SECTION XXVII

CareConnect Insurance Company, Inc.
SILVER CSR 100-150% FPL 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	None None	Non-Participating Provider services are not Covered except as required for Emergency Care.	
Out-of-Pocket Limit • Individual • Family	$1,000 $2,000		
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)	$10 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Specialist Office Visits (or Home Visits)	$20 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	Covered in full	Non-Participating Provider Services Are	

Exams*		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	See Surgical Services Cost-Sharing	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 • Performed in Specialist Office	 $10 Copayment $20 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	
• 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)	$50 Copayment	$50 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	$50 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	$50 Copayment	$50 Copayment	See Benefit For Description
Urgent Care Center	$30 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**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services	$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
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	$10 Copayment $20 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	$25 Copayment **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 **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	5% Coinsurance	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 • Performed as Inpatient Hospital Services	 $10 Copayment $10 Copayment Included as part of Inpatient Hospital Service Cost Sharing **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
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office	 $10 Copayment $10 Copayment $10 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

• Performed as Outpatient Hospital Services	**Preauthorization Required**		
Chiropractic Services	$20 Copayment **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 • Performed in a Specialist Office • Performed as Outpatient Hospital Services	$10 Copayment $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 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 Services	$10 Copayment $10 Copayment $10 Copayment **Preauthorization Required**	$10 Copayment $10 Copayment $10 Copayment **Preauthorization Required**	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)	$15 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	$10 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 • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	$10 Copayment $10 Copayment $10 Copayment $10 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	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 • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$10 Copayment $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 Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
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 Specialist office visit Cost-Sharing $10 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	
Maternity & Newborn Care			See Benefit For

• 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	Description 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 by USPSTF and HRSA	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	Covered for duration of breast feeding
• Inpatient Hospital Services and Birthing Center	$100 Copayment per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Physician and Midwife Services for Delivery	$25 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Breast Pump	Covered in Full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost-Sharing **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	

Outpatient Hospital Surgery Facility Charge	$25 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 Services	 $10 Copayment $20 Copayment $20 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 • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $10 Copayment $10 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)	$15 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	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	$20 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) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center	$25 Copayment per admission $25 Copayment $25 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 All transplants must be performed at designated Facilities

• Office Surgery	$20 Copayment (specialist) $10 Copayment (PCP) **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 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	$10 Copayment **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	680 hours per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	$10 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	 $10 Copayment $10 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	5% Coinsurance **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	5% Coinsurance **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Single Purchase Once Every 3 Years
Cochlear Implants	5% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One Per Ear Per Time Covered

	Preauthorization Required		
Hospice Care • Inpatient • Outpatient	 $100 Copayment per admission $10 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 5 Visits for Family Bereavement Counseling
Medical Supplies	5% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices • External • Internal	 5% Coinsurance Included as part of inpatient Hospital service Cost-Sharing **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 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)	$100 Copayment 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	$50 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Skilled Nursing Facility	$100 Copayment per admission	Non-Participating Provider Services Are	200 Days Per

(Includes Cardiac & Pulmonary Rehabilitation)	**Preauthorization Required**	Not Covered and You Pay the Full Cost	Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	5% Coinsurance 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)	$100 Copayment 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)	$100 Copayment 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)	$10 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)	$100 Copayment 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	$10 Copayment	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-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	 $6 Copayment $15 Copayment $30 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
Up to a 90 Day Supply For Maintenance Drugs Tier 1 Tier 2 Tier 3	 $18 Copayment $45 Copayment $90 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

		Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1 Tier 2 Tier 3	 $15 Copayment $37.50 Copayment $75 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
Enteral Formulas Tier 1 Tier 2 Tier 3	 $6 Copayment $15 Copayment $30 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	
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse, not subject to Deductible	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse, not subject to Deductible	Up to $200 per 6 month period; up to an additional $100 per 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 • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Prosthodontics & Periodontics • Orthodontics	$10 Copayment $10 Copayment $10 Copayment $10 Copayment **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 Dental Exam & Cleaning Per 6-Month Period
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	$10 Copayment 5% Coinsurance 5% Coinsurance	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 Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12-Month Period