[SECTION XXVII]

CareConnect Insurance Company, Inc.
SILVER CSR 200-250% 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	 $1,650 $3,300	 Non-Participating Provider services are not Covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family	 $5,700 $11,400		
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)	$30 Copayment 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)	$50 Copayment 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	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	 $30 Copayment after Deductible $50 Copayment 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	
• All other preventive services required by USPSTF and HRSA.	Covered in full		
• *When preventive services are not	Use Cost Sharing for appropriate service		

provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	(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)	$150 Copayment after Deductible	$150 Copayment after Deductible	See Benefit For Description
Non-Emergency Ambulance Services	$150 Copayment 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	$250 Copayment after Deductible	$150 Copayment after Deductible	See Benefit For Description
Urgent Care Center	$70 Copayment 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	$50 Copayment after Deductible $50 Copayment 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
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	$30 Copayment after Deductible $50 Copayment 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	$100 Copayment 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 **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Autologous Blood Banking	25% Coinsurance 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 • Performed as Inpatient Hospital Services	 $30 Copayment after Deductible $30 Copayment after Deductible 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 • Performed as Outpatient Hospital Services	 $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment 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
Chiropractic Services	$50 Copayment after Deductible	Non-Participating Provider Services Are	See Benefit For

	Preauthorization Required	Not Covered and You Pay the Full Cost	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	$30 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
• Performed in a Specialist Office	$50 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$50 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Dialysis • Performed in a PCP Office	$30 Copayment after Deductible	$30 Copayment after Deductible	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	$30 Copayment after Deductible	$30 Copayment after Deductible	
• Performed as	$30 Copayment after Deductible	$30 Copayment after Deductible	

Outpatient Hospital Services	**Preauthorization Required**		
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment 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
Home Health Care	$30 Copayment 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 (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	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment 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 Copayment after Deductible per	Non-Participating Provider Services Are	See Benefit For

	admission	Not Covered and You Pay the Full Cost	Description
Laboratory Procedures • Performed in a PCP Office	$30 Copayment 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	$50 Copayment after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Performed as Outpatient Hospital Services	$50 Copayment 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	$30 Copayment 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	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description One (1) Home

accordance with the comprehensive guidelines supported by USPSTF and HRSA • 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	Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
• Inpatient Hospital Services and Birthing Center	$1,500 Copayment after Deductible per admission	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
• Physician and Midwife Services for Delivery	$100 Copayment after Deductible	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 the 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	$100 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Preadmission Testing	$0 Copayment 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	$30 Copayment after Deductible $50 Copayment after Deductible $50 Copayment 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	$30 Copayment after Deductible $30 Copayment 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)	$30 Copayment 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	$50 Copayment 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) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	$100 Copayment after Deductible per admission $100 Copayment after Deductible $100 Copayment after Deductible $30 Copayment after Deductible (PCP) $50 Copayment after Deductible (Specialist) **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 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 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	$30 Copayment 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	$30 Copayment 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	$30 Copayment after Deductible $30 Copayment 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	25% 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	25% 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	25% 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	$1,500 Copayment after Deductible per	Non-Participating Provider Services Are	210 Days per Plan Year

admission • Outpatient $30 Copayment after Deductible **Preauthorization Required**	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	Five (5) Visits for Family Bereavement Counseling
Medical Supplies	25% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Prosthetic Devices • External • Internal	25% Coinsurance after Deductible 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 (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)	$1,500 Copayment 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	$250 Copayment 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)	$1,500 Copayment after Deductible per admission **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)	$1,500 Copayment 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)	$1,500 Copayment 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)	$1,500 Copayment after Deductible **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)	$30 Copayment 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)	$1,500 Copayment after Deductible **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	$30 Copayment 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-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	$10 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	$35 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	$70 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Up to a 90 Day Supply For Maintenance Drugs Tier 1	$30 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	$105 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	$210 Copayment not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
Up to a 90 Day Supply			See Benefit For

Tier 1 Tier 2 Tier 3	$25 Copayment not subject to Deductible $87.50 Copayment not subject to Deductible $175 Copayment not subject to 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
Enteral Formulas Tier 1 Tier 2 Tier 3	 $10 Copayment $35 Copayment $70 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
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 Care • Preventive Dental Care • Routine Dental Care	 $30 Copayment after Deductible $30 Copayment 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	One (1) Dental Exam & Cleaning Per six (6)-Month Period

• Major Dental Care (Oral Surgery, Endodontics, Prosthodontics & Periodontics • Orthodontics	$30 Copayment after Deductible $30 Copayment 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	
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	$30 Copayment after Deductible 25% Coinsurance after Deductible 25% 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