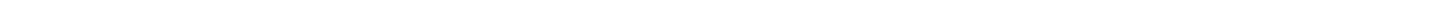
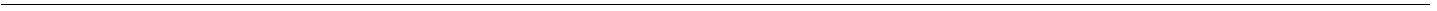
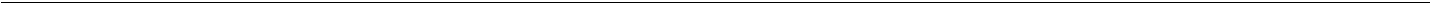
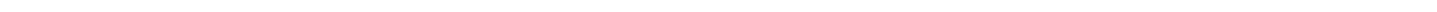
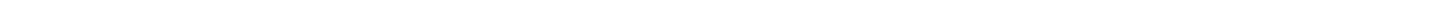
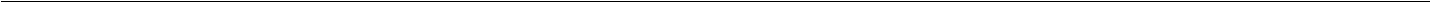
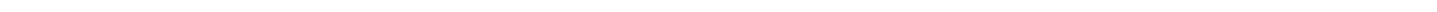
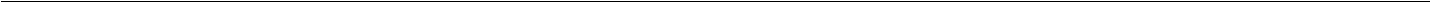
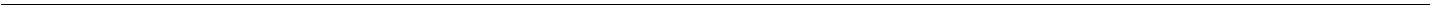


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Qualified High Deductible Health Plan

**PLAN DESIGN & BENEFITS**

<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	50%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	50%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	50%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	50%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	50%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	50%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	50%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	50%; after deductible
<b>Residential Treatment Facility</b>	20%; after deductible	50%; after deductible
<b>Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible	50%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b> Limited to 120 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%; after deductible	20%; after deductible
<b>Home Health Care</b>	20%; after deductible	20%; after deductible
<b>Hospice Care - Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Covered 100%; after deductible	Covered 100%; after deductible
<b>Hospice Care - Outpatient</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	Covered 100%; after deductible	Covered 100%; after deductible
<b>Private Duty Nursing</b>	50%; after deductible	50%; after deductible
<b>Outpatient Short-Term Rehabilitation</b> Includes speech, physical, occupational therapy; limited to 60 visits per calendar year	20%; after deductible	50%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 24 visits per calendar year.	20%; after deductible	50%; after deductible

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