[SECTION XXVIII]
CARECONNECT INSURANCE COMPANY, INC.
Gold EPO20/40 Tradition SCHEDULE OF BENEFITS
HIGH Rx

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • **Individual** • **Family**	$1,750 $3,500	Non-Participating Provider services are not Covered except as required for Emergency Care.	
Prescription Drug Deductible • Individual • Family	$100 $300		
Out-of-Pocket Limit • Individual • Family	$3,000 $6,000		
[Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year]			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$20 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Specialist Office Visits (or Home Visits)	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• 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	
• [Sterilization Procedures for Women*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
• [Vasectomy	$20 Copayment (PCP) $40 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	

• Bone Density Testing*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
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)	$100 Copayment	$100 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	$100 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	$200 Copayment	$200 Copayment.	See Benefit For Description
Urgent Care Center	$40 Copayment	Non-Participating Provider Services Are	See Benefit For

		Not Covered and You Pay the Full Cost	Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$40 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% 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	See Benefit For Description
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	$20 Copayment $40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible **Preauthorization Required**	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 **Preauthorization Required**	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 Rehabilitation • Performed in a Specialist Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed as Outpatient Hospital Services	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Inpatient Hospital Services	10% Coinsurance after Deductible per admission **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chemotherapy • Performed in a PCP Office	$20 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Specialist Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$40 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chiropractic Services	$40 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 (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

	Procedures) **Preauthorization Required**		
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% 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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	$20 Copayment $40 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	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)	$20 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	$20 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 • Performed in a PCP Office	$20 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in Specialist Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Home infusion counts towards home health care visit limits
• Home Infusion Therapy	$20 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
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 • Performed in a PCP Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Freestanding Laboratory Facility or Specialist Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office	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
• Performed in Specialist Office	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Outpatient Facilities	$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity & Newborn Care • Prenatal Care	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Inpatient Hospital Services and Birthing Center	10% Coinsurance after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Physician and Midwife Services for Delivery	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Breast Pump	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Postnatal Care	Covered in full	Non-Participating Provider Services Are	Covered for

	Preauthorization Required	Not Covered and You Pay the Full Cost	duration of breast feeding
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible **Preauthorization Required**	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			See Benefit For Description
• Performed in a PCP Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed in a Freestanding Radiology Facility or Specialist Office	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Therapeutic Radiology Services			See Benefit For Description
• Performed in a Freestanding Radiology Facility or Specialist Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$40 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$20 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. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 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 Specialists	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)			See Benefit For Description All transplants must be performed at designated Facilities
• Inpatient Hospital Surgery	10% Coinsurance after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Outpatient Hospital Surgery	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Surgery Performed at an Ambulatory		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

Surgical Center • Office Surgery	10% Coinsurance after Deductible 10% Coinsurance after Deductible **Preauthorization Required**	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
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder	$20 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	$20 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $20 Copayment $20 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
Durable Medical Equipment & Braces	10% Coinsurance after Deductible **Preauthorization Required for Items Above $500**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids	10% Coinsurance after Deductible **Preauthorization Required**	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 **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient • Outpatient	 10% Coinsurance after Deductible per admission $20 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	210 Days per Plan Year 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	
Prosthetic Devices • External • Internal	 10% Coinsurance after Deductible 10% 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)	10% 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	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 **Preauthorization Required**	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)	10% 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)	10% 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)	10% 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) • Office Visits	 $20 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use	10% Coinsurance after Deductible per	Non-Participating Provider Services Are	See Benefit For

Services (for a continuous confinement when in a Hospital)	admission **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.**	Not Covered and You Pay the Full Cost	Description
Outpatient Substance Use Services • Office Visits	 $20 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited
PRESCRIPTION DRUGS *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.	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	 $15 Copayment $35 Copayment after Deductible $75 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 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	 $45 Copayment $105 Copayment after Deductible $225 Copayment 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
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $38 Copayment $88 Copayment after Deductible $188 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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Enteral Formulas	$15 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
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	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
PEDIATRIC DENTAL &VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			One (1) Dental

• Preventive Dental Care • Routine Dental Care • Major Dental Care(Oral Surgery, Endodontics Prosthodontics & Periodontics • Orthodontics	$20 Copayment $20 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible **Orthodontics & Major Dental Require Preauthorization**	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	Exam & Cleaning Per six (6) -Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	$20 Copayment 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	One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses & Frames in a 12-Month Period