

[SECTION XXVIII]

CareConnect Insurance Company, Inc.  
SILVER EPO PLAN SCHEDULE OF BENEFITS

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>•</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>\$2,000</p> <p>\$4,000</p> <p>\$6,750</p> <p>\$13,500</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 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>Specialist Office Visits (or Home Visits)</p>	<p>\$50 Copayment 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><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> </ul>	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</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>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>	See Surgical Services Cost-Sharing	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		
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer</li> </ul>		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

<ul style="list-style-type: none"> <li>Performed in PCP Office</li> <li>Performed in Specialist Office</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>\$30 Copayment after Deductible (PCP)/</p> <p>\$50 Copayment after Deductible</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>	
<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)	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	\$150 Copayment after Deductible <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 plus any amounts charged by the Non-Participating Provider that exceed the Allowed Amount.	See Benefit For Description
Urgent Care Center	\$70 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>PROFESSIONAL SERVICES</b>	<b>Participating Provider Member</b>	<b>Non-Participating Provider Member</b>	<b>Limits</b>

AND OUTPATIENT CARE	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
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>	\$50 Copayment after Deductible  \$50 Copayment 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 after Deductible  \$50 Copayment 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	See Benefit For Description
Ambulatory Surgical Center Facility Fee	\$100 Copayment 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)	Covered in full <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	30% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefits For Description
Cardiac & Pulmonary Rehabilitation			See Benefits For Description

<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>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>Included as Part of Inpatient Hospital Service Cost Sharing <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>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>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible <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>\$50 Copayment after Deductible <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 Procedures)</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

	<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>	\$30 Copayment after Deductible  \$50 Copayment after Deductible  \$50 Copayment 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 after Deductible  \$30 Copayment after Deductible  \$30 Copayment after Deductible <b>Preauthorization Required</b>	\$30 Copayment after Deductible  \$30 Copayment after Deductible  \$30 Copayment after Deductible	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)	\$30 Copayment after Deductible <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 after Deductible	Non-Participating Provider Services Are	40 Visits per

	<b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	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>	\$30 Copayment after Deductible  \$30 Copayment after Deductible  \$30 Copayment after Deductible  \$30 Copayment 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  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	\$0 Copayment after Deductible per admission	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> </ul>	Included as part of the PCP office visit Cost-Sharing	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 Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul>	<p>Included as part of the Specialist office visit Cost-Sharing</p> <p>\$30 Copayment 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>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> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$30 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 Copayment 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>Maternity &amp; Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Prenatal Care that is</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are</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</p>



<p>not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</p> <ul style="list-style-type: none"> <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>(Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$1,500 Copayment after Deductible per admission</p> <p>\$100 Copayment after Deductible</p> <p>Covered in Full</p> <p>Included in Physician and Midwife Services for Delivery Cost-Sharing</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>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>Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>\$100 Copayment 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>\$0 Copayment 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> </ul>	<p>\$30 Copayment after Deductible</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 in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$50 Copayment after Deductible</p> <p>\$50 Copayment 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>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>\$30 Copayment after Deductible</p> <p>\$30 Copayment 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>See Benefit For Description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$30 Copayment 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>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 &amp; Other</p>	<p>\$50 Copayment after Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

		Second Opinions on Diagnosis of Cancer are Covered at Participating Cost Sharing for Non-Participating Specialist	
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery; Transplants; &amp; Interruption of Pregnancy)</p> <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>	<p>\$100 Copayment after Deductible per admission</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$30 Copayment after Deductible (PCP)/ \$50 Copayment after Deductible (Specialist) <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>\$30 Copayment after Deductible</p>	<p>See Benefit For Description</p> <p>All transplants must be performed at designated Facilities</p>
Telemedicine Program	Covered In Full	\$30 Copayment after Deductible	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	\$30 Copayment after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Assistive Communication	\$30 Copayment after Deductible	Non-Participating Provider Services Are	See Benefit For

Devices for Autism Spectrum Disorder	<b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	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 after Deductible  \$30 Copayment 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
Durable Medical Equipment & Braces	30% 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	30% 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	30% 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>	\$1,500 Copayment after Deductible per admission  \$30 Copayment 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	210 Days per Plan Year  Five (5) Visits for Family Bereavement Counseling
Medical Supplies	30% 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> </ul>	30% Coinsurance after Deductible	Non-Participating Provider Services Are	One (1) prosthetic

<ul style="list-style-type: none"> <li>Internal</li> </ul>	<p>Included as part of inpatient Hospital service Cost-Sharing</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>device, per limb, per lifetime with coverage for repairs and replacements</p> <p>Unlimited See Benefit For Description</p>
<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)	<p>\$1,500 Copayment after Deductible per admission</p> <p><b>Preauthorization Required. However, Preauthorization is not required for Emergency Admissions.</b></p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost. However, if the inpatient services are Emergency Services, You pay \$1,500 per admission after Deductible plus any amounts charged by the Non-Participating Provider that exceed the Allowed Amount.	See Benefit For Description
Observation Stay	\$250 Copayment 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)	<p>\$1,500 Copayment after Deductible per admission</p> <p><b>Preauthorization Required</b></p>	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)	<p>\$1,500 Copayment after Deductible per admission</p> <p><b>Preauthorization required</b></p>	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 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)	\$1,500 Copayment 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)	\$30 Copayment after Deductible	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)	\$1,500 Copayment 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	\$30 Copayment after Deductible	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  Tier 2  Tier 3	\$10 Copayment not subject to Deductible  \$35 Copayment not subject to Deductible  \$70 Copayment not subject to 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
Up to a 90 Day Supply For Maintenance Drugs Tier 1  Tier 2  Tier 3	\$30 Copayment not subject to Deductible  \$105 Copayment not subject to Deductible  \$210 Copayment not subject to 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
<b>Mail Order Pharmacy</b>			

Up to a 90 Day Supply Tier 1	\$25 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$87.50 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$175 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas			See Benefit For Description
Tier 1	\$10 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 2	\$35 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$70 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
	<b>Preauthorization Required</b>		
<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, 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
<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> </ul>	\$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Dental Exam & Cleaning Per six (6)-Month Period



<ul style="list-style-type: none"> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics, Periodontics)</li> <li>• Orthodontics</li> </ul>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 Copayment 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><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 after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% 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>