

**[SECTION XXVIII]**  
**CARECONNECT INSURANCE COMPANY, INC.**  
**Cost-Share Silver EPO 40/60 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>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>\$1,500</p> <p>\$3,000</p> <p>\$100</p> <p>\$300</p> <p>\$ 6,000</p> <p>\$12,000</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 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>\$60 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>

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<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>	\$40 Copayment (PCP)/\$60 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
		Non-Participating Provider Services Are	

<ul style="list-style-type: none"> <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>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>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)	30% Coinsurance after Deductible	30% Coinsurance after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	30% 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  Copayment waived if Hospital admission	\$350 Copayment	\$350 Copayment	See Benefit For Description
Urgent Care Center	\$60 Copayment after Deductible	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 after Deductible <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>	\$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	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 after Deductible  \$60 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	30% 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)	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 Benefit For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>Performed in a</li> </ul>	\$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Specialist Office</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>30% Coinsurance after Deductible per admission</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
<p>Chemotherapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p> <p>30% Coinsurance after Deductible</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Chiropractic Services</p>	<p>\$60 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>

Clinical Trials	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; 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
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>	<p>\$40 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p> <p>30% Coinsurance 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>	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</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p>	<p>\$40 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p>	<p>See Benefit For Description</p> <p>Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year</p>

<p>Setting</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>30% Coinsurance after Deductible <b>Preauthorization Required</b></p>	<p>30% Coinsurance after Deductible</p>	
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$40 Copayment after Deductible <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</p>
<p>Home Health Care</p>	<p>\$40 Copayment after Deductible <b>Preauthorization Required</b></p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>40 Visits per Plan Year</p>
<p>Infertility Services</p>	<p>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures) <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>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>\$60 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>See Benefit For Description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> <li>Home Infusion Therapy</li> </ul>	<p>30% Coinsurance after Deductible</p> <p>\$40 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>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 Freestanding Laboratory Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p> <p>30% 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>Medications Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	<p>Included as part of the PCP office visit</p> <p>Cost-Sharing</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 Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul>	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>\$40 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>Maternity &amp; Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Inpatient Hospital Services and Birthing Center</li> <li>Physician and Midwife Services for Delivery</li> <li>Breast Pump</li> <li>Postnatal Care</li> </ul>	<p>Covered in full</p> <p>30% Coinsurance after Deductible per admission</p> <p>30% Coinsurance after Deductible</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>See Benefit For Description</p> <p>One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

	<b>Preauthorization Required</b>		
Outpatient Hospital Surgery Facility Charge	30% Coinsurance after Deductible <b>Preauthorization Required</b>	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 <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>	\$100 Copayment  \$100 Copayment  \$100 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Therapeutic Radiology Services <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as</li> </ul>	\$100 Copayment  \$100 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are	See Benefit For Description

Outpatient Hospital Services	<b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$40 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. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$60 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	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 Surgery</li> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul>	30% Coinsurance after Deductible per admission  30% Coinsurance after Deductible  30% 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  Non-Participating Provider Services Are	See Benefit For Description

	30% Coinsurance after Deductible <b>Preauthorization Required</b>	Not Covered and You Pay the Full Cost	
Telemedicine Medicine	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 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 Devices for Autism Spectrum Disorder	\$40 Copayment after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For 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>	\$40 Copayment after Deductible  \$40 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	Covered in full <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	Covered in full <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	Covered in full <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> </ul>	30% Coinsurance after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	210 Days per Plan Year
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	\$40 copayment after Deductible <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Five (5) Visits for Family Bereavement Counseling
Medical Supplies	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Prosthetic Devices <ul style="list-style-type: none"> <li>External</li> </ul>	Covered in full	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
<ul style="list-style-type: none"> <li>Internal</li> </ul>	Covered in full <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	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)	30% 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	\$350 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	30% 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)	30% 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)	30% 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)	30% 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	\$40 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)	30% Coinsurance after Deductible per admission <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

	<b>OASAS-certified Facilities.</b>		
Outpatient Substance Use Services	\$40 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling
<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	\$15 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	\$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 after Deductible	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 after Deductible	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	Covered in full  <b>Preauthorization Required</b>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse, 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>			One (1) Dental Exam & Cleaning Per six (6)-Month
• Preventive Dental	\$40 Copayment after Deductible	Non-Participating Provider Services Are	

<p>Care</p> <ul style="list-style-type: none"> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics &amp; Periodontics)</li> <li>• Orthodontics</li> </ul>	<p>\$40 Copayment after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible  <b>Orthodontics &amp; Major Dental Require Preauthorization</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>Period</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>\$40 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>