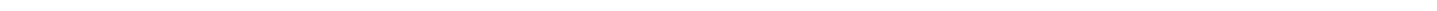
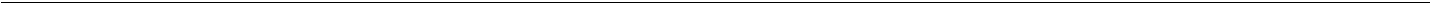
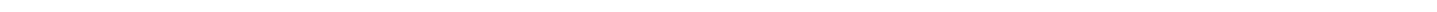
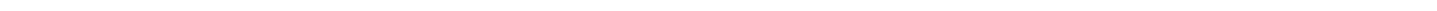
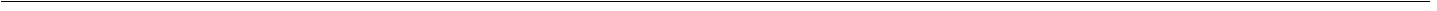
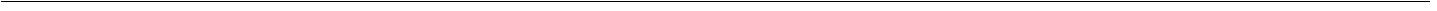
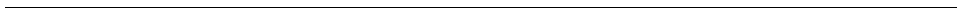


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Qualified High Deductible Health Plan

PLAN DESIGN & BENEFITS

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