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# CARECONNECT NORTHWELL HEALTH EMPLOYEE PLAN
## SCHEDULE OF BENEFITS

| **COST-SHARING** | **Participating Provider Member Responsibility for Cost-Sharing** | |
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| **Deductible**<br>• Individual<br>• Family | None<br>None | |
| **Medical Out-of-Pocket Limit**<br>• Individual<br>• Family | $3,000<br>$6,000 | |
| **Pharmacy Out-of-Pocket Limit**<br>• Individual<br>• Family | $3,000<br>$6,000 | |
| **Combined Out-of-Pocket Limit**<br>• Individual<br>• Family | $6,000<br>$12,000 | |
| **OFFICE VISITS** | **Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Primary Care Office Visits (or Home Visits) | $15 Copayment | See Benefit For Description |
| Specialist Office Visits (or Home Visits) | $35 Copayment | See Benefit For Description |

| PREVENTIVE CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| • Well Child Visits and Immunizations | Covered in full* | See Benefit For Description |
| • Adult Annual Physical Examinations | Covered in full* | |
| • Adult Immunizations | Covered in full* | |
| • Routine Gynecological Services/Well Woman Exams | Covered in full* | |
| • Mammography Screenings | Covered in full* | |
| • Sterilization Procedures for Women | Covered in full* | |
| • Vasectomy | $15 Copayment (PCP)/$35 Copayment (Specialist) | |
| • Bone Density Testing | Covered in full* | |
| • Screening for Prostate Cancer | Covered in full* | |
| • All other preventive services required by USPSTF and HRSA | Covered in full*<br><br>*When services are not provided in accordance with the comprehensive guidelines for preventive services supported by USPSTF and HRSA appropriate cost share for applicable services will apply (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures, Diagnostic Testing, etc.) | |

| EMERGENCY CARE | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Pre-Hospital Emergency Medical Services (Ambulance Services) | $100 Copayment | See Benefit For Description |
| Non-Emergency Ambulance Services | $100 Copayment<br>**Preauthorization Required** | See Benefit For Description |
| Emergency Department<br><br>(Copayment waived if Hospital admission) | $200 Copayment | See Benefit For Description |
| Urgent Care Center | $20 Copayment at NSLIJ Urgi-Care (GoHealth); $40 Copayment all other locations | See Benefit For Description |
| **PROFESSIONAL SERVICES AND OUTPATIENT CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Advanced Imaging Services<br>• Performed in a Freestanding Radiology Facility or Office Setting<br>• Performed as Outpatient Hospital Services | Covered in full<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required** | See Benefit For Description |
| Allergy Testing & Treatment<br>• Performed in a PCP Office<br>• Performed in a Specialist Office | $15 Copayment<br><br>$35 Copayment | See Benefit For Description |
| Ambulatory Surgical Center Facility Fee | Covered in full<br>**Preauthorization Required** | See Benefit For Description |

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| Anesthesia Services (all settings) | Covered in full | See Benefit For Description |
| Autologous Blood Banking | 10% Coinsurance | See Benefits For Description |
| Cardiac & Pulmonary Rehabilitation<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services<br>• Performed as Inpatient Hospital Services | $15 Copayment<br>**Preauthorization Required**<br>$15 Copayment<br>**Preauthorization Required**<br>Included as part of Inpatient Hospital Service Cost Sharing<br>**Preauthorization Required** | See Benefits For Description |
| Chemotherapy<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services | Covered in full<br>Covered in full<br>Covered in full<br>**Preauthorization Required** | See Benefit For Description |
| Chiropractic Services | $35 Copayment<br>**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)<br>**Preauthorization Required** | See Benefit For Description |

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| Diagnostic Testing<br>• Performed in a PCP Office<br><br>• Performed in a Specialist Office<br><br>• Performed as Outpatient Hospital Services | $15 Copayment<br>**No Preauthorization Required unless it includes sedation or anesthesia**<br><br>$35 Copayment<br>**No Preauthorization Required unless it includes sedation or anesthesia**<br><br>$35 Copayment<br>**Preauthorization Required** | See Benefit For Description |
| Dialysis<br>• Performed in a PCP Office<br><br>• Performed in a Freestanding Center or Specialist Office Setting<br><br>• Performed as Outpatient Hospital Services | $15 Copayment<br><br>$15 Copayment<br><br>$15 Copayment<br>**Preauthorization Required** | See Benefit For Description<br><br>Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year. (Subject to a $15 copayment) |
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | $25 Copayment<br>**Preauthorization Required** | 60 visits per condition, per lifetime combined therapies |
| Home Health Care | Covered in full<br>**Preauthorization Required** | 200 Visits per Plan Year |
| Infertility Services<br>(Basic & Comprehensive) | Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)<br>**Preauthorization Required** | See Benefit For Description |

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| Artificial Insemination | 100% covered at any CareConnect Participating Network Provider, no lifetime max<br>**Preauthorization Required** | See Benefit For Description |
| Assisted Reproductive Technology | 80% Covered up to 3 cycles/Lifetime at Center of Human Reproductive Services (CHR)<br>**No Preauthorization Required. Services are only covered at CHR, located at 300 Community Drive, Manhasset** | See Benefit For Description |
| Infusion Therapy<br>• Performed in a PCP Office<br><br>• Performed in Specialist Office<br><br>• Performed as Outpatient Hospital Services<br><br>• Home Infusion Therapy | <br>$15 Copayment<br>**Preauthorization Required**<br><br>$15 Copayment<br>**Preauthorization Required**<br><br>$15 Copayment<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required** | See Benefit For Description<br><br><br><br><br><br><br><br><br><br>Home infusion counts towards home health care visit limits |
| Inpatient Medical Visits | Covered in full | See Benefit For Description |
| Laboratory Procedures<br>• Performed in a PCP Office<br><br>• Performed in a Freestanding Laboratory Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | <br>Covered in full<br>***Some genetic tests may require a Preauthorization**<br><br>Covered in full<br>***Some genetic tests may require a Preauthorization**<br><br>Covered in full<br>**Preauthorization Required** | See Benefit For Description |

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| Maternity & Newborn Care | | See Benefit For Description |
| • Prenatal Care | Covered in full<br>**Preauthorization Required** | |
| • Inpatient Hospital Services and Birthing Center | Covered in full<br>**Preauthorization Required** | One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early |
| • Physician and Midwife Services for Delivery | Covered in full<br>**Preauthorization Required** | |
| • Breast Pump | Covered in Full<br>**Preauthorization Required** | Covered for duration of breast feeding |
| • Postnatal Care | Covered in Full<br>**Preauthorization Required** | |
| Outpatient Hospital Surgery Facility Charge | Covered in full<br>**Preauthorization Required** | See Benefit For Description |
| Preadmission Testing | Covered in full | See Benefit For Description |
| Diagnostic Radiology Services | | See Benefit For Description |
| • Performed in a PCP Office | Covered in full | |
| • Performed in a Freestanding Radiology Facility or Specialist Office | Covered in full | |
| • Performed as Outpatient Hospital Services | Covered in full | |

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| Therapeutic Radiology Services<br>• Performed in a Freestanding Radiology Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | Covered in full<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required** | See Benefit For Description<br><br>See Benefit For Description |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | $25 Copayment<br>**Preauthorization Required** | 60 visits per condition, per lifetime combined therapies. Speech and Physical Therapy are only Covered following a Hospital stay or surgery. |
| Second Opinions on the Diagnosis of Cancer, Surgery & Other | $35 Copayment | See Benefit For Description |
| Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)<br>• Inpatient Hospital Surgery<br><br>• Outpatient Hospital Surgery<br><br>• Surgery Performed at an Ambulatory Surgical Center<br><br>• Office Surgery | Covered in full<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required**<br><br>Covered in full<br>**Preauthorization Required** | See Benefit For Description<br><br>All transplants must be performed at designated Hospitals |

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| ADDITIONAL SERVICES, EQUIPMENT & DEVICES | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| ABA Treatment for Autism Spectrum Disorder | $15 Copayment<br>**Preauthorization Required** | See Benefit For Description |
| Acupuncture | $35 Copayment<br>**Preauthorization Required** | See Benefit For Description |
| Assistive Communication Devices for Autism Spectrum Disorder | $15 Copayment<br>**Preauthorization Required** | See Benefit For Description |
| Diabetic Equipment, Supplies & Self-Management Education<br>• Diabetic Equipment, Supplies and Insulin (30-Day Supply)<br>• Diabetic Education | $15 Copayment<br>$15 Copayment<br>**No Preauthorization required for up to 12 visits annually; Preauthorization required for visits 13 and up.** | See Benefit For Description |
| Durable Medical Equipment & Braces | 10% Coinsurance<br>**Preauthorization Required for items above $500 (all breast pumps require a Preauthorization)** | See Benefit For Description |

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| External Hearing Aids and Hearing Aid Accessories | Covered in full for covered dependents under age 26 | See Benefit For Description<br><br>$15,000 limit per year. Maximum of one pair of external hearing aids per year.<br>External hearing aid evaluation can only be performed by, and written recommendation for external hearing aid issued by, a Participating Provider who is a physician.<br><br>Member is required to submit to CareConnect Administrative Services for reimbursement. |
| Cochlear Implants | 10% Coinsurance<br>**Preauthorization Required** | One (1) per Ear while enrolled under this Certificate |
| Hospice Care<br>• Inpatient<br><br><br>• Outpatient | Covered in full<br>**Preauthorization Required**<br><br>$15 Copayment<br>**Preauthorization Required** | 210 Days per Plan Year<br><br>Five (5) Visits for Family Bereavement Counseling |
| Medical Supplies | 10% Coinsurance | See Benefit For Description |
| Prosthetic Devices<br>• External<br><br><br>• Internal | 10% Coinsurance<br>**Preauthorization Required**<br><br>Included as part of inpatient Hospital service Cost-Sharing<br>**Preauthorization Required** | One (1) prosthetic device, per limb, per lifetime<br><br>Unlimited<br>See Benefit For Description |

| INPATIENT SERVICES & FACILITIES | Participating Provider Member Responsibility for Cost-Sharing | Limits |
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| Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) | Covered in full<br>**Preauthorization Required** | See Benefit For Description |
| Observation Stay | Covered in full<br>**Notification Required** | See Benefit For Description |
| Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) | $250 per admission<br>**Preauthorization Required** | 200 Days Per Plan Year |
| Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) | Covered in full<br>**Preauthorization Required** | 60 Consecutive Days Per Condition, Per Lifetime |
| **MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Mental Health Care (for a continuous confinement when in a Hospital) | Covered in full<br>**Preauthorization Required** | See Benefit For Description |
| Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) | $15 Copayment<br>**No Preauthorization Required. (Outpatient therapies such as ECT requires a Preauthorization)** | See Benefit For Description |

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| Inpatient Substance Use Services (for a continuous confinement when in a Hospital) | Covered in full<br>**Preauthorization Required.** | See Benefit For Description |
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| Outpatient Substance Use Services | $15 Copayment | Unlimited |
| ****PRESCRIPTION DRUGS** | **Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| **Retail Pharmacy** | | |
| 30 Day Supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3<br><br>Specialty (Designated Pharmacy) | <br>$0 Copayment<br><br>$50 Copayment<br><br>50% to maximum $500 Copayment<br><br>20% to maximum $150 Copayment<br><br>**Preauthorization Required for Certain Drugs** | See Benefit For Description<br><br>Note: Certain Assisted Reproductive Technology (ART) medication not on our formulary will be covered up to a $15,000 lifetime maximum and must be filled through Vivo Pharmacy |

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| Up to a 90 Day Supply For Maintenance Drugs<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br><br>$0 Copayment<br><br>$150 Copayment<br><br>50% to maximum $1,500 Copayment<br><br>**Preauthorization Required for Certain Drugs** | See Benefit For Description |
| **Mail Order Pharmacy** | | |
| Up to a 90 Day Supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$0 Copayment<br><br>$125 Copayment<br><br>50% to maximum $1,250 Copayment<br><br>**Preauthorization Required for Certain Drugs** | See Benefit For Description |
| Enteral Formulas<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br><br>$0 Copayment<br>**Preauthorization Required**<br><br>$50 Copayment<br>**Preauthorization Required**<br><br>50% to maximum $500 Copayment<br>**Preauthorization Required** | See Benefit For Description |

***Please refer to the formulary for prior authorization, step therapy and quantity limits.*