

Health Insurance for Individuals & Families



U S UNITED SECURITY
L H LIFE AND HEALTH INSURANCE COMPANY

6640 South Cicero Avenue, Bedford Park, IL 60638

Quality Products from Caring Professionals

Plan Feature

Protector Plus
PPO

Advantage Care
PPO/HSA Qualified

APEX
Any Provider

Lifetime Maximum	UNLIMITED	UNLIMITED	UNLIMITED
Deductibles (In Network)	\$500, \$1,000, \$1,500, \$2,500, \$5,000 and \$10,000 (Maximum 3 Per Family)	Individual: \$1,500, \$2,500, \$3,750, \$5,000 Family: \$2,500, \$5,000, \$7,500, \$10,000	\$250, \$500, \$1,000, \$2,500 and \$5,000 (Maximum 3 Per Family)
Coinsurance Options (In Network)	80/20 to \$10,000 80/20 to \$5,000 70/30 to \$10,000 100% with \$10,000 deductible	100%	80/20 to \$5,000 50/50 to \$2,000
Out of Network	See page 3	See page 4	No Penalty
Non-Preventive Doctor Office Visits	Subject to deductible and coinsurance or Optional Physicians Office Copay: \$25 copay up to \$500 benefit per person per year.	Subject to deductible	Subject to deductible and coinsurance
Inpatient Charges	Subject to deductible and coinsurance	Subject to deductible	Subject to deductible and coinsurance
Outpatient Charges	Subject to deductible and coinsurance	Subject to deductible	Subject to deductible and coinsurance
Outpatient Prescription Drugs	Subject to deductible and coinsurance or Optional Prescription Drug Card: \$50 Deductible per person per year Generic: \$15 Co-pay Formulary: \$30 Co-pay Non-Formulary: \$50 Co-pay Specialty: 25% coinsurance	Subject to deductible	Plans with \$250, \$500 or \$1,000 deductibles: \$50 Deductible Generic: \$15 Co-pay Formulary: \$30 Co-pay Non-Formulary: \$50 Co-pay Specialty: 25% coinsurance (Subject to deductible and coinsurance with \$2,500 and \$5,000 deductibles)
Wellness	Unlimited coverage. No deductible, copays, coinsurance.* * In-network services only. Out-of-network services subject to penalties.	Unlimited coverage. No deductible, copays, coinsurance.* * In-network services only. Out-of-network services subject to penalties.	Unlimited coverage. No deductible, copays, coinsurance.
Dental	Not covered unless the Optional Dental Benefit is selected	80% Preventative Services; 50% Restorative Services; \$250 per year on Individual Plan; \$500 per year on Family Plan; No Deductible, No Waiting Period	Subject to deductible and coinsurance; \$200 per year per person for exams, cleaning and x-rays. Full Dental Option available
Emergency Room	Subject to deductible and coinsurance	Subject to deductible	Subject to deductible and coinsurance
24 Hour Coverage	Included	Included	Included
Initial Rate Guarantee	12 months	12 months	12 months
Optional Benefits	Maternity Coverage Accident Benefit Prescription Drug Card Term Life Full Dental Physicians Office Copay See page 3 for benefit details	Maternity Coverage Term Life See page 4 for benefit details	Maternity Coverage Accident Benefit Full Dental Term Life See page 5 for benefit details

* May vary by state

Eligibility Requirements: The plans are available to newly qualified applicants ages 19 through 64 years and 6 months.

Protector Plus - Preferred Provider Plan



No single plan design works for everyone. With that in mind, USL&H's Protector Plus allows you to build the plan that fits your needs. Deductibles ranging from \$500-\$10,000 are available with optional benefit choices that provide first dollar coverage. You choose the plan design that fits your healthcare needs and your budget!

SPECIAL PLAN FEATURES

Common Accident Benefit– When 2 or more covered family members are injured in the same accident, only one deductible must be met for the resulting expense.

Wellness Services– Wellness services are now covered first-dollar on an unlimited basis! No deductible, coinsurance, copayments. Covers all services required by the U.S. Preventive Services Task Force, such as immunizations, PSA screening, pap smears, mammograms and physical exams.*

Prescription Drug Discount Card– Even if you do not select the optional prescription drug card, the Protector Plus plan will still cover your prescription drug charges, subject to deductible and coinsurance. USL&H has also worked with our Pharmacy Benefit Manager, CareMark, to provide you with a free discount card. **This is not a Prescription Co-Pay Drug Card**, but rather a card that will allow for discounts and/or lower out-of-pocket expense on many prescription drugs.

100% Pre-Admission Testing– USL&H will pay 100% for Pre-Admission tests done within 7 days of an inpatient surgery. Deductible and coinsurance do not apply.

Network Providers– This plan utilizes Preferred Provider Organizations (PPO's) to help control costs and save you money. Charges incurred outside of USL&H's PPO networks are subject to a double deductible and a 20% reduction in coinsurance.



* In-network services only. Out-of-network services subject to penalties.

PROTECTOR PLUS OPTIONAL BENEFITS

Network Physician Copay– After a \$25 copay per visit, USL&H will cover non-preventive Physician's visits at 100%, up to \$500 per person per year. Charges exceeding \$500 will be subject to deductible & coinsurance.

Prescription Drug Copay Card– \$50 calendar year deductible per person then:

- **Generic**- \$15 copay
- **Preferred Brand**- \$30 copay
- **Non-Preferred Brand**- \$50 copay
- **Specialty**– 25% coinsurance

Dental Benefit– \$100 calendar year deductible per person, \$1,000 yearly maximum per person. 80% coverage for preventive charges, 50% for restorative charges. Charges are subject to a six month waiting period. Orthodontics are not covered. Coverage is for any dentist.

Supplemental Accident– 100% coverage for the first \$500 of covered expenses due to an accident. Expenses in excess of \$500 are subject to the deductible and coinsurance.

Maternity Benefit– Six month waiting period for conception, 15 month waiting period for delivery with charges being covered the same as any other illness. There is no separate deductible for the baby. If delivery occurs prior to the 15 month waiting period, benefits are limited to \$1,000.

Term Life– Available to the primary insured and spouse in the following amounts:

\$10,000 \$20,000 \$30,000 \$40,000 \$50,000

Advantage Care (PPO/HSA Qualified)



- ◆ HSA Qualified plan for individuals and families who wish to contribute to a HSA Account and save money on their federal taxes
- ◆ One annual deductible for all covered family members
- ◆ Lower premiums as compared to most first dollar plans

Why an HSA?

A HSA (Health Savings Account) allows an individual to set aside pre-tax money to pay for qualified medical expenses. To fight rising medical costs, individuals are taking control of their health care dollars by putting pre-tax money into a HSA. Funds from your HSA may be used to pay for services which are applied to your deductible, as well as other qualified expenses. Any unused money in your HSA at the end of the year rolls over to the following year.

SPECIAL PLAN FEATURES

Wellness Services– Wellness services are now covered first-dollar on an unlimited basis! No deductible, coinsurance, copayments. Covers all services required by the U.S. Preventive Services Task Force, such as immunizations, PSA screening, pap smears, mammograms and physical exams.*

Dental Care– included at no additional cost!

- **No Waiting Period** • **No Deductible** • **Any Dentist**

80% coverage for:

- One cleaning per year, oral exams, and dental x-rays.

50% coverage for restorative services:

- Orthodontia is excluded.

\$250 yearly benefit for individual plan

\$500 yearly benefit for family plans

100% Coinsurance– As long as you use network providers, covered charges are paid at 100% after your calendar year deductible.

Prescription Drug Discount Card– Eligible prescription drugs are covered at 100%, subject to deductible and coinsurance. USL&H has also worked with our Pharmacy Benefit Manager, CareMark, to provide you with a free discount card. **This is not a Prescription Co-Pay Drug Card**, but rather a card that will allow for discounts and/or lower out-of-pocket expense on many prescription drugs.

Network Providers– This plan utilizes Preferred Provider Organizations (PPO's) to help control costs and save you money. Charges incurred outside of USL&H's designated PPO networks are subject to a double deductible and 80/20 to \$10,000 coinsurance. Please be sure to verify your providers' participation in the PPO Network.

ADVANTAGE CARE OPTIONAL BENEFITS

Maternity Benefit– Six month waiting period for conception, 15 month waiting period for delivery with charges being covered the same as any other illness. There is no separate deductible for the baby. If delivery occurs prior to the 15 month waiting period, benefits are limited to \$1,000.

Term Life– Available to the primary insured and spouse in the following amounts:

\$10,000 \$20,000 \$30,000 \$40,000 \$50,000



* In-network services only. Out-of-network services subject to penalties.

APEX Benefit Care – Any Provider Plan



- ◆ Use any doctor
- ◆ Use any hospital
- ◆ No pre-certification required

SPECIAL PLAN FEATURES

Wellness Services- Wellness services are now covered first-dollar on an unlimited basis! No deductible, coinsurance, copayments. Covers all services required by the U.S. Preventive Services Task Force, such as immunizations, PSA screening, pap smears, mammograms and physical exams.

Prescription Drug Card- Included with the \$250, \$500 and \$1,000 deductibles. A \$50 calendar year deductible per person applies, then the following copays:

- **Generic-** \$15
- **Preferred Brand-** \$30
- **Non-Preferred-** \$50
- **Specialty** – 25% coinsurance

USL&H will issue a **free prescription drug discount card** for Apex policies that do not include the above Prescription Drug Co-Pay Card. The discount card is made available by our Pharmacy Benefit Manager, Caremark, to provide savings on prescription drugs. The discount card is not a Prescription Co-Pay Drug Card, but it will allow for discounts and/or lower the out-of-pocket expense on many prescription drugs.

Preventive Dental Benefit- USL&H covers up to \$200 per person per year for dental exams, cleanings, and x-rays at no additional cost. (Subject to deductible and coinsurance).

Preferred Plan Providers- You may use any provider you wish, however, if you use doctors and hospitals in USL&H's PPO network, you will receive discounts from those providers. USL&H pays an additional 10% coinsurance on those claims. (Does not include emergency room visits).

Common Accident Benefit- When 2 or more covered family members are injured in the same accident, only one deductible must be met for the resulting expense during that calendar year.



APEX OPTIONAL BENEFITS

Rate Reducer- Elect 50/50 of \$2,000 coinsurance instead of the usual 80/20 of \$5,000. Your out of pocket is still \$1,000 after the deductible, but you save 10% on the base premium. Not available with deductibles above \$1,000.

Dental Benefit- \$100 calendar year deductible per person, \$1,000 yearly maximum per person. 80% coverage for preventive charges, 50% for restorative charges. Coverage limited to \$200 for exams, cleanings and x-rays the first six months. Additional charges are subject to a six month waiting period. Orthodontics are not covered. Coverage is for any dentist.

Zero Deductible Accident Benefit/AD&D- Eliminate your deductible for all charges incurred within 90 days that are a result of an accident. The coinsurance still applies. In addition, this benefit includes a \$25,000 Accidental Death and Dismemberment benefit for the primary insured and covered spouse, and a \$1,000 AD&D benefit for each covered child over six months of age. Not available with deductibles above \$1,000.

Maternity Benefit- Six month waiting period for conception, 15 month waiting period for delivery. Maternity charges are covered the same as any other illness. Well-baby care in the hospital is covered with no separate deductible for the baby. If the delivery occurs prior to the 15 month waiting period, all maternity benefits are limited to \$1,000.

Term Life- Available to the primary insured and spouse in the following amounts:
\$10,000 \$20,000 \$30,000 \$40,000 \$50,000

STATE VARIATIONS

MISSOURI

- Inpatient Alcoholism is covered up to 30 days per calendar year.
- Mental and Nervous disorders, Chemical Dependency, and Outpatient Alcoholism are excluded, unless the optional Applied Behavior Analysis, Chemical Dependency and Mental Illness Offer is elected and current.
- The Hospital Pre-Admission Review and Concurrent Review limitation does not apply.
- Chiropractic services are covered as any other illness, up to 26 visits per year.

MANDATED OFFERS

MISSOURI

Missouri Applied Behavior Analysis, Chemical Dependency and Mental Illness Offer

This benefit provides Chemical Dependency coverage through a nonresidential treatment program, or partial or full-day program services, up to 26 days per calendar year, inpatient coverage for a residential treatment program, up to 21 days per calendar year, and coverage for medical or social setting detoxification up to 6 days per calendar year, and a lifetime maximum of 10 episodes of treatment.

Outpatient treatment for a recognized Mental Illness is treated the same as any other illness. Inpatient treatment for a recognized Mental Illness is treated the same as any other illness, up to 90 days per calendar year.

This benefit also includes two sessions per calendar year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical worker for the purpose of diagnosis or assessment. These visits are subject to any deductible, coinsurance, or copayment provisions.

The Applied Behavior Analysis coverage provides a maximum benefit of \$40,000 per calendar year for individuals through 18 years of age, subject to any deductible, coinsurance, or copayment provisions.

The Autism Spectrum Disorder benefit provides coverage for medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder, subject to any deductible, coinsurance, or copayment provisions.

GENERAL COVERAGE LIMITATIONS AND EXCLUSIONS

(Your State May Vary)

PRE-EXISTING CONDITIONS LIMITATION

(Not Applicable To Children Under Age 19)

“Pre-Existing Condition” means an injury or sickness for which an insured person received medical advice, care or treatment within 12 months before that person’s insurance began under the policy or produced symptoms within that 12 month period which would have led a prudent person to seek diagnosis, care or treatment. If the condition is not fully disclosed in the application, such condition will not be eligible for payment until the insured person has been covered for 24 continuous months unless excluded by a rider. (NOTE: Health conditions fully disclosed on the application and not excluded from coverage are NOT considered “pre-existing” conditions).

LIMITATIONS – The following expenses are limited by the Policy.

• For manual or mechanical diagnoses and treatment of body structure to restore normal function of the muscular, connective, or nervous system is limited to \$20 per visit and a maximum of 20 visits per Benefit Period. • For Home Health Care by a Home Health Care Agency, visits will be limited up to 60 visits per insured per benefit period, not to exceed \$30 per visit. • For medically necessary durable equipment, rental fees will be limited up to reasonable and customary purchased price of the equipment. • Assistant Surgeon benefits will be eligible for up to 20% of the eligible Primary Surgeon’s fee. • Room and Board charges for each day of a Hospital stay are limited to the average semi-private room rate. • Treatment, services and supplies received outside the United States or Canada will be limited to \$10,000, except if due to any injury or acute onset of sickness sustained while traveling. • Human Organ/Tissue Transplant expenses, including Donor Organ Acquisition expenses, are covered up to \$1,000,000 if services are performed within the preferred transplant network. Expenses incurred outside the preferred transplant network are limited to \$100,000. Donor Organ Acquisition expenses incurred outside the preferred transplant network facility are limited to \$5,000. • Intensive care is limited to three times the Average Semi-Private (A.S.P.) room rate for the first 90 days, and the A.S.P. rate thereafter. • Emergency air, ground, and water ambulance is limited to \$10,000 per person per calendar year.

PRESCRIPTION DRUG LIMITATIONS AND EXCLUSIONS

• The pharmacist will substitute generic medications, when available, for brand name medications. • The amount of Covered Medications will be limited to a 30 day supply, however, Covered Medications that are maintenance medications obtained through the mail, under the mail order program, are limited to a 90-day supply • Non-maintenance drugs in which a 30-day supply is in excess of what is considered a necessary standard of practice shall be limited to less than a 30-day supply. • Except for inhalers, “prepackaged” medications that are packaged in standardized containers from a prescription medication manufacturer shall not be dispensed in more than one standardized container per prescription order. A maximum of two inhalers per prescription order may be obtained at one time. • Except for the administration of insulin, injectable medications, bee sting kits, Anakits and Epi-pens are excluded. Insulin injectors without a needle are covered if Medically Necessary, that is, where a syringe and needle are inappropriate because the insured cannot find an appropriate site for the injection. • Purchases made at non-network pharmacies will be subject to the deductible and co-insurance provisions of the policy.

No benefit will be paid for charges incurred for: • Prescription orders by dentists and physicians for conditions which the Company determines to be dental in nature, are excluded. • Cosmetics, health or beauty aids, dietary supplements, anoretics (i.e. appetite suppressants), diet medications, retinoic acid for cosmetic purposes, medication prescribed to remove or lessen wrinkles in the skin, and topical minoxidil and other medications to treat baldness, are excluded. • Medications dispensed in connection with, or because of, a cosmetic or Non-Medically Necessary procedure, are excluded. • Placebo injections and medications are excluded. • Implantable medications and devices (e.g., pain control, Norplant and other contraceptive medications and devices), drug infusion pumps and release devices, are excluded. • Medical and surgical appliances, durable medical equipment, medical supplies, and oxygen and oxygen supplies, are excluded. • Allergy desensitization products are excluded. • Aphrodisiacs are excluded. • Progesterone is excluded. • Contraceptives, oral or other, whether medication or a device, regardless of the purpose for which prescribed unless mandated by state regulation. • Drugs which are intended to promote fertility. • Drugs or medicines delivered or administered to an insured person by the prescriber. • Any drug or medication dispensed by a Hospital, Extended Care Facility, nursing home or similar facility. • Any drug or medicine labeled “Caution – Limited by Federal Law to Investigational Use”, or experimental drugs even though a charge is made to the patient. • Hypodermic syringes or needles, except when purchased in conjunction with an insulin prescription. • Immunizing agents, injectibles (except insulin), biological sera, blood or plasma, or any drug prescribed for parental use. • A non-legend patent or proprietary medicine or medication. • Medications for mental and nervous disorders.

EXCLUSIONS – The following exclusions apply to expenses which will NOT be paid by the Policy. Charges incurred:

• For outpatient alcoholism or any substance abuse treatment. • For artificial insemination or in-vitro fertilization. • For an inpatient stay when the stay is primarily for a behavioral problem, social maladjustment or any other antisocial action which is not specifically the result of mental illness. • For which the insured person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage. • For contraceptive methods. • During the commission of a crime or while engaged in an illegal act, illegal occupation or felonious act or aggravated assault. • For Custodial Care or Rehabilitative Care. • For dental care or treatment except: as provided in the Preventative Dental Care Benefit, or provided in the Optional Rider, or for an injury to sound, natural teeth or removal of a tumor or cyst while insured. • Prior to the insured person’s effective date of coverage under the Policy, or after coverage is terminated, unless Extension of Benefits applies. • For conditions or activities specifically excluded or limited by a Certificate Rider. • For any procedure or treatment that is deemed to be experimental or investigational in nature by any appropriate medical assessment body. • For hearing aids, eyeglasses, lenses, frames or for the exams for fitting them. • For eye refractions or radical keratotomy procedures. • For all charges in connection with a Hospital admittance between 12:00 noon Friday and 12:00 noon Sunday unless: the confinement is necessary due to a medical emergency; a Physician confirms a medical necessity exists; or surgery is scheduled for the next day. • Paid under a no-fault auto insurance plan. • For normal pregnancy or child birth unless the optional maternity benefit is elected and current. Complications of Pregnancy are covered without the maternity option. • For a Pre-Existing Condition. • For Private Duty nursing. • In excess of the Reasonable and Customary charge or services which are not Medically Necessary. • As a result of participation in a riot. • For failure to keep a scheduled visit or charges to complete a claim for. • For services performed by a close relative or household member. • For sex transformations or sexual dysfunction. • For elective sterilizations or reversals, or abortions unless the life of the mother is endangered if the fetus were carried to term. • In connection with any intentional self-inflicted injury or illness, or attempted suicide, whether sane or insane. • For treatment of Temporomandibular Joint Syndrome (TMJ). • For injuries sustained while under the influence of alcohol or non-prescription drugs. • For vitamins or food supplements. • As a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. • For weight control programs or treatment of obesity not caused by an organic condition. • Arising out of, or in the course of, any occupation for wage or profit for which the insured person is entitled to benefits under any Workers’ Compensation or Occupational Disease Law, or any such similar law.

ADDITIONAL ADVANTAGE CARE LIMITATION

Inpatient rehabilitative care, excluding treatment for alcoholism, mental and nervous disorders, and substance abuse is covered up to 30 days per calendar year to a maximum of \$3,000 per calendar year. Outpatient rehabilitation therapy (resulting from an inpatient hospitalization or outpatient surgery) for physical, occupational and/or speech services is covered up to a combined total of 30 visits per calendar year, not to exceed \$3,000 per calendar year.

Protector Plus and Advantage Care Out of Network Emergency Provision

Charges incurred in an out of network facility will be paid at the in network level of benefits if:

1. Confinement or emergency room treatment is due to an emergency,
2. You cannot be moved because your condition is life threatening, as determined by the attending doctor,
3. You are unable to communicate your choice of hospital,
4. Local law or regulation dictates that you be transported to a specific hospital,
5. The participating provider dictates that you be confined in a non-network facility due to a medical necessity.

ADVANTAGE CARE and PROTECTOR PLUS

UTILIZATION REVIEW REQUIREMENTS COST CONTROL PROVISIONS – To help reduce your premium, certain cost control provisions are provided:

• Hospital Pre-Admission Review and Concurrent Review – Whenever hospital admission is necessary, the insured must notify the appropriate pre-authorization party at least three days in advance (or within 48 hours after an emergency admission) so that they may review and evaluate the necessity of hospital confinement and the length of stay. While hospital confined, the appropriate pre-authorization party will remain in contact with the doctor or hospital to coordinate timely discharge or movement to other facilities providing appropriate levels of care.

THIS BROCHURE PROVIDES A BRIEF DESCRIPTION OF THE BENEFITS, LIMITATIONS AND EXCLUSIONS. SEE THE ACTUAL POLICY FOR COMPLETE TERMS AND CONDITIONS.

National Pharmacy Network:

CVS Caremark: www.caremark.com

PPO Network Options

PHCS
www.phcs.com

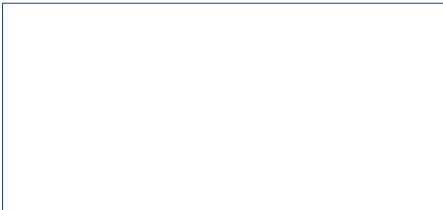
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