

**[SECTION XXVIII]
CARECONNECT INSURANCE COMPANY, INC.
VALUE GOLD 20/50 SCHEDULE OF BENEFITS**

<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>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$500 \$1000</p> <p>\$3,750 \$7,500</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>\$20 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* • Adult Annual Physical Examinations* 	<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>See Benefit For Description</p>

<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 	\$20 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 Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. 	Covered in full	Non-Participating Provider Services Are	

<ul style="list-style-type: none"> *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)	Not Covered and You Pay the Full Cost	
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 admission	\$250 Copayment	\$250 Copayment.	See Benefit For Description
Urgent Care Center	\$75 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	\$50 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<p>Advanced Imaging Services</p> <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	<p>\$100 Copayment</p> <p>\$100 Copayment 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>Allergy Testing & Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>\$20 Copayment</p> <p>\$50 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>See Benefit For Description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>20% Coinsurance after deductible 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>Anesthesia Services (all settings)</p>	<p>20% Coinsurance after deductible 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>Autologous Blood Banking</p>	<p>20% Coinsurance after deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Cardiac & Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office 	<p>\$20 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 as Outpatient Hospital Services Performed as Inpatient Hospital Services 	<p>\$50 Copayment</p> <p>20% Coinsurance after deductible per admission 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>Chemotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$20 Copayment</p> <p>\$50 Copayment</p> <p>20% Coinsurance after deductible 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>	See Benefit For Description
Chiropractic Services	<p>\$50 Copayment</p> <p>Preauthorization Required</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Clinical Trials	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures)</p> <p>Preauthorization Required</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office 	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

<ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$60 Copayment</p> <p>\$60 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>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	<p>\$20 Copayment</p> <p>\$50 Copayment</p> <p>20% Coinsurance after deductible</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>Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</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>60 visits per condition, per Plan Year combined therapies</p>
<p>Home Health Care</p>	<p>\$20 Copayment</p> <p>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</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

	Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required		
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 	\$20 Copayment \$50 Copayment 20% Coinsurance after deductible \$20 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	20% Coinsurance after deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Laboratory Facility or Specialist Office 	\$40 Copayment \$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	See Benefit For Description

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	<p>\$40 Copayment</p> <p>Preauthorization Required</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<p>Medications Administered in Office or Outpatient Facilities</p> <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	See benefit for description
<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 	\$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
<p>Maternity & Newborn Care</p> <ul style="list-style-type: none"> Prenatal Care 	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"> Inpatient Hospital Services and Birthing Center 	20% Coinsurance after deductible 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 	20% Coinsurance after deductible	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	Covered for duration of breast feeding
<ul style="list-style-type: none"> Postnatal Care 	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

	Preauthorization Required		
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	20% Coinsurance after deductible	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 	\$60 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 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 	\$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	\$50 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, per Plan Year

Speech Therapy)			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 	20% Coinsurance after Deductible per admission 20% Coinsurance after Deductible 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 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 All transplants must be performed at designated Facilities
Telemedicine Program	Covered In Full	Non-Participating Provider Services Are	See Benefit For

		Not Covered and You Pay the Full Cost	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	\$20 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	\$20 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 	\$20 Copayment \$20 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 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 <ul style="list-style-type: none"> Inpatient Outpatient 	20% Coinsurance after deductible per admission \$20 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 <ul style="list-style-type: none"> • 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)	Covered in Full	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	Covered in Full	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	\$0 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 after Deductible up to max \$500	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	\$0 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 after Deductible up to max \$1,500	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$0 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 after Deductible up to max \$1,250	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$0 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	Non-Participating Provider Member	

	Responsibility for Cost-Sharing	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 	\$20 Copayment \$20 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 <ul style="list-style-type: none"> • Exams • Lenses & Frames • Contact Lenses 	\$20 Copayment 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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) Exam Per 12-Month Period; One (1) Prescribed Lenses & Frames in a 12-Month Period

