SCHEDULE OF BENEFITS - MEDICAL (PLAN WOODHAVEN B)

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	$200	$500
- Family, embedded	$400	$1,000
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	$0	$2,500
- Family, embedded	$0	$5,000
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 WOODHAVEN B)

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%	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 Deductible after $15 Copay	100% after Deductible and $15 Copay
Emergency Room Facility	100% after In-Network Deductible and $50 Copay	
Emergency Room Physician	100% after In-Network 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.		

SCHEDULE OF BENEFITS - MEDICAL (PLAN WOODHAVEN B)

		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		100% after Deductible and $15 Copay	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 Deductible	80% after Deductible
Surgical Care Physician (Surgeon) - Outpatient		100% after Deductible	80% after Deductible
Diagnostic X-Ray, Laboratory and Advanced Imaging		100% after Deductible	80% after Deductible
Independent Laboratory Services Ordered by a Non-Network Physician		100% after Deductible	100% after Deductible
Independent Laboratory Services Ordered by a Network Physician		100% after In-Network Deductible	
Allergy Testing and Injections		100% after Deductible after $15 Copay	80% after Deductible
CHARGES FOR OTHER SERVICES			
Durable Medical Equipment		100% after In-Network Deductible	
Human Organ Transplant		100% after Deductible	Not Covered
Hospice		100% after Deductible	Not Covered
Home Health Care		100% after Deductible	Not Covered
Skilled Nursing Care – Nursing Home		100% after Deductible	Not Covered
Skilled Nursing Care – Residential Home		100% after Deductible	Not Covered
Infertility Counseling and Treatment (Limited Benefits)		100% after Deductible	60% after Deductible
Inpatient Rehabilitation Facility		100% after Deductible	Not Covered
Psychiatric Facility	Inpatient	100% after Deductible	80% after Deductible
	Outpatient	100% after Deductible and $15 Copay	
Substance Abuse Facility	Inpatient	100% after Deductible	80% after Deductible
	Outpatient	100% after Deductible and $15 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 $15 Copay	80% after Deductible
LASIK Surgery	Inpatient Outpatient	100% after Deductible	100% after Deductible

SCHEDULE OF BENEFITS - MEDICAL (PLAN WOODHAVEN B)

	We Pay In-Network	We Pay Out-of-Network
Hearing Examination Audiology test covered with medical diagnosis	100% after Deductible and $15 Copay	80% after Deductible
Hearing Aids (Each Ear: Original plus Replacements with a Prescription Change or one time in each 3-year period measured from Original or last Replacement)	100% after Deductible	Not Covered
Male Sterilization Inpatient Outpatient	100% after Deductible	80% after Deductible
Prosthetics	100% after Deductible	80% 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: 100% after Deductible and $15 Copay Other Location: 100% after Deductible	80% 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: 100% after Deductible and $15 Copay Other Location: 100% after Deductible	80% after Deductible
Spinal Manipulation Maximum 20 visits per Calendar Year	100% after Deductible after $15 Copay	80% 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	80% after Deductible

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