[SECTION XXVIII]

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

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$4,250 $8,500	Non-Participating Provider services are not Covered except as required for emergency care.	
Prescription Drug Deductible • Individual • Family	$100 $300		
Out-of-Pocket Limit • Individual • Family	$7,150 $14,300		
[Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year]			
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Specialist Office Visits (or Home Visits)	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• 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	
• [Sterilization Procedures for Women*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	

		Not Covered and You Pay the Full Cost]	
• [Vasectomy	$40 Copayment (PCP)/$60 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• All other preventive services required by USPSTF and HRSA.	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)		
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	$350 Copayment	$350 Copayment	See Benefit For Description
Urgent Care Center	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$60 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit for Description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	$60 Copayment $60 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 • Performed in a PCP Office • Performed in a Specialist Office	$40 Copayment $60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Ambulatory Surgical Center Facility Fee	$350 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed as Outpatient Hospital Services	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Inpatient Hospital Services	20% Coinsurance after Deductible per admission **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chemotherapy • Performed in a PCP Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

• Performed in a Specialist Office	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$60 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Chiropractic Services	$60 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost **Preauthorization Required**	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 • Performed in a PCP Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Specialist Office	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$60 Copayment	Non-Participating Provider Services Are	

	Preauthorization Required	Not Covered and You Pay the Full Cost	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	$40 Copayment $60 Copayment $60 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 Performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$60 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	$40 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 • Performed in a PCP Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in Specialist Office	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Outpatient Hospital Services	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Home Infusion Therapy	$40 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	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 • Performed in a PCP Office	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a	$60 Copayment	Non-Participating Provider Services Are	

Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	Not Covered and You Pay the Full Cost $60 Copayment **Preauthorization Required**	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities	 Included as part of the PCP office visit Cost-Sharing Included as part of the PCP office visit Cost-Sharing $40 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
Maternity & Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center	 Covered in full 20% Coinsurance after Deductible per admission	 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 1 Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early

• Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	$100 Copayment Covered in Full Covered in Full **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	Covered for duration of breast feeding
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 • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital	$40 Copayment $60 Copayment $60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are	See Benefit For Description

Services		Not Covered and You Pay the Full Cost	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	$60 Copayment $60 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)	$60 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	$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist	See Benefit For Description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other			See Benefit For Description

Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • 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 **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	All transplants must be performed at designated Facilities
Telemedicine Program	Covered In Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
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	$40 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	$40 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 • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education	 $40 Copayment $40 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	20% 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	20% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Single Purchase Once(1) Every three (3) Years
Cochlear Implants	20% 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 • Inpatient • Outpatient	 20% Coinsurance after Deductible per admission $40 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	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Prosthetic Devices • External • Internal	20% Coinsurance after Deductible 20% 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)	20% 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	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	20% Coinsurance after Deductible **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)	20% 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)	20% 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)	20% 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)	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	20% Coinsurance after Deductible per admission **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	$40 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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy.			
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	 $15 Copayment $35 Copayment after Deductible $75 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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $45 Copayment $105 Copayment after Deductible $225 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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2	 $38 Copayment $88 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

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	
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 Provider**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Prosthodontics & Periodontics • Orthodontics	$40 Copayment $40 Copayment 20% Coinsurance after Deductible 20% 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 • Exams	$40 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Exam Per 12-Month Period; One (1)

• Lenses & Frames • Contact Lenses	20% Coinsurance after Deductible 20% 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	Prescribed Lenses & Frames in a 12-Month Period