

PROTECTOR PLUS MEDICAL PLAN FOR INDIVIDUALS

CHOOSE THE PLAN THAT'S RIGHT FOR YOU!

United Security Life and Health Insurance Company's **Protector Plus** option is designed to save our insureds valuable dollars on their health insurance premiums without sacrificing quality comprehensive coverage. **Protector Plus** is intended to encourage the use of Preferred Providers from which we receive special discounts. Secondly, **Protector Plus** is designed to cover the big bills while our insureds will take responsibility for their minor bills. **Protector Plus** is intended to avoid overutilization, which is a major factor in determining health insurance premiums and renewal rate increases.

In Network Benefits

I.	EACH CALENDAR YEAR	THEN YOU CHOOSE YOUR COINSURANCE		THEN
		OPTION A	OPTION B	
	<p>YOU pay the Preferred Provider deductible of your choice.</p> <p>\$ 500 \$ 1,000 \$ 1,500 \$ 2,500 \$ 5,000</p>	<p>We Pay 80% of the next \$10,000 of covered expenses</p> <p>You Pay 20% of the next \$10,000 of covered preferred provider expenses</p>	<p>We Pay 80% of the next \$5,000 of covered expenses</p> <p>You Pay 20% of the next \$5,000 of covered preferred provider expenses</p>	<p>We Pay 100% of all Covered Expenses up to your choice of \$2,000,000 or \$5,000,000</p> <p>You Pay Nothing!</p>

When charges are incurred outside of United Security Life and Health Insurance Company's Preferred Provider network, a separate calendar year out-of-network deductible will apply. This calendar year deductible will be equal to two times (2x) the preferred provider deductible selected. In addition, the coinsurance chosen will be paid at 60% to \$10,000 on option A and 60% to \$5,000 on option B for charges incurred out-of-network. All benefits are subject to the reasonable and customary limitation.

Special Provisions: Charges incurred at 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 hospitals. 4. Local law or regulation dictates you be transported to a specific hospital. 5. The participating doctor or network hospital at which you are being treated dictates that you be confined in a non-network facility due to a medical necessity.

In Network Benefits

II.	EACH CALENDAR YEAR	THEN
		<p>YOU pay a deductible of \$10,000</p>

There is no separate deductible for out-of-network charges on the \$10,000 deductible option. The coinsurance, however, will be paid at 80% of the next \$10,000 for out-of-network charges.

SPECIAL PLAN FEATURES



In conjunction with MSC, USL&H insureds will receive special discounts when using the MSC \$cript \$ave card at participating pharmacies. Just present your card at any participating facility and receive significant discounts on prescription drugs!

• ALSO INCLUDED FOR ALL POLICYHOLDERS •

- **100% PRE-ADMISSION TESTING** — It can be less expensive to have routine tests prior to admission. We will cover this 100% — NO DEDUCTIBLE!
- **INCREASED INSURANCE FOR GOOD HEALTH** — If we do not pay benefits in a calendar year we will pay an extra 5% coinsurance the next year up to a cumulative maximum of 100%.
- **OUTPATIENT PRESCRIPTION DRUG COVERAGE** — After using your MSC discount card, just send in your outpatient prescription receipts and they will be covered at your chosen level of benefits. There are no yearly maximums for prescriptions; just the policy maximum (subject to deductible and co-insurance).
- **HUMAN ORGAN TRANSPLANT** — We will pay up to \$1,000,000 when treated by network providers approved by USL&H prior to the beginning of the evaluation.
- **DEDUCTIBLE CARRYOVER** — Any portion of your deductible satisfied in Oct., Nov. or Dec. also applies the following year.
- **INTENSIVE CARE UNIT** — Covered up to 90 days.
- **24 HOUR COVERAGE** — Included at no additional cost. Individuals who do not carry Workers' Compensation are covered for a work related illness or injury.
- **PREFERRED PROVIDER NETWORK** — When insureds seek care from our preferred providers, health care ultimately costs less because of special discounts received. Your benefits will be greater with these providers and there are no claim forms to fill out.

COVERED EXPENSES (Partial listing)

IN HOSPITAL

- Semi Private Room/Board
- General Nursing Care
- Surgeon/Assistant Surgeons
- Anesthesia
- X-rays, Laboratory Tests
- Prescription Drugs
- Organ Transplants
- Pathology
- Chemotherapy/Radiation Therapy
- Second Surgical Opinion
- Oxygen, Blood, Equipment
- Intensive Care

OUTPATIENT

- Physician Services
- Hospice Care
- Pre-Admission Testing
- Emergency Care
- Home Health Care
- Ambulance Services
- Physical Therapy
- Dialysis
- X-ray, Laboratory
- Chiropractic Therapy
- Braces, Casts/Splints
- Prescription Drugs
- Outpatient Surgery

RENEWABILITY/RENEWAL PREMIUMS

RENEWABILITY — You Can't Be Singled Out For Cancellation

This plan is renewable to age 65 or date of eligibility for Medicare, (whichever occurs first) based on timely payment of premiums as they become due. The Company can decline to renew all policies in a state, jurisdiction or rating area where contract holders reside, or if false or fraudulent statements are made in connection with a claim.

RENEWAL PREMIUMS — You Can't Be Singled Out For A Renewal Rate Increase

All premiums are made on an area-wide basis. Premiums are scheduled to increase slightly on each policy anniversary due to aging. They may also be adjusted on any premium due date after the first 12 months of coverage to reflect USL&H's experience for all people insured under this policy form.

IMPORTANT OPTIONS

Available at time of issue only!

• NETWORK PHYSICIAN COPAY OPTION

Pay a \$25 copay per visit, and USL&H will cover Physician's Office charges at 100%, up to \$500 per calendar year. The deductible and coinsurance applies to charges in excess of \$500. Wellness and preventative charges are included.

• PRESCRIPTION DRUG CARD OPTION

After a \$50 deductible, prescription drugs are covered at the following levels:

Generic Drugs \$15 per prescription
 Formulary Brand Drugs \$30 per prescription
 Non-Formulary Brand Drugs \$50 per prescription

• DENTAL BENEFIT OPTION

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

• \$5,000,000 LIFETIME MAXIMUM OPTION

Give yourself peace of mind by increasing the lifetime maximum of your policy from \$2,000,000 to \$5,000,000.

• SUPPLEMENTAL ACCIDENT BENEFIT

Insured's can elect to buy additional protection which will pay 100%, no deductible, for charges incurred as a result of an accident, up to \$500 per occurrence.

• TERM LIFE INSURANCE

Choice of five levels of coverage for you and your spouse.

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

• MATERNITY BENEFIT-OPTION PLUS

Six month waiting period for conception • Same as any other illness • Subject to the deductible and co-insurance provisions • Includes Well-Baby Care in hospital and no separate deductible for baby • This benefit is limited to \$1,000 if delivery occurs within the first 15 months.

THIS IS A BRIEF DESCRIPTION OF THE HIGHLIGHTS OF THIS POLICY, NOT A CONTRACT.

SEE THE ACTUAL POLICY FOR COMPLETE TERMS AND CONDITIONS.

MANDATORY OFFERS

• MENTAL ILLNESS AND CHEMICAL DEPENDENCY 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 not subject to any deductible, coinsurance, or copayment provisions.

• CHILD HEALTH OFFER

This benefit provides coverage for the periodic review of a child's physical and emotional status, including examinations, immunizations, and standard laboratory testing. The examinations are available from birth to age 12 at specified intervals.

GENERAL COVERAGE LIMITATIONS AND EXCLUSIONS

PRE-EXISTING CONDITIONS LIMITATION

"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 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 listed on the application and not excluded from coverage are NOT considered "pre-existing" conditions.)

LIMITATIONS — The following expenses are limited by the Policy. Charges incurred:

• For manual or mechanical diagnoses and treatment of body structure to restore normal function of the muscular, connective or nervous system will be limited to \$20 per visit to a maximum of 20 visits per Benefit Period • Inpatient alcoholism is limited to 30 days per benefit period. • For treatment, services and supplies received outside the United States or Canada will be limited to \$10,000, except if due to an injury or acute onset of sickness sustained while traveling. • Human Organ/Tissue Transplant — Covered up to \$100,000 (out of network) per covered procedure (\$1,000,000 if approved by network). Life Donor Maximum: \$5,000 per covered procedure (out of network). Donor Organ Acquisitions: \$5,000 per covered procedure (out of network). • Intensive care is limited to three times the A.S.P. (Average Semi-Private) room rate, up to 90 days thereafter A.S.P.

PRESCRIPTION DRUG LIMITATIONS — No benefit will be paid for charges incurred for:

• 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

parenteral use. • a non-legend patent or propriety medicine or medication. • vitamins, cosmetics, dietary supplements, health or beauty aids, or hair loss • a single prescription or refill in excess of 34-day supply except the following which are limited to 100 dose supply: Nitroglycerine; Oral Anti-Diabetics; Oral Estrogens (natural or synthetic); Phenobarbital; Thyroid U.S.P.

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

• For preventative care, except as provided for with the optional Network Physician Copay benefit. • For outpatient alcoholism, inpatient or outpatient substance abuse, and mental and nervous treatment, unless the optional Mental Illness and Chemical Dependency benefit is selected and current. • 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. • 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 Rehabilitation Care. • For Dental Care or treatment except 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 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, childbirth or routine well baby care unless: the Optional Maternity Care Benefit was elected and effective; or treatment is for Complications of Pregnancy. • For a Pre-Existing Condition. • For Private Duty nursing except for Home Health Care. • 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 form. • 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, while sane. • For treatment of Temporomandibular Joint Syndrome (TMJ). • For injuries sustained while under the influence of alcohol or non-prescription drugs. • 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.

OUTPATIENT SURGERY/TEST LIST

Adenoidectomy	Arthroscopy	Hemorrhoidectomy/Fissurectomy
All Foot Surgery:	Bronchoscopy	Mammoplasty
• Arthrotomy	Cardiac Catheterization	MRI (Magnetic Resonance Imaging)
• Avulsion of Nail Plate	Carpal Tunnel Release	Myringoplasty
• Bunionectomy	CAT Scan	Nasal Endoscopy
• Capsulotomy	(Computerized Axial Tomography)	Rhinoplasty
• Condylectomy	Cataract Extraction	Septoplasty
• Hammertoe Correction	Colonoscopy	Tonsillectomy
• Joint Fusion Synovectomy	Dilation & Curettage	Varicose Vein Surgery
• Neuroma	Endoscopic Retrograde	Any procedure requiring overnight/23 hour observation
• Osteotomy	Cholangiopancreatography (ERCP)	
• Phalangectomy	Esophagogastrosctopy (ECD)	

PPBROMO



10275 WEST HIGGINS ROAD • ROSEMONT, ILLINOIS 60018
 847/298-1400 • 800/875-4422

PPO MAJOR MEDICAL PLAN

Optional Drug Card & Doctor's Office Copay

12 Month Rate Guarantee

Protector Plus



U S UNITED SECURITY
L H LIFE AND HEALTH INSURANCE COMPANY

**For Individuals and Families
 Missouri**

Marketed by: