

**[SECTION XXVIII]
 CARECONNECT INSURANCE COMPANY, INC.
 Platinum EPO 30/30 Tradition SCHEDULE OF BENEFITS
 High Rx**

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Prescription Drug Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family <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>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$0 \$0</p> <p>\$100 \$300</p> <p>\$1,000 \$2,000</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>Non-Participating Provider services are not Covered except as required for emergency care.</p>	
<p>OFFICE VISITS</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$30 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)	\$30 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
<ul style="list-style-type: none"> Well Child Visits and Immunizations* Adult Annual Physical Examinations* Adult Immunizations* Routine Gynecological Services/Well Woman Exams* Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer [Sterilization Procedures for Women* [Vasectomy 	<p>Covered in full</p> <p>\$30 Copayment (PCP)/\$30 Copayment (Specialist)</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>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"> • Bone Density Testing* • Screening for Prostate Cancer • All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	<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 & 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>	
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	\$200 Copayment	\$200 Copayment.	See Benefit For Description

admission			
Urgent Care Center	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	\$30 Copayment Preauthorization Required	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"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$30 Copayment \$30 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
Allergy Testing & Treatment <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	\$30 Copayment \$30 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	\$200 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	\$30 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Autologous Blood Banking	\$200 Copayment	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"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services 	\$30 Copayment \$30 Copayment \$500 Copayment per admission 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
Chemotherapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	\$30 Copayment \$30 Copayment \$30 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
Chiropractic Services	\$30 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 Procedures) Preauthorization Required	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"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$30 Copayment \$30 Copayment \$30 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting 	\$30 Copayment \$30 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	See Benefit For Description Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$30 Copayment Preauthorization Required	Not Covered and You Pay the Full Cost	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 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	\$30 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	\$30 Copayment \$30 Copayment \$30 Copayment \$30 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 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	Covered in full per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures			See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility or Specialist Office 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$30 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Medications Administered in Office or Outpatient Facilities			See benefit for description
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> Performed in Outpatient Facilities 	\$30 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity & Newborn Care			See Benefit For

<ul style="list-style-type: none"> • Prenatal Care 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Description
<ul style="list-style-type: none"> • Inpatient Hospital Services and Birthing Center 	\$500 Copayment per admission	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
<ul style="list-style-type: none"> • Physician and Midwife Services for Delivery 	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Breast Pump 	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Postnatal Care 	Covered in Full Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	\$200 Copayment 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
<ul style="list-style-type: none"> • Performed in a PCP Office 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Performed in a Freestanding Radiology Facility or Specialist Office 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Therapeutic Radiology Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	\$30 Copayment \$30 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
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 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	\$30 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

<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	<p>Covered in full per admission</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full Preauthorization Required</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>All transplants must be performed at 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>ADDITIONAL SERVICES, EQUIPMENT & DEVICES</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>ABA Treatment for Autism Spectrum Disorder</p>	<p>\$30 Copayment Preauthorization Required</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>\$30 Copayment Preauthorization Required</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 & Self-Management Education</p> <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education 	<p>\$30 Copayment</p> <p>\$30 Copayment</p> <p>Preauthorization Required</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 & Braces</p>	<p>\$200 Copayment</p> <p>Preauthorization Required for Items Above \$500</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>\$200 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>Single Purchase Once Every three (3) Years</p>
<p>Cochlear Implants</p>	<p>\$200 Copayment</p> <p>Preauthorization Required</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"> • Inpatient • Outpatient 	<p>\$500 Copayment per admission</p> <p>\$30 Copayment</p> <p>Preauthorization Required</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	\$200 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Prosthetic Devices <ul style="list-style-type: none"> • External • Internal 	\$200 Copayment \$200 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	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)	\$500 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost.	See Benefit For Description
Observation Stay	\$200 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)	\$500 Copayment	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)	\$500 Copayment 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)	\$500 Copayment per admission	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)	\$500 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$30 Copayment	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)	\$500 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Outpatient Substance Use Services	\$30 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	\$15 Copayment	Non-Participating Provider Services Are	See Benefit For Description

Tier 2	\$35 Copayment after Deductible	Not Covered and You Pay the Full Cost 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	
Mail Order Pharmacy			
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 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 <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Prosthodontics & Periodontics) • Orthodontics 	\$30 Copayment \$30 Copayment \$200 Copayment \$200 Copayment 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	One (1) Dental Exam & Cleaning Per six (6)-Month Period
Pediatric Vision Care <ul style="list-style-type: none"> • Exams 	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses &

<ul style="list-style-type: none"> • Lenses & Frames • Contact Lenses 	<p>10% Coinsurance</p> <p>10% Coinsurance</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>Frames in a 12-Month Period</p>
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