Major Medical Choice Plus

SCHEDULE OF BENEF	ITS	
In-Network Deductible ¹		1,500/family
Out-of-Network Deductible		3,000/family
In-Network Maximum Out-of-Pocket Expense ²		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	80%	50%
(limited of 25% of primary surgeon's allowable fee) Mental/Nervous Treatment	80%4	50%
(Hospitals & Physician Inpatient or Outpatient) Alcohol/Drug Addiction (Hagnital & Physician In nations or Outpatient)	80%5	50%
(Hospital & Physician In-patient or Outpatient) 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)		
Speech Therapy (Maximum of 30 visits/calendar year)	80%	50%
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 innetwork 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 BENFI	TS	
In-Network Deductible ⁶	\$1,000/person	3,000/family
Out-of-Network Deductible		66,000/family
In-Network Maximum Out-of-Pocket Expense ⁷	\$3,000/person	59,000/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) Speech Therapy (Maximum of 30 visits/calendar year) All Other Covered Expenses (including Urgent Care)	80%	50%
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 innetwork 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 BI	ENFITS	
In-Network Deductible ¹¹	\$2,000/person \$6,000/fam	nily
Out-of-Network Deductible	\$4,000/person \$12,000/fa	
In-Network Maximum Out-of-Pocket Expense ¹²	\$4,000/person \$12,000/fa	
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	80%13	50%
Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray		
Assistant Surgeons	80%	50%
(limited of 25% of primary surgeon's allowable fee)	8070	3070
Mental/Nervous Treatment	80%14	50%
(Hospitals & Physician Inpatient or Outpatient)	8070	3070
Alcohol/Drug Addiction	80%15	50%
(Hospital & Physician Inpatient or Outpatient)	8070	3070
Skilled Nursing Facility	80%	50%
(Maximum 60 days/calendar year)	3070	3070
Hospice	100%	100%
(Maximum 180 days/lifetime)	10070	10070
Emergency Room Visits	\$100 Fee	
(Fee waived if admitted to hospital from ER or if treated for an	then applicable co. incurance	
accidental injury or if referred to ER by a Physician)	then applicable co	
Physical/Occupational Therapy		
(Combined Maximum of 30 visits/calendar year)		
Speech Therapy	80%	50%
(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	\$30	50%
General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist		
Office Visit* Co-pay for Specialist	\$50	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred	\$5/\$35/\$60 (30 day),	
brand)	\$12.50/\$87.50/\$150 (90	Not Applicable
	day-mail), \$15/\$105/\$180	11
D '.' D C (#500 #000)	(90 day-retail)	
Prescription Drug Coverage (\$500-\$999)	\$65 copay (30 day),	Not Applicable
Danielia Danielia (#1000 #1400)	\$162.50 (90 day)	
Prescription Drug Coverage (\$1000-\$1499)	\$130 copay (30 day), \$325	Not Applicable
	(90 day)	11

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 innetwork 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 BEN	FITS	
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)	000/	500/
Speech Therapy (Maximum of 30 visits/calendar year) All Other Covered Expenses (including Urgent Care)	80%	50%
Prescription Drug Coverage (generic, preferred brand, non-preferred	80% (30 day),	Not Applicable
brand, specialty)	50% (90 day),	140t Applicable

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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 innetwork 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 BENEF	ITS	
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 innetwork 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 BENEF	ITS	
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 innetwork 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 BENEF	ITS	
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

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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 innetwork 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 BENEF	ITS	
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 innetwork 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 BENEF	ITS	
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 innetwork 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

COLLEGIA DE DEVICE	ITO	
SCHEDULE OF BENEF		Φ10.000/C '1 *
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 innetwork 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 BENEF	ITS	
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) Speech Therapy (Maximum of 30 visits/calendar year) All Other Covered Expenses (including Urgent Care)	90%	50%
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 innetwork 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 BEN	IEFITS	
In-Network Aggregate Deductible ⁵⁶		0/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	70%58	50%
Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray		
Assistant Surgeons	70%	50%
(limited of 25% of primary surgeon's allowable fee)	50	
Mental/Nervous Treatment	70% ⁵⁹	50%
(Hospitals & Physician Inpatient or Outpatient)	5 00/60	5 00/
Alcohol/Drug Addiction	70%60	50%
(Hospital & Physician Inpatient or Outpatient)	700/	500/
Skilled Nursing Facility	70%	50%
(Maximum 60 days/calendar year)		
Hospice (Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits		
(Fee waived if admitted to hospital from ER or if treated for an	\$300 Fee then applicable co-insurance	
accidental injury or if referred to ER by a Physician)		
Physical/Occupational Therapy		50%
(Combined Maximum of 30 visits/calendar year)	70%	
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	\$30	50%
General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist		
Office Visit** Co-pay for Specialist	\$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred	\$12/\$80/\$200 (30	
brand)	day), \$30/\$200/\$500	
	(90 day-mail),	Not Applicable
	\$36/\$240/\$600 (90	
D 12 D C (11)	day-retail)	3T / A 1' 11
Prescription Drug Coverage (specialty) * Individual maximum of \$9,100 is embedded for covered individuals w	\$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 innetwork 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 BEN		
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	70% ⁶³	50%
(room & board, ICU & ancillary charges) Inpatient Physician		
Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray		
Assistant Surgeons	70%	50%
(limited of 25% of primary surgeon's allowable fee)		3070
Mental/Nervous Treatment	70%64	50%
(Hospitals & Physician Inpatient or Outpatient)	7078	
Alcohol/Drug Addiction	70%65	50%
(Hospital & Physician Inpatient or Outpatient)	70%	30%
Skilled Nursing Facility	70%	50%
(Maximum 60 days/calendar year)	7078	3070
Hospice	100%	100%
(Maximum 180 days/lifetime)	10078	10070
Emergency Room Visits	\$300 Fee then applicable co-insurance	
(Fee waived if admitted to hospital from ER or if treated for an		
accidental injury or if referred to ER by a Physician)		
Physical/Occupational Therapy		50%
(Combined Maximum of 30 visits/calendar year)		
Speech Therapy	70%	
(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	\$30	50%
General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	\$30	30%
Office Visit** Co-pay for Specialist	\$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred	\$12/\$80/\$200 (30 day),	
brand)	\$30/\$200/\$500 (90 day-	NI_4 A1:1:1:
	mail), \$36/\$240/\$600	Not Applicable
	(90 day-retail)	
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 innetwork 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 &}quot;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

Out-of-Network Aggregate Deductible \$6 In-Network Aggregate Maximum Out-of-Pocket Expense 57 Out-of-Network Aggregate Maximum Out-Of-Pocket Expense Ut	\$7,900/person \$15,800	/family	
In-Network Aggregate Maximum Out-of-Pocket Expense 57 Out-of-Network Aggregate Maximum Out-Of-Pocket Expense Ut	\$7,900/person \$15,800		
Out-of-Network Aggregate Maximum Out-Of-Pocket Expense U		\$6,500/person \$13,000/family	
		\$7,900/person \$15,800/family*	
Annual Maximum including Transplants Ui	Unlimited		
	Jnlimited		
Plan Pays After Deductible	In-Network	Out-of-Network	
Outpatient Surgery, Outpatient Hospital, Inpatient Hospital		50%	
(room & board, ICU & ancillary charges) Inpatient Physician	$70\%^{68}$		
Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray			
Assistant Surgeons	70%	50%	
(limited of 25% of primary surgeon's allowable fee)	7070	3070	
Mental/Nervous Treatment Inpatient	$70\%^{69}$	50%	
(Hospitals & Physician Inpatient or Outpatient)	7078		
Alcohol/Drug Addiction	$70\%^{70}$	500/	
(Hospital & Physician Inpatient and Outpatient)	/070	50%	
Skilled Nursing Facility	70%	50%	
(Maximum 60 days/calendar year)	/070	3070	
Hospice	1000/	1000/	
(Maximum 180 days/lifetime)	100%	100%	
Emergency Room Visits	\$300 Fee then applicable co-insurance		
(Fee waived if admitted to hospital from ER or if treated for an			
accidental injury or if referred to ER by a Physician)			
Physical/Occupational Therapy		50%	
(Combined Maximum of 30 visits/calendar year)			
Speech Therapy	70%		
(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	¢20	50%	
General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist	\$30		
Office Visit** Co-pay for Specialist	\$60	50%	
	\$12/\$80/\$200 (30 day),		
	\$30/\$200/\$500 (90 day-	L 37 / A 11 11	
	mail), \$36/\$240/\$600	Not Applicable	
	90 day-retail)		
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 innetwork 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 BENI	EFITS	
In-Network Aggregate Deductible ⁷¹		,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	100% ⁷³	50%
(room & board, ICU & ancillary charges) Inpatient Physician		
Visits, Surgery, Anesthesia (including CRNA's), Laboratory, X-ray		
Assistant Surgeons	100%	50%
(limited of 25% of primary surgeon's allowable fee)	10070	2070
Mental/Nervous Treatment	100%74	50%
(Hospitals & Physician Inpatient or Outpatient)		
Alcohol/Drug Addiction	100% ⁷⁵	50%
(Hospital & Physician Inpatient or Outpatient)		
Skilled Nursing Facility	100%	
(Maximum 60 days/calendar year) Hospice		
(Maximum 180 days/lifetime)	100%	100%
Emergency Room Visits		
(Fee waived if admitted to hospital from ER or if treated for an	\$300 Fee then applicable	
accidental injury or if referred to ER by a Physician)	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	\$30	50%
General/Family/Internal/Pediatrics/OBGYN/Psychiatry/Psychologist		30%
In-network Office Visit** Co-pay for Specialist	\$60	50%
Prescription Drug Coverage (generic/preferred brand/non-preferred	\$12/\$80/\$200 (30	
brand)	day), \$30/\$200/\$500	
	(90 day-mail),	Not Applicable
	\$36/\$240/\$600 (90	
	day-retail)	27
Prescription Drug Coverage (specialty) * In dividual magnitude of \$0,100 is such added for sovered individuals as	\$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 innetwork 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).