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	**THN Network**	**Cofinity Network**	**Out-of-Network**
- Individual	$1,300	$1,500	
- Family, aggregate	$2,600	$3,000	
"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.	THN, Cofinity and Out-of-Network Deductibles accumulate together		
Coinsurance	**THN Network**	**Cofinity Network**	**Out-of-Network**
- Individual	N/A	$1,000	
- Family, aggregate	N/A	$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.	Cofinity and Out-of-Network Coinsurance Maximums accumulate together		
Out of Pocket Limit	**THN Network**	**Cofinity Network**	**Out-of-Network**
- Individual	$4,000	$6,350	
- Family, embedded	$8,000	$12,700	
"Embedded" = Claims paid after the Individual Out of Pocket Limit is satisfied for an individual family member will have no additional Cost Sharing (Deductible, Benefit Percentage amounts, and Copays) taken for that individual family member. Claims paid after the Family Out of Pocket Limit is satisfied will have no additional Cost Sharing taken for the entire family.	Cofinity and Out-of-Network Cost Sharing Maximums accumulate together		

CHARGES FOR PREVENTIVE CARE SERVICES	Tier 1-Network	Tier 2-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			
	THN Network	Cofinity Network	Out-of-Network
Urgent Care Facility	100% after Deductible	80% after $10 copay and Deductible	60% after Deductible
Urgent Care Physician	100% after Deductible	80% after Deductible	60% after Deductible
Emergency Room Facility	100% after Deductible	80% after $100 copay and Cofinity Deductible	
Emergency Room Physician	100% after Deductible	80% after Cofinity Deductible	
Ambulance	100% after Deductible	80% after Cofinity 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)			
	THN Network	**Cofinity Network**	**Out-of-Network**
Office Visit	100% after Deductible	80% after $10 copay and Deductible	60% after Deductible
Inpatient Facility	100% after Deductible	80% after Deductible	60% after Deductible
Outpatient Facility	100% after Deductible	80% after Deductible	60% after Deductible
Inpatient Physician	100% after Deductible	80% after Deductible	60% after Deductible
Outpatient Physician	100% after Deductible	80% after Deductible	60% after Deductible
Surgical Care Facility	100% after Deductible	80% after Deductible	60% after Deductible
Surgical Care Physician (Surgeon) - Inpatient and Outpatient	100% after Deductible	80% after $10 copay and Deductible	60% after Deductible
Pathology, Anesthesia & Radiology	100% after Deductible	80% after Deductible	60% after Deductible
Diagnostic Laboratory, X-Ray, and Advanced Imaging	100% after Deductible	80% after $10 copay and Deductible	60% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician	100% after Deductible	80% after $10 copay and Deductible	60% after Deductible
Independent Laboratory Services Ordered by a Network Physician	100% after Deductible	80% after $5 copay and Deductible	
Allergy Testing and Injections	100% after Deductible	80% after Deductible	60% after Deductible
CHARGES FOR OTHER SERVICES			
	THN Network	**Cofinity Network**	**Out-of-Network**
Durable Medical Equipment	100% after Deductible	80% after Deductible	
Human Organ Transplant	100% after Deductible	80% after Deductible	60% after Deductible
Hospice	100% after Deductible	80% after Deductible	60% after Deductible
Home Health Care	100% after Deductible	80% after Deductible	60% after Deductible
Skilled Nursing Care - Nursing Home (Maximum 45 days per Calendar Year)	100% after Deductible	80% after Deductible	60% after Deductible
Skilled Nursing Care - Residential Home	Not Covered	Not Covered	
Infertility Counseling and Treatment (Limited Benefit)	100% after Deductible	80% after Deductible	60% after Deductible
Psychiatric Facility - Inpatient and Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
Substance Abuse Facility - Inpatient and Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
Partial Hospital Program for Mental Health	100% after Deductible	80% after Deductible	60% after Deductible
Dietician Services (Maximum 6 visits per Calendar Year)	100% after Deductible	80% after Deductible	60% after Deductible
LASIK Surgery	100% after Deductible	80% after Deductible	60% after Deductible

	THN Network	Cofinity Network	Out-of-Network
Hearing Examination Audiology test covered with medical diagnosis	100% after Deductible	80% after Deductible	60% after Deductible
Hearing Aids	100% after Deductible	80% after Deductible	60% after Deductible
Male Sterilization - Inpatient and Outpatient	100% after Deductible	80% after Deductible	60% after Deductible
Prosthetics	100% after Deductible	80% after Deductible	60% after Deductible
CHARGES FOR THERAPY SERVICES			
	THN Network	**Cofinity Network**	**Out-of-Network**
Rehabilitative Services *(Limits do not apply to Autism Spectrum Disorders.)			
Outpatient Speech Therapy	100% after Deductible	In Physician's Office: 80% after $10 copay and Deductible Other Location: 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	100% after Deductible	In Physician's Office: 80% after $10 copay and Deductible Other Location: 80% after Deductible	60% after Deductible
Outpatient Physical Therapy	100% after Deductible		60% after Deductible
Outpatient Occupational Therapy	100% after Deductible		60% after Deductible
Spinal Manipulation (Calendar Year Maximum = 30 visits)*	100% after Deductible	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	