)</li>   <li>• Diabetic Education</li> </ul>	<p>\$35 Copayment</p> <p>\$35 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>	
Durable Medical Equipment & Braces	20% Coinsurance after deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids	20% 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	20% 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>   <li>• Outpatient</li> </ul>	20% Coinsurance after deductible per admission  \$35 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	20% Coinsurance after deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Prosthetic Devices <ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul>	20% Coinsurance after deductible  20% 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 (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)	20% 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	20% 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)	20% 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 Rehabilitation Services (Physical, Speech & Occupational therapy)	20% 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)	20% 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)	Covered in Full	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 <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
Outpatient Substance Use Services	Covered in Full	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	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>

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>Retail Pharmacy</b>			
30 Day Supply Tier 1	\$0 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$50 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance after Deductible up to max \$500	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	\$0 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$150 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance after Deductible up to max \$1,500	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	\$0 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 after Deductible up to	Non-Participating Provider Services Are	

	max \$1,250	Not Covered and You Pay the Full Cost	
<b>Enteral Formulas</b>	\$0 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>			One (1) Dental Exam & Cleaning Per six (6)-Month Period
<ul style="list-style-type: none"> <li>Preventive Dental Care</li> </ul>	\$35 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Routine Dental Care</li> </ul>	\$35 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Major Dental Care (Oral Surgery, Endodontics, Prosthodontics &amp; Periodontics)</li> </ul>	20% Coinsurance after deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Orthodontics</li> </ul>	20% Coinsurance after deductible <b>Orthodontics &amp; Major Dental</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

	<b>Require Preauthorization</b>		
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses &amp; Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$35 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 &amp; Frames in a 12-Month Period</p>