

[SECTION XXVIII]

CARECONNECT INSURANCE COMPANY, INC.
Silver EPO 30/50 Tradition SCHEDULE OF BENEFITS
LOW Rx

<p>COST-SHARING</p> <p>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>\$4,800 \$9,600</p> <p>\$7,100 \$14,200</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>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$50 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* 	<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>

<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Adult Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • [Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
<ul style="list-style-type: none"> • [Vasectomy 	\$30 Copayment (PCP) \$50 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider Services Are	

<ul style="list-style-type: none"> • 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>Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & 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>	
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)	\$150 Copayment	\$150 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$150 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment waived if Hospital admission	\$300 Copayment	\$300 Copayment	See Benefit For Description
Urgent Care Center	\$50 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PROFESSIONAL SERVICES	Participating Provider Member	Non-Participating Provider Member	Limits

AND OUTPATIENT CARE	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
Acupuncture	\$50 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 	\$50 Copayment \$50 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 \$50 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 Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	10% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Cardiac & Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	<p>\$50 Copayment</p> <p>\$50 Copayment</p> <p>10% Coinsurance after Deductible per admission</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>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"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$30 Copayment</p> <p>\$50 Copayment</p> <p>\$50 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>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>\$50 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

	Preauthorization Required		
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 	\$50 Copayment \$50 Copayment \$50 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 	\$30 Copayment \$50 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 Dialysis Performed by Non-Participating Providers is limited to 10

<ul style="list-style-type: none"> Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	<p>\$50 Copayment Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>visits per calendar year</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$30 Copayment Preauthorization Required</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>\$30 Copayment Preauthorization Required</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 & Diagnostic Procedures) 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>Infusion Therapy</p> <ul style="list-style-type: none"> Performed in a PCP Office 	<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>

<ul style="list-style-type: none"> • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy 	<p>\$50 Copayment</p> <p>\$50 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>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"> • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services 	<p>\$50 Copayment</p> <p>\$50 Copayment</p> <p>\$50 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>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"> • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities 	<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>\$30 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 & Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care 	<p>Covered in full</p> <p>10% Coinsurance after Deductible per admission</p> <p>\$100 Copayment</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>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>

Outpatient Hospital Surgery Facility Charge	\$350 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	\$50 Copayment \$50 Copayment \$50 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"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	\$50 Copayment \$50 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	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 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 Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	\$100 Copayment per admission \$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 Non-Participating Provider Services Are	See Benefit For Description All transplants must be performed at designated Facilities

	Preauthorization Required	Not Covered and You Pay the Full Cost	
Telemedicine Program	Covered In Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$30 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	\$30 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education 	\$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
Durable Medical Equipment & Braces	10% Coinsurance after Deductible Preauthorization Required for Items Above \$500	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids	10% Coinsurance after Deductible	Non-Participating Provider Services Are	Single Purchase

	Preauthorization Required	Not Covered and You Pay the Full Cost	Once Every three (3) Years
Cochlear Implants	10% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Per Ear Per Time Covered
Hospice Care <ul style="list-style-type: none"> Inpatient Outpatient 	10% Coinsurance after Deductible per admission \$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	210 Days per Plan Year Five (5) Visits for Family Bereavement Counseling
Medical Supplies	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> External Internal 	10% Coinsurance after Deductible 10% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements Unlimited See Benefit For Description
INPATIENT SERVICES & FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	10% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost.	See Benefit For Description
Observation Stay	10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	10% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	200 Days Per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	10% Coinsurance after Deductible per admission Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	10% Coinsurance after Deductible per admission Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 Days Per Plan Year
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	10% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Outpatient Mental Health Care (including Partial Hospitalization & Intensive Outpatient Program Services)	\$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)	10% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.	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	\$10 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$50 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$250	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	\$30 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$150 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$750	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$125 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$625	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$10 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, 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
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 10% Coinsurance after Deductible 10% Coinsurance after Deductible Orthodontics & Major Dental Require Preauthorization	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Dental Exam & Cleaning Per six (6)-Month Period
Pediatric Vision Care <ul style="list-style-type: none"> • Exams • Lenses & Frames • Contact Lenses 	\$30 Copayment 10% Coinsurance after Deductible 10% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are	One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses & Frames in a 12-Month Period

		Not Covered and You Pay the Full Cost	
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