

[SECTION XXVII]

**CARECONNECT INSURANCE COMPANY, INC.
NON-STD Silver CSR 200-250% FPL EPO Tradition SCHEDULE OF BENEFITS
Low Rx**

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$4,000</p> <p>\$8,000</p> <p>\$6,000</p> <p>\$12,000</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>Non-Participating Provider services are not Covered except as required for Emergency Care.</p>	
<p>OFFICE VISITS</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$40 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* 	<p>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	<p>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	

<ul style="list-style-type: none"> • Adult Immunizations* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • 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	
<ul style="list-style-type: none"> • Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Vasectomy 	\$40 Copayment (PCP)/\$60 Copayment (Specialist)	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	Non-Participating Provider Services Are	

<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA. *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. 	<p>Covered in full</p> <p>Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)</p>	<p>Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
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	\$150 Copayment	See Benefit For Description
Non-Emergency Ambulance Services	\$150 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	\$350 Copayment	\$350 Copayment	See Benefit For Description
Urgent Care Center	\$60 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
Acupuncture	\$60 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$60 Copayment \$60 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	\$40 Copayment \$60 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	\$350 Copayment Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Anesthesia Services (all settings)	20% 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	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	\$40 Copayment \$40 Copayment 20% Coinsurance after Deductible per admission 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 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
Chiropractic Services	\$60 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 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 by Non-Participating Providers is limited to 10 visits per calendar year

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 <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Laboratory Facility or Specialist Office Performed as Outpatient Hospital Services 	\$40 Copayment \$60 Copayment \$60 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 <ul style="list-style-type: none"> 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 \$40 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
Maternity & Newborn Care <ul style="list-style-type: none"> Prenatal Care 	Covered in full	Non-Participating Provider Services Are	See Benefit For Description

<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center Physician and Midwife Services for Delivery Breast Pump Postnatal Care 	<p>20% Coinsurance after Deductible per admission</p> <p>\$100 Copayment</p> <p>Covered in Full</p> <p>Covered in Full</p> <p>Preauthorization Required</p>	<p>Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>One (1) Home Care Visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>\$350 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Preadmission Testing</p>	<p>Covered in full</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office 	<p>\$ 40 Copayment</p> <p>\$ 60 Copayment</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	<p>\$60 Copayment</p> <p>\$60 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$40 Copayment</p> <p>Preauthorization Required</p>	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	60 visits per condition, Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p>	\$60 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

		Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist	
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy)</p> <ul style="list-style-type: none"> Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery 	<p>\$100 Copayment per admission</p> <p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See Benefit For Description</p> <p>All transplants must be performed at designated Facilities</p>
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	\$40 Copayment 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	\$40 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	<ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education 	<p>\$40 Copayment</p> <p>\$40 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	See Benefit For Description
Durable Medical Equipment & Braces		20% 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		20% 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		20% 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	<ul style="list-style-type: none"> Inpatient Outpatient 	<p>20% Coinsurance after Deductible per admission</p> <p>\$40 copayment Preauthorization Required</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p> <p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>210 Days per Plan Year</p> <p>Five (5) Visits for Family Bereavement Counseling</p>
Medical Supplies		20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description

Prosthetic Devices <ul style="list-style-type: none"> • External 	20% Coinsurance after Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	One (1) prosthetic device, per limb, per lifetime
<ul style="list-style-type: none"> • Internal 	20% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	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)	20% 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	20% 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)	20% 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)	20% 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)	20% 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

NSLIJE/NSLIJ NS S40-60L (200-250%)

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)	20% 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)	\$40 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)	20% 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 Service	\$40 Copayment	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	\$10 Copayment	Non-Participating Provider Services Are	See Benefit For Description

NSLIJE/NSLIJ NS S40-60L (200-250%)

Tier 2	\$50 Copayment	Not Covered and You Pay the Full Cost Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$250	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	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$150 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$750	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Mail Order Pharmacy			
Up to a 90 Day Supply Tier 1	\$25 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See Benefit For Description
Tier 2	\$125 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	50% Coinsurance max to \$625	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Enteral Formulas	\$10 Copayment 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 DENTAL & VISION CARE	Participating Provider Member Responsibility for Cost-Sharing Provider	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics) • Orthodontics 	\$40 Copayment \$40 Copayment 20% Coinsurance after Deductible 20% Coinsurance 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 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 6-Month Period
Pediatric Vision Care <ul style="list-style-type: none"> • Exams • Lenses & Frames • Contact Lenses 	\$40 Copayment 20% Coinsurance after Deductible 20% 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

