

**SCHEDULE OF BENEFITS - MEDICAL (PLAN CARO - C )**

In-Network benefits are based on the Preferred Provider Organization's approved amount. Out-of-Network benefits are based on the Reasonable and Customary amount. Benefits are determined after any applicable Deductible and Coinsurance, and are subject to Annual, Lifetime and Other Maximums, General Exclusions and other applicable limitations.

| <b>Deductible</b>   | <b><u>In-Network</u></b> | <b><u>Out-of-Network</u></b> |
|---|--------------------------|------------------------------|
| - Individual  | \$100                    | \$200                        |
| - Family, embedded  | \$200                    | \$400                        |
| Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.  |                          |                              |
| <p>“Embedded” = Claims paid <u>after</u> the Individual Deductible is satisfied for an individual family member will have no additional Deductible taken for that individual family member. Claims paid <u>after</u> the Family Deductible is satisfied will have no additional Deductible taken for the entire family.</p>   |                          |                              |
| <b>Coinsurance Maximum</b>  | <b><u>In-Network</u></b> | <b><u>Out-of-Network</u></b> |
| - Individual  | \$500                    | \$1,500                      |
| - Family, embedded  | \$1,000                  | \$3,000                      |
| Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.  |                          |                              |
| <p>“Embedded” = Claims paid <u>after</u> the Individual Coinsurance Maximum is satisfied for an individual family member will have no additional Coinsurance taken for that individual family member. Claims paid <u>after</u> the Family Coinsurance Maximum is satisfied will have no additional Coinsurance taken for the entire family.</p>   |                          |                              |
| <b>Cost Sharing Maximum</b>   | <b><u>In-Network</u></b> | <b><u>Out-of-Network</u></b> |
| - Individual  | \$6,350                  | \$12,700                     |
| - Family, embedded  | \$12,700                 | \$25,400                     |
| Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.  |                          |                              |
| <p>“Embedded” = Claims paid <u>after</u> the Individual Cost Sharing Maximum is satisfied for an individual family member will have no additional Cost Sharing (Deductible, Coinsurance, and Copays) taken for that individual family member. Claims paid <u>after</u> the Family Cost Sharing Maximum is satisfied will have no additional Cost Sharing taken for the entire family.</p> |                          |                              |

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**You pay after the Copay and/or Deductible as stated.  
 "No Charge" = No Copay, No Deductible, and No Coinsurance.**

|  | <u>We Pay<br/>In-Network</u>              | <u>We Pay<br/>Out-of-Network</u> |
|--|---|----------------------------------|
| <b>CHARGES FOR PREVENTIVE CARE SERVICES</b>  |   |                                  |
| <p><b>The following Preventive Care and Screening Services:</b></p> <ul style="list-style-type: none"> <li>• Annual Adult Preventive Exam</li> <li>• Annual Gynecological Exam</li> <li>• Fecal Occult Blood Screening</li> <li>• Prostate Specific Antigen (PSA) Screening</li> </ul>   | 100%                                      | 100%                             |
| <p><b>All Other Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:</b></p> <p>-- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or</p> <p>-- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or</p> <p>-- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved.</p> <p>-- Includes annual routine vision exam as part of a physical to determine vision loss.</p> <p>*****</p> <p>Please consult the recommendations and guidelines for age, frequency and other guidelines. Some examples of screening include high blood pressure, breast cancer (mammograms), cervical cancer (PAP), cholesterol, depression, diabetes, colorectal cancer (colonoscopies), and prostate cancer (PSA). Examples of immunizations include HIV, DTP, Hepatitis A, Hepatitis B, HIB, HPV, MMR, and Flu Shots.</p> <p>Copies of the recommendations and guidelines may be obtained from the following web sites. You may also call 800-211-1534 to obtain a no-cost paper copy from US Health and Life Insurance Company.</p> <p><a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits/">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</a></p> <p><a href="http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html">http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html</a></p> <p><a href="http://www.hrsa.gov">www.hrsa.gov</a></p> | 100%                                      | 70% after Deductible             |
| <b>CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY</b>   |   |                                  |
| Urgent Care Facility   | 100% (Deductible Waived)                  | 70% after Deductible             |
| Urgent Care Physician  | 100% (Deductible Waived)                  | 70% after deductible             |
| Emergency Room Facility  | 100% after \$25 Copay (Deductible Waived) |                                  |
| Emergency Room Physician   | 100% (Deductible Waived)                  |                                  |
| Ambulance  | 100%                                      |                                  |
| <p>No copayment, deductible, or coinsurance applies to Out-of-Network emergency services if the In-Network Cost Sharing Maximum has been reached. Out-of-Network providers will be reimbursed at the same level of benefits as In-Network providers, and they may bill you for the balance.</p>  |   |                                  |

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|   | <b><u>We Pay</u></b><br><b><u>In-Network</u></b> | <b><u>We Pay</u></b><br><b><u>Out of Network</u></b> |
|---|--|--|
| <b>CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY<br/>(INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)</b> |  |  |
| Office Visit  | 100% after Deductible and \$20 Copay             | 70% after Deductible                                 |
| Inpatient Facility  | 90% after Deductible                             | 70% after Deductible                                 |
| Inpatient Physician   | 90% after Deductible                             | 70% after Deductible                                 |
| Outpatient Facility   | 90% after Deductible                             | 70% after Deductible                                 |
| Outpatient Physician  | 90% after Deductible                             | 70% after Deductible                                 |
| Surgical Care Facility  | 90% after Deductible                             | 70% after Deductible                                 |
| Surgical Care Physician (Surgeon) – Inpatient<br>(including Maternity)  | 90% after Deductible                             | 70% after Deductible                                 |
| Surgical Care Physician (Surgeon) - Outpatient  | 90% after Deductible                             | 70% after Deductible                                 |
| Diagnostic X-Ray, Laboratory and Advanced Imaging   | 90% after Deductible and \$5 Copay               | 70% after Deductible                                 |
| Independent Laboratory Services Ordered by a Non-Network Physician  | 90% after Deductible and \$5 Copay               | 90% after Deductible                                 |
| Independent Laboratory Services Ordered by a Network Physician  | 90% after In-Network Deductible and \$5 Copay    |  |
| Allergy Testing and Injections  | 100% after Deductible                            | 70% after Deductible                                 |
| <b>CHARGES FOR OTHER SERVICES</b>   |  |  |
| Durable Medical Equipment   | 90% after In-Network Deductible                  |  |
| Human Organ Transplant  | 90% after Deductible                             | 70% after Deductible                                 |
| Hospice   | 90% after Deductible                             | 70% after Deductible                                 |
| Home Health Care  | 90% after Deductible                             | 70% after Deductible                                 |
| Skilled Nursing Care – Nursing Home   | 90% after Deductible                             | 70% after Deductible                                 |
| Skilled Nursing Care – Residential Home   | 90% after Deductible                             | 70% after Deductible                                 |
| Infertility Counseling and Treatment<br>(Limited Benefits)  | 90% after Deductible                             | 70% after Deductible                                 |
| Inpatient Rehabilitation Facility   | 90% after Deductible                             | 70% after Deductible                                 |
| Psychiatric Facility  | Inpatient  | 90% after Deductible                                 |
|   | Outpatient                                       | 50% after Deductible                                 |
| Substance Abuse Facility  | Inpatient  | 90% after Deductible                                 |
|   | Outpatient                                       | 50% after Deductible                                 |
| Partial Hospital Program for Mental Health  | 90% after Deductible                             | 50% after Deductible                                 |
| Dietician Services<br>(Maximum 6 visits per Calendar Year)  | 100% after Deductible and \$20 Copay             | 70% after Deductible                                 |
| LASIK Surgery   | Inpatient  | 90% after Deductible                                 |
|   | Outpatient                                       | 70% after Deductible                                 |

