

POS HIGH DEDUCTIBLE HEALTH PLAN \$5,000 INDIVIDUAL/\$10,000 FAMILY — A

For use with Health Savings Account (HSA)

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations, which may be set forth in the policy.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CONTRACT YEAR COST SHARE		
■ Individual Plan Deductible (Plan Deductible is combined for In- and Out-of-network health services and prescription drugs)	\$5,000 Individual	
■ Family Plan Deductible (Plan Deductible is combined for In- and Out-of-network health services and prescription drugs)	\$10,000 Family	
■ Individual Coinsurance Maximum (does not include the Plan Deductible and is for health services only)	Not Applicable	\$5,000 Individual
■ Family Coinsurance Maximum (does not include the Plan Deductible and is for health services only)	Not Applicable	\$10,000 Family
■ Individual Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance Maximum, and is for health services only)	\$5,000 Individual	\$10,000 Individual
■ Family Out-of-Pocket Maximum (includes Plan Deductible and Coinsurance Maximum, and is for health services only)	\$10,000 Family	\$20,000 Family
■ Out-of-Network Reimbursement	Not Applicable	Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
DAILY HOSPITAL ROOM AND BOARD		
■ Hospitalization for Illness or Injury (includes semi-private room and board; excludes all maternity-related services)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 100 days per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room	No Member cost after Plan Deductible	Same as In-network
■ Walk-In/Urgent Care Centers	No Member cost after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	No Member cost after Plan Deductible	50% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital Services	Included in Hospital Services
OUT-OF-HOSPITAL CARE		
■ Primary Care Provider Office Services (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some in-network preventive care services. Refer to the Plan Deductible Information for details.)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Gynecological Preventive Exam Office Services (one per contract year)	No Member cost (Plan Deductible waived)	50% after Plan Deductible
■ Maternity Care Office Services	Not a covered benefit	Not a covered benefit
OTHER BENEFITS		
■ Ambulance Services	No Member cost after Plan Deductible	Same as In-network
■ Home Health Services (up to 100 visits per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Non-Advanced Radiology Services (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	50% after Plan Deductible

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
■ Advanced Radiology (includes services for MRI, PET and CAT Scan, and Nuclear Cardiology performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Chiropractic Services (up to 10 visits per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Routine Vision Exam (one per contract year)	No Member cost (Plan Deductible waived)	50% after Plan Deductible
■ Durable Medical Equipment and Supplies (includes services for Durable Medical Equipment including Prosthetics, Disposable Medical Supplies and Ostomy Supplies and Equipment up to \$2,500 per contract year)	No Member cost after Plan Deductible	50% after Plan Deductible
■ Lifetime Maximum	Unlimited	

PRESCRIPTION DRUG OPTIONS Covered prescription drugs through retail Participating Pharmacies or our mail order service. Generics are dispensed unless the Member pays the Generic Drug Cost Share plus the difference in price between the Generic Equivalent and the Brand Name Drug.

■ Individual Plan Deductible (The Contract Year Plan Deductible can be reached by any combination of covered Health Services or covered prescription drug services)	\$5,000 Individual	\$10,000 Individual
■ Family Plan Deductible (The Contract Year Plan Deductible can be reached by any combination of covered Health Services or covered prescription drug services) If you have Family Coverage, then covered Health Services and covered prescription drugs will be applied to the Family Plan Deductible until the total amount is met without regard to which family member uses the benefits.	\$10,000 Family	\$20,000 Family
■ Individual Pharmacy Cost-Share Maximum (Maximum does not include Deductible)	None	\$10,000 Individual
■ Family Pharmacy Cost-Share Maximum (Maximum does not include Deductible)	None	\$20,000 Family
■ Out-of-Network Reimbursement	None	Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.

	Tier One	Tier Two	Tier Three
30-Day supply through participating retail pharmacies	No Member cost after Plan Deductible	No Member cost after Plan Deductible	No Member cost after Plan Deductible
90-Day supply through participating Mail Order Vendor	No Member cost after Plan Deductible	No Member cost after Plan Deductible	No Member cost after Plan Deductible

PLAN DEDUCTIBLE INFORMATION

The Plan Deductible **does not** apply to the following covered health services when they are rendered by a Participating Provider. Please note that the limitation provisions detailed below only show you when those services do not apply to the Plan Deductible for the identified in-network services.

- Bone Density screenings, age 50 or older, **one every 23 months**
- Colorectal cancer screenings, fecal occult blood test, sigmoidoscopy or colonoscopy (including an associated biopsy performed during a colonoscopy), age 50 or older, **one per contract year**
- Gynecological preventive exam, **one per contract year**
- Immunizations for:
 - Children* - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Influenza, Measles, Meningitis, Mumps, Pertussis, Pneumococcus, Polio, Rotavirus, Rubella, and Tetanus
 - Adults* - Chickenpox, Diphtheria, Hemophilus Influenza B, Hepatitis A, Hepatitis B, Herpes Zoster, Influenza, Measles, Meningitis, Mumps, Pertusis, Pneumococcus, Polio, Rubella and Tetanus
- Mammography screenings for:
 - One routine screening between the ages of 35 and 40, then**
 - One routine screening per contract year at age 40 or older**
- Newborn well baby visits
- Outpatient laboratory services (**one per contract year**) associated with preventive exams *limited to*:
 - Blood count
 - Cervical cancer screening - Pap tests
 - Chlamydia and Gonorrhea screening
 - Cholesterol screening
 - Fasting plasma glucose
 - Hematocrit or hemoglobin
 - Human Papillomavirus
 - Lead screening
 - Tuberculin Test
 - Urinalysis
 - Venipuncture
- Preventive exams for adult (**one per contract year**) and pediatric exams as coded by the most current edition American Medical Association's Current Procedural Terminology Coding Manual, including an electrocardiogram
- Prostate cancer screening and associated laboratory tests, age 50 and older, **one per contract year**
- Routine vision exam, **one per contract year**