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 Benefit Percentage, and are subject to Annual, Lifetime and Other Maximums, General Exclusions and other applicable limitations		
Deductible	**In-Network**	**Out-of-Network**
- Individual	$0	
- Family, aggregate	$0	
"Aggregate" = If the coverage is covering a family, no benefits are payable for any individual within a family until the entire Family Deductible is satisfied. Claims paid after the Family Deductible is satisfied will have no additional Deductible taken for the entire family.	In-Network and Out-of-Network Deductibles accumulate together	
Coinsurance	**In-Network**	**Out-of-Network**
- Individual	$1,000	
- Family, aggregate	$2,000	
"Aggregate" = If the coverage is covering a family, the entire Family Benefit Percentage Maximum must be satisfied. Claims paid after the Family Benefit Percentage Maximum is satisfied will have no additional Benefit Percentage taken for the entire family.	In-Network and Out-of-Network Coinsurance Maximums accumulate together	
Out of Pocket Limit	**In-Network**	**Out-of-Network**
- Individual	$6,350	
- Family, aggregate	$12,700	
"Aggregate" = If the coverage is covering a family, the entire Family Benefit Percentage Maximum must be satisfied. Claims paid after the Family Benefit Percentage Maximum is satisfied will have no additional Benefit Percentage taken for the entire family.	In-Network and Out-of-Network Deductibles accumulate together	

CHARGES FOR PREVENTIVE CARE SERVICES	In-Network	Out-of-Network
The following Preventive Care and Screening Services: - Annual Adult Preventive Exam - Annual Gynecological Exam - Fecal Occult Blood Screening - Prostate Specific Antigen (PSA) Screening	100%	Not Covered
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. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html http://www.hrsa.gov/womensguidelines/	100%	Not Covered

PHYSICIAN AND FACILITY SERVICES URGENT CARE AND EMERGENCY		
	In-Network Network	Out-of-Network
Urgent Care Facility	80% after Deductible	60% after Deductible
Urgent Care Physician	80% after Deductible and $10 Copay	60% after Deductible
Emergency Room Facility	100% after Deductible	
Emergency Room Physician	100% after Deductible	
Ambulance	100% after Deductible	
No Copay, Deductible, or Benefit Percentage 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 for the balance.		

CHARGES FOR FACILITY SERVICES OTHER THAN URGENT CARE AND EMERGENCY (INCLUDES MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)		
	In-Network	**Out-of-Network**
Office Visit	80% after Deductible and $10 Copay	60% after Deductible
Inpatient Facility	80% after Deductible	60% after Deductible
Outpatient Facility	80% after Deductible	60% after Deductible
Inpatient Physician	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 and Outpatient	80% after Deductible and $10 Copay	60% after Deductible
Pathology, Anesthesia & Radiology	80% after Deductible	60% after Deductible
Diagnostic Laboratory and Advanced Imaging	80% after Deductible	60% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician	80% after Deductible and $10 Copay	60% after Deductible
Independent Laboratory Services Ordered by a Network Physician	80% after Deductible and $5 Copay	
Allergy Testing and Injections	80% after Deductible	60% after Deductible
CHARGES FOR OTHER SERVICES		
	In-Network	**Out-of-Network**
Pathology, Anesthesia & Radiology – Physician Services	80% after Deductible	60% after Deductible
Diagnostic Laboratory and Advanced Imaging – Physician Services	80% after Deductible	60% after Deductible
Durable Medical Equipment	80% after 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 (Maximum 45 days per Calendar Year)	80% after Deductible	60% after Deductible
Skilled Nursing Care - Residential Home	Not Covered	Not Covered
Infertility Counseling and Treatment (Limited Benefit)	80% after Deductible	60% after Deductible
Psychiatric Facility - Inpatient and Outpatient	80% after Deductible	60% after Deductible
Substance Abuse Facility - Inpatient and 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	60% after Deductible

	In-Network	Out-of-Network
LASIK Surgery	80% after Deductible	60% after Deductible
Hearing Examination Audiology test covered with medical diagnosis	80% after Deductible	60% after Deductible
Hearing Aids	80% after Deductible	60% after Deductible
Male Sterilization - Inpatient and Outpatient	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
CHARGES FOR THERAPY SERVICES		
	In-Network	**Out-of-Network**
Rehabilitative Services *(Limits do not apply to Autism Spectrum Disorders.)		
Outpatient Speech Therapy	80% after Deductible	60% after Deductible
Outpatient Physical Therapy		60% after Deductible
Outpatient Occupational Therapy		60% after Deductible
Habilitative Services *(Limits do not apply to Autism Spectrum Disorders.)		
Outpatient Speech Therapy	80% after Deductible	60% after Deductible
Outpatient Physical Therapy		60% after Deductible
Outpatient Occupational Therapy		60% after Deductible
Spinal Manipulation (Calendar Year Maximum = 30 visits)*	80% after Deductible	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		
BEFORE Deductible is Satisfied	Subject to Deductible	
AFTER Deductible is Satisfied	See Prescription Drug Schedule for applicable Prescription Drug Copay, Deductible and Coinsurance	