II. SCHEDULE OF BENEFITS

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	 $6,550 $13,100	 $13,100 $26,200
Coinsurance After Deductible	20%	40%
Lifetime Maximum (Amount payable per eligible individual, includes all benefits paid for covered hospital, medical and prescription benefits)	Unlimited	
Out-of-Pocket Maximum (Includes deductibles and copays) Individual Family	 $7,000 $14,000	 $14,000 $28,000
Physician Office Visits and Other In-office Services Primary Care Physician	 20% coinsurance, after deductible	 40% coinsurance, after deductible
Specialist (Includes cardiologists, psychiatrists, dermatologists, podiatrists, etc)	20% coinsurance, after deductible	40% coinsurance, after deductible
Preventative Care Benefits (One annual exam per calendar year including blood screening urine tests, chest, x-ray, EKG & mammography)	No Charge	20% coinsurance, after deductible
Diagnostic Tests (X-rays and blood tests)	20% coinsurance, after deductible	40% coinsurance, after deductible
Imaging Services (CT and MRI scans require prior authorization)	20% coinsurance, after deductible	40% coinsurance, after deductible
Ambulance	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room (Waived if admitted)	20% coinsurance, after deductible	20% coinsurance, after deductible

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Urgent Care Services	20% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Benefits Daily Hospital Room and Board, Semi-Private and other allowable expenses	20% coinsurance, after deductible	40% coinsurance, after deductible
Outpatient Surgery Center (Includes ambulatory surgery centers)	20% coinsurance, after deductible	40% coinsurance, after deductible
-Physician & Surgeon Fees	20% coinsurance, after deductible	40% coinsurance, after deductible
Mental and Substance Use Disorder -Inpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
-Outpatient	20% coinsurance, after deductible	40% coinsurance, after deductible
Home Health Care	20% coinsurance, after deductible	40% coinsurance, after deductible
Hospice Care Services	No Charge	20% coinsurance, after deductible
Skilled Nursing Facility	20% coinsurance, after deductible	40% coinsurance, after deductible
Durable Medical Equipment (Total rental not to exceed purchase price)	20% coinsurance, after deductible	40% coinsurance, after deductible
External Prosthetic Devices -Wigs, toupee or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia-male pattern baldness)	20% coinsurance, after deductible, and any amount over $350 maximum	40% coinsurance, after deductible, and any amount over $350 maximum

HDHP PLUS PLAN

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Breast Pumps	No Charge and any amount up to a maximum of $250	40% coinsurance, after deductible and any amount up to a maximum of $250
Physical, Occupational and Speech Therapy (Limited up to 60 combined visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Chiropractic Care Services (Limited to 30 visits per calendar year)	20% coinsurance, after deductible	40% coinsurance, after deductible
Vision Benefits		
Eye Exam (Once every year)	No Charge	No Charge
Prescription Corrective Eyeglasses or Contact Lenses (Every year)	Up to $100	Up to $100

HDHP PLUS PLAN

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	**Out-of-Network**
Retail 30-Day Supply		
Generic Drugs	$5 copay	20% coinsurance, after deductible
Preferred Brand Name Drugs	$50 copay	20% coinsurance, after deductible
Non-Preferred Brand Name Drugs	$60 copay	20% coinsurance, after deductible
Mail-Order 90-Day Supply		
Generic Drugs	$15 copay	Not Covered
Preferred Brand Name Drugs	$150 copay	Not Covered
Non-Preferred Brand Name Drugs	$180 copay	Not Covered