Major Medical Choice Plus

SCHEDULE OF BENEFITS		
In-Network Deductible[1]	$500/person	$1,500/family
Out-of-Network Deductible	$1,000/person	$3,000/family
In-Network Maximum Out-of-Pocket Expense[2]	$2,500/person	$7,500/family
Out-of-Network Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%[3]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%[4]	50%
Alcohol/Drug Addiction (Hospital & Physician In-patient or Outpatient)	80%[5]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day), 50% (90 day)	Not Applicable

[1] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[2] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[3] "In-Network" also includes applicable services performed by certain out-of-network providers at an in-network provider facility (unless the provider satisfies advance patient notice and consent requirements).

[4] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies advance patient notice and consent requirements).

[5] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the provider satisfies advance patient notice and consent requirements).

Major Medical HD 1000

SCHEDULE OF BENFITS		
In-Network Deductible[6]	$1,000/person	$3,000/family
Out-of-Network Deductible	$2,000/person	$6,000/family
In-Network Maximum Out-of-Pocket Expense[7]	$3,000/person	$9,000/family
Out-of-Network Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%[8]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%[9]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%[10]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits & Emergency Ambulance Transport	80%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day), 50% (90 day)	Not Applicable

[6] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[7] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[8] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[9] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[10] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Major Medical HD 2000 Enhanced

SCHEDULE OF BENFITS		
In-Network Deductible[11]	$2,000/person $6,000/family	
Out-of-Network Deductible	$4,000/person $12,000/family	
In-Network Maximum Out-of-Pocket Expense[12]	$4,000/person $12,000/family	
Out-of-Network Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%[13]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%[14]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%[15]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit* Co-pay for Specialist	$50	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$5/$35/$60 (30 day), $12.50/$87.50/$150 (90 day-mail), $15/$105/$180 (90 day-retail)	Not Applicable
Prescription Drug Coverage ($500-$999)	$65 copay (30 day), $162.50 (90 day)	Not Applicable
Prescription Drug Coverage ($1000-$1499)	$130 copay (30 day), $325 (90 day)	Not Applicable

[11] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[12] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[13] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[14] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[15] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Prescription Drug Coverage ($1500-$2000)	$200 copay (30 day), $500 (90 day)	Not Applicable
Prescription Drug Coverage (above $2000)	$275 copay (30 day), $687.50 (90 day)	Not Applicable
Prescription Drug Coverage (specialty)	$275 copay	Not Applicable

**Excludes any other procedures performed during the visit.*

Major Medical HD 5000

SCHEDULE OF BENFITS		
In-Network Deductible[16]	$5,000/person	$12,700/family
Out-of-Network Deductible	$10,000/person	$30,000/family
In-Network Maximum Out-of-Pocket Expense[17]	$9,100/person	$18,200/family
Out-of-Network Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	80%[18]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	80%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	80%[19]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	80%[20]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	80%	50%
Hospice (Maximum 180 days/lifetime)	100%	
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$100 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	80%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	80% (30 day), 50% (90 day)	Not Applicable

[16] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[17] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[18] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[19] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[20] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option I

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[21]	$1,500/single	$3,000/family
Out-of-Network Aggregate Deductible	$3,000/single	$6,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[22]	$1,500/single	$3,000/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%[23]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	100%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	100%[24]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	100%[25]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	100%	50%
Hospice (Maximum 180 days/lifetime)	100%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	100%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	100%	50%
All Other Covered Expenses (including Urgent Care)	100%	50%
Physician Office Visits	100%	50%
Emergency Room Visits & Emergency Ambulance Transport	100%	100%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	100 %	Not Applicable

[21] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[22] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[23] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[24] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[25] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option II

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[26]	$2,500/single	$5,000/family
Out-of-Network Aggregate Deductible	$5,000/single	$10,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[27]	$3,750/single	$7,500/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%[28]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%[29]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%[30]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day), 75% (90 day)	Not Applicable

[26] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[27] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[28] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[29] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[30] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option III

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[31]	$3,000/single	$6,000/family
Out-of-Network Aggregate Deductible	$6,000/single	$12,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[32]	$4,500/single	$9,000/family
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%[33]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%[34]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient and Outpatient)	90%[35]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day), 75% (90 day)	Not Applicable

[31] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[32] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[33] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[34] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[35] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option IV

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[36]	$3,500/single	$7,000/family
Out-of-Network Aggregate Deductible	$7,000/single	$14,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[37]	$5,250/single	$10,500/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%[38]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%[39]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient and Outpatient)	90%[40]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day), 75% (90 day)	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[36] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[37] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[38] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[39] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[40] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option VI

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[41]	$3,500/single	$7,000/family
Out-of-Network Aggregate Deductible	$5,000/single	$10,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[42]	$7,000/single	$12,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%[43]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%[44]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%[45]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	70%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	70%	50%
All Other Covered Expenses (including Urgent Care)	70%	50%
Physician Office Visits	70%	50%
Emergency Room Visits & Emergency Ambulance Transport	70%	70%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	70% (30 day), 50% (90 day)	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[41] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[42] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[43] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[44] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[45] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option VII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[46]	$5,000/single	$10,000/family*
Out-of-Network Aggregate Deductible	$10,000/single	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[47]	$7,500/single	$15,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%[48]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%[49]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%[50]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)	90%	50%
All Other Covered Expenses (including Urgent Care)	90%	50%
Physician Office Visits	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day), 75% (90 day)	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

[46] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[47] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[48] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[49] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[50] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

HDHP Option VIII

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[51]	$6,000/person	$12,000/family*
Out-of-Network Aggregate Deductible	$10,000/person	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[52]	$7,500/person	$15,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	90%[53]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	90%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	90%[54]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	90%[55]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	90%	50%
Hospice (Maximum 180 days/lifetime)	90%	50%
Emergency Room Visits & Emergency Ambulance Transport	90%	90%
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	90%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Prescription Drug Coverage (generic, preferred brand, non-preferred brand, specialty)	90% (30 day), 75% (90 day)	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*
*** Excludes any other procedures performed during the visit*

[51] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[52] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[53] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[54] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[55] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Premier Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[56]	$1,750/person	$3,500/family
Out-of-Network Aggregate Deductible	$3,500/person	$7,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[57]	$5,000/person	$10,000/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%[58]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%[59]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%[60]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day), $30/$200/$500 (90 day-mail), $36/$240/$600 (90 day-retail)	Not Applicable
Prescription Drug Coverage (specialty)	$250	Not Applicable

** Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[56] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[57] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[58] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[59] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[60] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Prime Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[61]	$3,000/person $6,000/family	
Out-of-Network Aggregate Deductible	$5,000/person $10,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense[62]	$7,900/person $15,800/family*	
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%[63]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	70%[64]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	70%[65]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day), $30/$200/$500 (90 day-mail), $36/$240/$600 (90 day-retail)	Not Applicable
Prescription Drug Coverage (specialty)	$250	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[61] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[62] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[63] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[64] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[65] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Select Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[66]	$3,500/person $7,000/family	
Out-of-Network Aggregate Deductible	$6,500/person $13,000/family	
In-Network Aggregate Maximum Out-of-Pocket Expense[67]	$7,900/person $15,800/family*	
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	70%[68]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	70%	50%
Mental/Nervous Treatment Inpatient (Hospitals & Physician Inpatient or Outpatient)	70%[69]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient and Outpatient)	70%[70]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	70%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	70%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Enhancement Package	**In-Network**	**Out-of-Network**
Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day), $30/$200/$500 (90 day-mail), $36/$240/$600 (90 day-retail)	Not Applicable
Prescription Drug Coverage (specialty)	$250	Not Applicable

**Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit.*

[66] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[67] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[68] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[69] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[70] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

Value Plus

SCHEDULE OF BENEFITS		
In-Network Aggregate Deductible[71]	$9,100/person	$18,200/family*
Out-of-Network Aggregate Deductible	$10,000/person	$30,000/family
In-Network Aggregate Maximum Out-of-Pocket Expense[72]	$9,100/person	$18,200/family*
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense	Unlimited	
Annual Maximum including Transplants	Unlimited	
Plan Pays After Deductible	**In-Network**	**Out-of-Network**
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital (room & board, ICU & ancillary charges) Inpatient Physician Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray	100%[73]	50%
Assistant Surgeons (limited of 25% of primary surgeon's allowable fee)	100%	50%
Mental/Nervous Treatment (Hospitals & Physician Inpatient or Outpatient)	100%[74]	50%
Alcohol/Drug Addiction (Hospital & Physician Inpatient or Outpatient)	100%[75]	50%
Skilled Nursing Facility (Maximum 60 days/calendar year)	100%	50%
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits (Fee waived if admitted to hospital from ER or if treated for an accidental injury or if referred to ER by a Physician)	$300 Fee then applicable co-insurance	
Physical/Occupational Therapy (Combined Maximum of 30 visits/calendar year)	100%	50%
Speech Therapy (Maximum of 30 visits/calendar year)		
All Other Covered Expenses (including Urgent Care)		
Enhancement Package	**In-Network**	**Out-of-Network**
In-network Office Visit Co-pay for General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	$30	50%
In-network Office Visit** Co-pay for Specialist	$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred brand)	$12/$80/$200 (30 day), $30/$200/$500 (90 day-mail), $36/$240/$600 (90 day-retail)	Not Applicable
Prescription Drug Coverage (specialty)	$250	Not Applicable

** Individual maximum of $9,100 is embedded for covered individuals with dependent coverage.*

*** Excludes any other procedures performed during the visit*

[71] Includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[72] Generally includes certain out-of-network providers of Ambulance Services, Emergency Services, and non-Emergency Services furnished at certain in-network provider facilities.

[73] "In-Network" also includes applicable services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies advance patient notice and consent requirements).

[74] "In-Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).

[75] "In Network" also includes certain inpatient services performed by an out-of-network provider at an in-network provider facility (unless the Provider satisfies the advance patient notice and consent requirements).