

[SECTION XXVIII]

**CARECONNECT INSURANCE COMPANY, INC.**  
**Silver EPO 40/60 Tradition SCHEDULE OF BENEFITS**  
**HIGH Rx**

<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>Prescription Drug 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>• 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>\$4,250</p> <p>\$8,500</p> <p>\$100</p> <p>\$300</p> <p>\$7,150</p> <p>\$14,300</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>\$40 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

Specialist Office Visits (or Home Visits)	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<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> </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>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>Vasectomy</li> <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>\$40 Copayment (PCP)/\$60 Copayment (Specialist)</p> <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)	\$150 Copayment	\$150 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$150 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	\$350 Copayment	\$350 Copayment	See Benefit For Description
Urgent Care Center	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<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	\$60 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>	\$60 Copayment  \$60 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
Allergy Testing & Treatment <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment  \$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Ambulatory Surgical Center Facility Fee	\$350 Copayment <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)	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
Autologous Blood Banking	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	\$40 Copayment  \$40 Copayment  20% 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	See Benefit For Description
Chemotherapy <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$60 Copayment</p> <p>\$60 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>	
Chiropractic Services	<p>\$60 Copayment</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p><b>Preauthorization Required</b></p>	See Benefit For Description
Clinical Trials	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</p> <p><b>Preauthorization Required</b></p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<p>Diagnostic Testing</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>\$40 Copayment</p> <p>\$60 Copayment</p> <p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are</p>	See Benefit For Description

	<b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	
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>	\$40 Copayment  \$60 Copayment  \$60 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 Performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$60 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	\$40 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

<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Outpatient Hospital Services</li> <li>Home Infusion Therapy</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>\$40 Copayment</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>See Benefit For Description</p> <p>Home Infusion counts towards Home Health Care Visit Limits</p>
<p>Inpatient Medical Visits</p>	<p>Covered in full per admission</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are</p>	<p>See Benefit For Description</p>



<p>Freestanding Laboratory Facility or Specialist Office</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$60 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>Medications Administered in Office or Outpatient Facilities</p> <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>	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the PCP office visit Cost-Sharing</p> <p>\$40 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Maternity &amp; Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Inpatient Hospital Services and Birthing Center</li> </ul>	<p>Covered in full</p> <p>20% Coinsurance after Deductible per admission</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>1 Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early</p>

<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> <li>Breast Pump</li> <li>Postnatal Care</li> </ul>	<p>\$100 Copayment</p> <p>Covered in Full</p> <p>Covered in Full <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>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>\$350 Copayment <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>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>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> <li>Performed as Outpatient Hospital</li> </ul>	<p>\$40 Copayment</p> <p>\$60 Copayment</p> <p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are</p>	<p>See Benefit For Description</p>

Services		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>	\$60 Copayment  \$60 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)	\$60 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	\$60 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)			See Benefit For Description

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>	\$100 Copayment per admission  \$100 Copayment  \$100 Copayment  \$100 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	All transplants must be performed at designated Facilities
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	\$40 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	\$40 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Diabetic Equipment, Supplies &amp; Self-Management Education</p> <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-Day Supply)</li> <li>• Diabetic Education</li> </ul>	<p>\$40 Copayment</p> <p>\$40 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>See Benefit For Description</p>
<p>Durable Medical Equipment &amp; Braces</p>	<p>20% Coinsurance after Deductible <b>Preauthorization Required for Items Above \$500</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>External Hearing Aids</p>	<p>20% Coinsurance after Deductible <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Single Purchase Once(1) Every three (3) Years</p>
<p>Cochlear Implants</p>	<p>20% Coinsurance after Deductible <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One (1) Per Ear Per Time Covered</p>
<p>Hospice Care</p> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	<p>20% Coinsurance after Deductible per admission</p> <p>\$40 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>210 Days per Plan Year</p> <p>Five (5) Visits for Family Bereavement Counseling</p>

Medical Supplies	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
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 Habilitation Services (Physical, Speech and 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

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)	\$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible per admission <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	\$40 Copayment	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	\$15 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$35 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$75 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	\$45 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$105 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$225 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<b>Mail Order Pharmacy</b>			
Up to a 90 Day Supply Tier 1	\$38 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$88 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	



Tier 3	\$188 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$15 Copayment <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<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 Provider</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> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics &amp; Periodontics)</li> <li>• Orthodontics</li> </ul>	<p>\$40 Copayment</p> <p>\$40 Copayment</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible <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>	
<b>Pediatric Vision Care</b>		Non-Participating Provider Services Are	One (1) Exam Per 12-Month

<ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses &amp; Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$40 Copayment</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</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>Period; One (1) Prescribed Lenses &amp; Frames in a 12-Month Period</p>
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