

[SECTION XXVIII]

CareConnect Insurance Company, Inc.  
BRONZE 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>• 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>\$4,000 \$8,000</p> <p>\$7,150 \$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>50% 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>Specialist Office Visits (or Home Visits)</p>	<p>50% 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><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>	50% Coinsurance after Deductible	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 <ul style="list-style-type: none"> <li>Performed in PCP Office</li> </ul> </li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

<ul style="list-style-type: none"> <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>50% Coinsurance 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)	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	50% Coinsurance 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  Coinsurance waived if Hospital admission	50% Coinsurance after Deductible	50% Coinsurance after Deductible,	See Benefit For Description
Urgent Care Center	50% Coinsurance after Deductible	Non-Participating Provider Services Are	See Benefit For

		Not Covered and You Pay the Full Cost	Description
<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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% Coinsurance after Deductible  50% Coinsurance after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Allergy Testing & Treatment <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	50% Coinsurance after Deductible  50% 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	See Benefit For Description
Ambulatory Surgical Center Facility Fee	50% Coinsurance after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	50% 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	50% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Cardiac &amp; Pulmonary Rehabilitation</p> <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>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% 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>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>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% 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>Clinical Trials</p>	<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>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

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

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>50% 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>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 Specialist office visit Cost-Sharing</p> <p>50% 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>Maternity &amp; Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care <ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> <li>Inpatient Hospital</li> </ul>	<p>Covered in Full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>50% 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</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>Services and Birthing Center</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>50% Coinsurance after Deductible</p> <p>Covered in Full</p> <p>50% Coinsurance after Deductible</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>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>50% 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>50% 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> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% 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>See Benefit For Description</p>
<p>Therapeutic Radiology</p>			<p>See Benefit For</p>

Services <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible  50% 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	Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance 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 Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	50% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Second Opinions on diagnosis of cancer are covered at Participating Cost Sharing for Non-Participating Specialist	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) <ul style="list-style-type: none"> <li>Inpatient Hospital</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider Services Are	See Benefit For Description  All transplants must be performed at

<p>Surgery</p> <ul style="list-style-type: none"> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</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>designated Facilities</p>
<p>Telemedicine Program</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><b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</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>ABA Treatment for Autism Spectrum Disorder</p>	<p>50% 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>Assistive Communication Devices for Autism Spectrum Disorder</p>	<p>50% 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>Diabetic Equipment, Supplies &amp; Self-Management Education</p> <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-Day Supply)</li> </ul>	<p>50% 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>

<ul style="list-style-type: none"> <li>Diabetic Education</li> </ul>	50% Coinsurance after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Durable Medical Equipment & Braces	50% 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	50% 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	50% 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>	50% Coinsurance after Deductible  50% 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	210 Days per Plan Year  Five (5) Visits for Family Bereavement Counseling
Medical Supplies	50% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul>	50% Coinsurance after Deductible  50% 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)	50% Coinsurance after Deductible <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	50% 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)	50% 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)	50% Coinsurance after Deductible <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)	50% Coinsurance after Deductible <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)	50% Coinsurance after Deductible <b>Preauthorization Required. However, Preauthorization is Not Required for</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

	<b>Emergency Admissions.</b>		
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	50% Coinsurance 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)	50% Coinsurance after Deductible <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	50% Coinsurance 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	\$10 Copayment after Deductible	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	\$70 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			See Benefit For Description
Tier 1	\$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 2	\$105 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$210 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			See Benefit For Description
Tier 1	\$25 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 2	\$87.50 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$175 Copayment after 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 <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</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>	50% Coinsurance 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> </ul>	50% Coinsurance after Deductible	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>		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> <li>Orthodontics</li> </ul>	50% Coinsurance after Deductible <b>Orthodontics &amp; Major Dental Require Preauthorization</b>		
<b>Pediatric Vision Care</b>			
<ul style="list-style-type: none"> <li>Exams</li> </ul>	50% Coinsurance after Deductible	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-
<ul style="list-style-type: none"> <li>Lenses &amp; Frames</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider Services Are	

<ul style="list-style-type: none"> <li>Contact Lenses</li> </ul>	50% Coinsurance after Deductible	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Month Period
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