[SECTION XXVII]

CareConnect Insurance Company, Inc.
CATASTROPHIC EPO PLAN SCHEDULE OF BENEFITS

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $7,150 $14,300	Non-Participating Provider services are not Covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family	 $7,150 $14,300		
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)	3 PCP office visits with $0 Copayment not subject to Deductible; Subsequent visits 0% Coinsurance 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)	0% Coinsurance 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	0% Coinsurance 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 • Performed in PCP Office	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed in Specialist Office	0% Coinsurance after Deductible	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		
• *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)	0% Coinsurance after Deductible	Covered in full after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Emergency Department Copayment waived if Hospital admission	0% Coinsurance after Deductible	Covered in full after Deductible,	See Benefit For Description
Urgent Care Center	0% Coinsurance 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**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	0% 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	See Benefit For Description
Allergy Testing & Treatment • Performed in a PCP	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Office • Performed in a Specialist Office		Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Ambulatory Surgical Center Facility Fee	0% Coinsurance 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)	0% 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	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation			See Benefit For Description
• Performed in a Specialist Office	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Inpatient Hospital Services	0% 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	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

• Performed in a Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% 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	
Chiropractic Services	0% Coinsurance 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 **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 • Performed in a Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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	See Benefit For Description
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Service	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization Required**	Covered in full after Deductible Covered in full after Deductible Covered in full after Deductible	See Benefit For Description Dialysis Performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services	0% Coinsurance after Deductible	Non-Participating Provider Services Are	60 visits per

(Physical Therapy, Occupational Therapy or Speech Therapy)	**Preauthorization Required**	Not Covered and You Pay the Full Cost	condition, per Plan Year combined therapies
Home Health Care	0% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	40 Visits per Plan Year
Infertility Services	0% Coinsurance after Deductible **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 • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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 Home infusion counts towards home health care visit limits
Inpatient Medical Visits	0% Coinsurance 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 • Performed in a Freestanding Laboratory Facility or Specialist Office	0% Coinsurance after Deductible 0% 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	See Benefit For Description

• Performed as Outpatient Hospital Services	0% Coinsurance 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 PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Outpatient Facilities	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity & Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	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	See Benefit For Description One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	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

by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	 0% Coinsurance after Deductible per admission 0% Coinsurance after Deductible Covered in Full 0% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Outpatient Hospital Surgery Facility Charge	0% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	0% Coinsurance 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	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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	See Benefit For Description

Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% 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	See Benefit For Description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	0% Coinsurance 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	0% Coinsurance 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			See Benefit For Description

Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	0% Coinsurance after Deductible per admission 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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	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	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance 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	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

(30-Day Supply) • Diabetic Education	0% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Durable Medical Equipment & Braces	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
External Hearing Aids	0% 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	0% 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	0% Coinsurance after Deductible per admission 0% 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	210 Days per Plan Year Five (5) Visits for Family Bereavement Counseling
Medical Supplies	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices • External • Internal	0% Coinsurance after Deductible 0% 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)	0% 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	0% 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)	0% 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)	0% 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)	0% 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)	0% 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)	0% Coinsurance after Deductible	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)	0% 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	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Unlimited; Up to 20 visits per calendar year may be used for family counseling
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

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.			
Retail Pharmacy			
30 Day Supply Tier 1 Tier 2 Tier 3	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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	See Benefit For Description
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% 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	See Benefit For Description
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	 0% Coinsurance after Deductible	 Non-Participating Provider Services Are	See Benefit For Description

Tier 2	0% Coinsurance after Deductible	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas Tier 1	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	0% Coinsurance after Deductible		
Tier 3	0% Coinsurance after Deductible		
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 Car • Preventive Dental Care	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1)Dental Exam & Cleaning Per six (6)-Month Period

• Routine Dental Care	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics & Periodontics	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Orthodontics	0% Coinsurance after Deductible **Orthodontics & Major Dental Require Preauthorization**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Pediatric Vision Care • Exams	0% Coinsurance after Deductible	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
• Lenses & Frames	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Contact Lenses	0% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	