SCHEDULE OF BENEFITS - MEDICAL (PLAN CARO - Z)

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.

Deductible	**In-Network**	**Out-of-Network**
- Individual	$150	$300
- Family, embedded	$300	$600
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Embedded" = Claims paid after the Individual Deductible is satisfied for an individual family member will have no additional Deductible taken for that individual family member. Claims paid after the Family Deductible is satisfied will have no additional Deductible taken for the entire family.		

Coinsurance Maximum	**In-Network**	**Out-of-Network**
- Individual	$1,000	$2,000
- Family, embedded	$2,000	$4,000
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Embedded" = Claims paid after the Individual Coinsurance Maximum is satisfied for an individual family member will have no additional Coinsurance taken for that individual family member. Claims paid after the Family Coinsurance Maximum is satisfied will have no additional Coinsurance taken for the entire family.		

Cost Sharing Maximum	**In-Network**	**Out-of-Network**
- Individual	$6,350	$12,700
- Family, embedded	$12,700	$25,400
Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum.		
"Embedded" = Claims paid after 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 after the Family Cost Sharing Maximum is satisfied will have no additional Cost Sharing taken for the entire family.		

SCHEDULE OF BENEFITS - MEDICAL (PLAN CARO - Z)

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

	We Pay In-Network	We Pay Out-of-Network
CHARGES FOR PREVENTIVE CARE SERVICES		
The following Preventive Care and Screening Services: • Annual Adult Preventive Exam • Annual Gynecological Exam • Fecal Occult Blood Screening • Prostate Specific Antigen (PSA) Screening	100%	100%
All Other Preventive Care and Screening Services and Immunizations for children, adolescents and adults that: -- have a rating of A or B in the current United States Preventive Services Task Force recommendations, or -- are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or -- are provided for in comprehensive guidelines supported by the Health Resources and Services Administration, with respect to the individual involved. -- Includes annual routine vision exam as part of a physical to determine vision loss. ********** 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. 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. https://www.healthcare.gov/what-are-my-preventive-care-benefits/ http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html www.hrsa.gov	100%	60% after Deductible
CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY		
Urgent Care Facility	80% (Deductible Waived)	80% after Deductible
Urgent Care Physician	80% (Deductible Waived)	80% after deductible
Emergency Room Facility	80% after $25 Copay (Deductible Waived)	
Emergency Room Physician	80% (Deductible Waived)	
Ambulance	80%	
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.		

SCHEDULE OF BENEFITS - MEDICAL (PLAN CARO - Z)

	We Pay In-Network	We Pay Out of Network
CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)		
Office Visit	80% after Deductible and $20 Copay	60% after Deductible
Inpatient Facility	80% after Deductible	60% after Deductible
Inpatient Physician	80% after Deductible	60% after Deductible
Outpatient Facility	80% after Deductible	60% after Deductible
Outpatient Physician	80% after Deductible	60% after Deductible
Surgical Care Facility	80% after Deductible	60% after Deductible
Surgical Care Physician (Surgeon) – Inpatient (including Maternity)	80% after Deductible	60% after Deductible
Surgical Care Physician (Surgeon) - Outpatient	80% after Deductible	60% after Deductible
Diagnostic X-Ray, Laboratory and Advanced Imaging	80% after Deductible and $5 Copay	60% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician	80% after Deductible and $5 Copay	80% after Deductible
Independent Laboratory Services Ordered by a Network Physician	80% after In-Network Deductible and $5 Copay	
Allergy Testing and Injections	80% after Deductible	60% after Deductible
CHARGES FOR OTHER SERVICES		
Durable Medical Equipment	80% after In-Network Deductible	
Human Organ Transplant	80% after Deductible	60% after Deductible
Hospice	80% after Deductible	60% after Deductible
Home Health Care	80% after Deductible	60% after Deductible
Skilled Nursing Care – Nursing Home	80% after Deductible	60% after Deductible
Skilled Nursing Care – Residential Home	80% after Deductible	60% after Deductible
Infertility Counseling and Treatment (Limited Benefits)	80% after Deductible	60% after Deductible
Inpatient Rehabilitation Facility	80% after Deductible	60% after Deductible
Psychiatric Facility Inpatient Outpatient	80% after Deductible	60% after Deductible
Substance Abuse Facility Inpatient Outpatient	80% after Deductible	60% after Deductible
Partial Hospital Program for Mental Health	80% after Deductible	60% after Deductible
Dietician Services (Maximum 6 visits per Calendar Year)	80% after Deductible and $20 Copay	60% after Deductible
LASIK Surgery Inpatient Outpatient	80% after Deductible	60% after Deductible

SCHEDULE OF BENEFITS - MEDICAL (PLAN CARO - Z)

	We Pay In-Network	We Pay Out-of-Network
Hearing Examination Audiology test covered with medical diagnosis	80% after Deductible and $5 Copay	60% after Deductible
Hearing Aids	Not Covered	Not Covered
Male Sterilization Inpatient Outpatient	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
CHARGES FOR THERAPY SERVICES		
Rehabilitative Services Outpatient Speech Therapy (Maximum 30 visits per Calendar Year)* Outpatient Physical Therapy (Maximum 30 visits per Calendar Year)* Outpatient Occupational Therapy (Maximum 30 visits per Calendar Year)* * These limits do not apply to Autism Spectrum Disorders.	In Physician's Office: 80% after Deductible and $20 Copay Other Location: 80% after Deductible	60% after Deductible
Habilitative Services Outpatient Speech Therapy (Maximum 30 visits per Calendar Year)* Outpatient Physical Therapy (Maximum 30 visits per Calendar Year)* Outpatient Occupational Therapy (Maximum 30 visits per Calendar Year)* * These limits do not apply to Autism Spectrum Disorders.	In Physician's Office: 80% after Deductible and $20 Copay Other Location: 80% after Deductible	60% after Deductible
Spinal Manipulation Maximum 30 visits per Calendar Year	80% after Deductible and $20 Copay	60% after Deductible
CHARGES FOR PEDIATRIC VISION SERVICES		
Pediatric Vision Benefits for Children under Age 19 Calendar Year Maximums: • 1 routine exam • 1 pair eyeglass lenses or contact lenses • 1 frame	100% after Deductible	60% after Deductible

PRESCRIPTION DRUG CARD CHARGES
Subject to Plan Limitations and Exclusions See Prescription Drug Schedule for applicable Copay, Deductible, and Coinsurance