

**SCHEDULE OF BENEFITS – (PLAN CARO - HARD CAP II)**

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>
<ul style="list-style-type: none"> <li>- Individual</li> <li>- Family, aggregate</li> </ul> Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.	\$1,300	\$2,600
“Aggregate” = If the certificate is covering a family, no benefits are payable for any individual within a family until the entire Family Deductible is satisfied. Claims paid <u>after</u> the Family Deductible is satisfied will have no additional Deductible taken for the entire family.	In-Network and Out-of-Network Deductibles accumulate together.	
<b>Coinsurance Maximum</b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
<ul style="list-style-type: none"> <li>- Individual</li> <li>- Family, aggregate</li> </ul> Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.	\$1,000	\$2,000
“Aggregate” = If the certificate is covering a family, the entire Family Coinsurance Maximum must be satisfied. Claims paid <u>after</u> the Family Coinsurance Maximum is satisfied will have no additional Coinsurance taken for the entire family.	In-Network and Out-of-Network Coinsurance Maximums accumulate together.	
<b>Cost Sharing Maximum</b>	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b>
<ul style="list-style-type: none"> <li>- Individual</li> <li>- Family, aggregate</li> </ul> Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.	\$6,350	\$12,700
“Aggregate” = If the certificate is covering a family, the entire Family Cost Sharing Maximum must be satisfied. Claims paid <u>after</u> the Family Cost Sharing Maximum is satisfied will have no additional Cost Sharing (Deductible, Coinsurance, and Copays) taken for the entire family.	In-Network and Out-of-Network Cost Sharing Maximums accumulate together.	

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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 In-Network</u>	<u>We Pay 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%	Not Covered
<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%	Not Covered
<b>CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY</b>		
Urgent Care Facility	100% after Deductible	80% after Deductible
Urgent Care Physician	100% after Deductible	80% after Deductible
Emergency Room Facility	100% after In-Network Deductible	
Emergency Room Physician	100% after In-Network Deductible	
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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	<u><b>We Pay In-Network</b></u>	<u><b>We Pay Out-of-Network</b></u>
<b>CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)</b>		
Office Visit	100% after Deductible	80% after Deductible
Inpatient Facility	100% after Deductible	80% after Deductible
Inpatient Physician	100% after Deductible	80% after Deductible
Outpatient Facility	100% after Deductible	80% after Deductible
Outpatient Physician	100% after Deductible	80% after Deductible
Surgical Care Facility	100% after Deductible	80% after Deductible
Surgical Care Physician (Surgeon) – Inpatient (including maternity)	100% after Deductible	80% after Deductible
Surgical Care Physician (Surgeon) - Outpatient	100% after Deductible	80% after Deductible
Diagnostic X-Ray, Laboratory and Advanced Imaging	100% after Deductible	80% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician	100% after Deductible	100% after Deductible
Independent Laboratory Services Ordered by a Network Physician	100% after In-Network Deductible	
Allergy Testing and Injections	100% after Deductible	80% after Deductible
<b>CHARGES FOR OTHER SERVICES</b>		
Durable Medical Equipment	90% after In-Network Deductible	
Human Organ Transplant	100% after Deductible	80% after Deductible
Hospice	90% Deductible Waived	80% after Deductible
Home Health Care	90% after Deductible	80% after Deductible
Skilled Nursing Care – Nursing Home (Maximum 45 days per Calendar Year)	90% after Deductible	80% after Deductible
Skilled Nursing Care – Residential Home	Not Covered	Not Covered
Infertility Counseling and Treatment (Limited Benefits)	100% after Deductible	Not Covered
Inpatient Rehabilitation Facility	100% after Deductible	80% after Deductible
Psychiatric Facility	Inpatient 100% after Deductible	80% after Deductible
	Outpatient	
Substance Abuse Facility	Inpatient 100% after Deductible	80% after Deductible
	Outpatient	
Partial Hospital Program for Mental Health	100% after Deductible	80% after Deductible
Dietician Services (Maximum 6 visits per Calendar Year)	100% after Deductible	80% after Deductible
LASIK Surgery	Inpatient 100% after Deductible	Not Covered
	Outpatient	

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	<b><u>We Pay In-Network</u></b>	<b><u>We Pay Out-of-Network</u></b>
Hearing Examination Audiology test covered with medical diagnosis	100% after Deductible	Not Covered
Hearing Aids	Not Covered	Not Covered
Male Sterilization Inpatient Outpatient	100% after Deductible	Not Covered
Prosthetics	90% after Deductible	80% after Deductible
<b>CHARGES FOR THERAPY SERVICES</b>		
<b>Rehabilitative Services</b>  Outpatient Speech Therapy  Outpatient Physical Therapy  Outpatient Occupational Therapy	In Physician's Office: 90% of after Deductible  Other Location: 90% of after Deductible	80% after Deductible
<b>Habilitative Services</b>  Outpatient Speech Therapy  Outpatient Physical Therapy  Outpatient Occupational Therapy	In Physician's Office: 90% of after Deductible  Other Location: 90% of after Deductible	80% after Deductible
<b>Spinal Manipulation</b> Maximum 30 visits per Calendar Year	100% after Deductible	50% after Deductible
<b>CHARGES FOR PEDIATRIC VISION SERVICES</b>		
Pediatric Vision Benefits for Children under Age 19 Calendar Year Maximums: <ul style="list-style-type: none"> <li>• 1 routine exam</li> <li>• 1 pair eyeglass lenses or contact lenses</li> <li>• 1 frame</li> </ul>	100% after Deductible	80% after Deductible
<b>PRESCRIPTION DRUG CARD CHARGES</b>		
<b>Before</b> Deductible is Satisfied	Subject to Deductible	
<b>After</b> Deductible is Satisfied	See Prescription Drug Schedule for applicable Prescription Drug Copay, Deductible, and Coinsurance	