

SCHEDULE OF BENEFITS - MEDICAL (PLAN TROOPERS) Modified 2015

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 | <u>In-Network</u> | <u>Out-of-Network</u> |
|--|--|------------------------------|
| <ul style="list-style-type: none"> - Individual - Family, embedded Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum. | \$250 \$500 | \$500 \$1000 |
| "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. | In-Network and Out-of-Network Deductibles accumulate separately. | |
| Coinsurance Maximum | <u>In-Network</u> | <u>Out-of-Network</u> |
| <ul style="list-style-type: none"> - Individual - Family, embedded Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum. | \$500 \$1000 | \$1,000 \$2000 |
| "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. | In-Network and Out-of-Network Deductibles accumulate separately. | |
| Cost Sharing Maximum | <u>In-Network</u> | <u>Out-of-Network</u> |
| <ul style="list-style-type: none"> - Individual - Family, embedded Deductible, Coinsurance, and Copays apply to the Cost Sharing Maximum. | \$6,350 \$12,700 | \$12,700 \$25,400 |
| "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. | In-Network and Out-of-Network Deductibles accumulate separately. | |

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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> |
|--|---------------------------------------|----------------------------------|
| CHARGES FOR PREVENTIVE CARE SERVICES | | |
| <p>The following Preventive Care and Screening Services:</p> <ul style="list-style-type: none"> • Annual Adult Preventive Exam • Annual Gynecological Exam • Fecal Occult Blood Screening • Prostate Specific Antigen (PSA) Screening | 100% | 100% |
| <p>All Other Preventive Care and Screening Services and Immunizations for children, adolescents and adults that:</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>https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p> <p>http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html</p> <p>www.hrsa.gov</p> | 100% | 80% after Deductible |
| CHARGES FOR PHYSICIAN AND FACILITY SERVICES - URGENT CARE AND EMERGENCY | | |
| Urgent Care Facility | 100% after Deductible | 100% after Deductible |
| Urgent Care Physician | 100% after \$10 copay and Deductible | 100% after deductible |
| Emergency Room Facility | 100% after Deductible and \$100 Copay | |
| Emergency Room Physician | 100% after Deductible | |
| Ambulance | 100% | |
| 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. | | |

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|---|--|--|
| CHARGES FOR PHYSICIAN AND FACILITY SERVICES - OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES) | | |
| Office Visit | 100% after \$10 copay and 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 \$10 copay and Deductible | 80% after Deductible |
| Surgical Care Physician (Surgeon) - Outpatient | 100% after \$10 copay and Deductible | 80% after Deductible |
| Diagnostic X-Ray, Laboratory and Advanced Imaging | 100% after \$10 copay and Deductible | 80% after Deductible |
| Independent Laboratory Services Ordered by a Non-Network Physician | 100% after \$10 copay and Deductible | 100% after Deductible |
| Independent Laboratory Services Ordered by a Network Physician | 100% after \$5 copay and In-Network Deductible | |
| Allergy Testing and Injections | 100% after Deductible | 80% after Deductible |
| CHARGES FOR OTHER SERVICES | | |
| Durable Medical Equipment | 90% after Deductible | |
| Human Organ Transplant | 100% after Deductible | 80% after Deductible |
| Hospice | 90% after Deductible | 80% after Deductible |
| Home Health Care | 90% after Deductible | 80% after Deductible |
| Skilled Nursing Care – Nursing Home | 100% after Deductible | 80% after Deductible |
| Skilled Nursing Care – Residential Home | 90% after Deductible | 80% after Deductible |
| Infertility Counseling and Treatment (Limited Benefits) | 100% after Deductible | 80% after Deductible |
| Inpatient Rehabilitation Facility | 100% after Deductible | 80% after Deductible |
| Psychiatric Facility | Inpatient | 100% after Deductible |
| | Outpatient | 100% after Deductible and \$10 Copay |
| Substance Abuse Facility | Inpatient | 100% after Deductible |
| | Outpatient | 100% after Deductible and \$10 Copay |
| Partial Hospital Program for Mental Health | 100% after Deductible | 80% after Deductible |
| Dietician Services (Maximum 6 visits per Calendar Year) | 100% after Deductible and \$10 Copay | 80% after Deductible |
| LASIK Surgery | Inpatient | 100% after Deductible |
| | Outpatient | 80% after Deductible |

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|---|--|--|
| Hearing Examination Audiology test covered with medical diagnosis | 100% after \$10 copay and Deductible | Not Covered |
| Hearing Aids | 100% after Deductible | Not Covered |
| Male Sterilization Inpatient Outpatient | 100% after Deductible | 80% after Deductible |
| Prosthetics | 90% after Deductible | 80% after Deductible |
| CHARGES FOR THERAPY SERVICES | | |
| Rehabilitative Services Outpatient Speech Therapy (Maximum 30 visits per Calendar Year) Outpatient Physical and Occupational Therapy (Maximum 30 visits per Calendar Year combined for Physical and Occupational Therapies)* * These limits do not apply to Autism Spectrum Disorders. | In Physician's Office: 100% after Deductible and \$10 Copay Other Location: 90% after Deductible | 80% after Deductible |
| Habilitative Services Outpatient Speech Therapy (Maximum 30 visits per Calendar Year) Outpatient Physical and Occupational Therapy (Maximum 30 visits per Calendar Year combined for Physical and Occupational Therapies)* * These limits do not apply to Autism Spectrum Disorders. | In Physician's Office: 100% after Deductible and \$10 Copay Other Location: 90% after Deductible | 80% after Deductible |
| Spinal Manipulation Maximum 30 visits per Calendar Year | 100% after Deductible and \$10 Copay | 80% after Deductible |
| CHARGES FOR PEDIATRIC VISION SERVICES | | |
| Pediatric Vision Benefits for Children under Age 19 Calendar Year Maximums: <ul style="list-style-type: none"> • 1 routine exam • 1 pair eyeglass lenses or contact lenses • 1 frame | 100% after Deductible | 80% after Deductible |

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