[SECTION XXVII]
CARECONNECT INSURANCE COMPANY, INC.
VALUE SILVER 100% Plan SCHEDULE OF BENEFITS

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $4,600 $9,200	Non-Participating Provider services are not Covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year	 $4,600 $9,200		
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)	2 PCP visits covered in full. Subsequent visits: Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Specialist Office Visits (or Home Visits)	Covered in full after Deductible	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 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]	
• Vasectomy	Covered in full after Deductible	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	Covered in full		

USPSTF and HRSA. • *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)	Non-Participating Provider Services Are 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)	Covered in full after Deductible	Covered in full after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	Covered in full after Deductible **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	Covered in full after Deductible	Covered in full after Deductible	See Benefit For Description
Urgent Care Center	Covered in full after Deductible	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	Covered in full after Deductible	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	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

• Performed as Outpatient Hospital Services	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	Covered in full after Deductible Covered in full 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
Ambulatory Surgical Center Facility Fee	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	Covered in full 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 • Performed as Outpatient Hospital Services	Covered in full after Deductible Covered in full 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

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

• Performed in a Specialist Office	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Dialysis • Performed in a PCP Office	Covered in full after Deductible	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
• Performed in a Freestanding Center or Specialist Office Setting	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in full after Deductible	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	Covered in full after Deductible **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	Non-Participating Provider Services Are	See Benefit For

	(Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**	Not Covered and You Pay the Full Cost	Description
Infusion Therapy • Performed in a PCP Office	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in Specialist Office	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Home Infusion Therapy	Covered in full after Deductible **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 after Deductible 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	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Freestanding Laboratory Facility or Specialist Office	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

• Performed as Outpatient Hospital Services	Covered in full after Deductible **Preauthorization Required**	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	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
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Outpatient Facilities	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity & Newborn Care • Prenatal Care	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Inpatient Hospital Services and Birthing Center	Covered in full after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost Non-Participating Provider Services Are	One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is

• Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	Covered in full after Deductible Covered in Full Covered in Full **Preauthorization Required**	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	discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	Covered in full after Deductible	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 Services	Covered in full after Deductible Covered in full after Deductible Covered in full 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
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

• Performed as Outpatient Hospital Services	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in full after Deductible **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	Covered in full after Deductible	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)			See Benefit For Description All transplants must be performed at designated Facilities
• Inpatient Hospital Surgery	Covered in full after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Outpatient Hospital Surgery	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Surgery Performed at an Ambulatory	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

Surgical Center • Office Surgery	Covered in full after Deductible **Preauthorization Required**	Non-Participating Provider Services Are 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 Cos	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	Covered in full after Deductible **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	Covered in full after Deductible **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	Covered in full after Deductible Covered in full 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	See Benefit For Description
Durable Medical Equipment & Braces	Covered in full 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	Covered in full 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	Covered in full 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	Covered in full after Deductible per admission Covered in full 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	210 Days per Plan Year Five (5) Visits for Family Bereavement Counseling
Medical Supplies	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices • External • Internal	Covered in full after Deductible Covered in full 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	Covered in full after Deductible per admission **Preauthorization Required. However, Preauthorization is Not**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost.	See Benefit For Description

& Pulmonary Rehabilitation, & End of Life Care)	**Required for Emergency Admissions.**		
Observation Stay	Covered in full 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)	Covered in full 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)	Covered in full 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)	Covered in full 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)	Covered in full 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	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Outpatient Program Services)			
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	Covered in full 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 after Deductible	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 Tier 2 Tier 3	 $0 Copayment Covered in full after Deductible Covered in full 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			See Benefit For

Maintenance Drugs Tier 1 Tier 2 Tier 3	 $0 Copayment Covered in full after Deductible Covered in full 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	Description
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $0 Copayment Covered in full after Deductible Covered in full 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
Enteral Formulas	Covered in full after Deductible **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 VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care • Exams	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Exam Per 12-Month Period; One (1) Prescribed

• Lenses & Frames	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Lenses & Frames in a 12-Month Period
• Contact Lenses	Covered in full after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	