

POS HIGH DEDUCTIBLE HEALTH PLAN \$3,000 INDIVIDUAL/\$6,000 FAMILY — A

For Use with a 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 health services and prescription drugs)	\$3,000	\$6,000
■ Family Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	\$6,000	\$12,000
■ Individual Copayment Maximum (does not include the Plan Deductible and is for health services only)	\$2,250 Individual	Not Applicable
■ Family Copayment Maximum (does not include the Plan Deductible and is for health services only)	\$4,500 Family	Not Applicable
■ Individual Coinsurance Maximum (does not include the Plan Deductible and is for health services only)	Not Applicable	\$4,000 Individual
■ Family Coinsurance Maximum (does not include the Plan Deductible and is for health services only)	Not Applicable	\$8,000 Family
■ Individual Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance Maximum, Copayment Maximum and is for health services only)	\$5,250 Individual	\$10,000 Individual
■ Family Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance Maximum, Copayment 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)	\$500 Copayment per day up to \$2,000 per contract year, after Plan Deductible	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 100 days per contract year)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room	\$150 Copayment per visit after Plan Deductible	Same as In-network
■ Walk-In/Urgent Care Centers	\$75 Copayment per visit after Plan Deductible	Same as In-network
SURGICAL SERVICES		
■ Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility) (The Plan Deductible does not apply to some in-network preventive care services. Refer to the Plan Deductible Information for details.)	\$500 Copayment per visit after Plan Deductible	30% 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.)	\$30 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	\$45 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services (one per contract year)	\$30 Copayment per visit (Plan Deductible waived)	30% 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	30% after Plan Deductible
■ Laboratory Services (includes services performed in a Hospital or laboratory facility)	No Member Cost after Plan Deductible	30% after Plan Deductible
■ Non-Advanced Radiology Services (includes services performed in a Hospital or radiology facility)	\$10 Copayment per visit after Plan Deductible	30% 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)	\$75 Copayment per visit up to 5 Copayments per contract year after Plan Deductible	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits per contract year)	\$45 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits per contract year combined for physical, speech, and occupational therapy)	\$45 Copayment per visit after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per contract year)	\$45 Copayment per visit (Plan Deductible waived)	30% 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)	20% after Plan Deductible	30% after Plan Deductible
■ Lifetime Maximum	Unlimited	\$1,000,000 - 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)	\$3,000 Individual	\$6,000 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.	\$6,000 Family	\$12,000 Family
■ Individual Pharmacy Cost-Share Maximum (Maximum does not include Deductible)	\$500 Individual	\$5,000 Individual
■ Family Pharmacy Cost-Share Maximum (Maximum does not include Deductible)	\$1,000 Family	\$10,000 Family
■ Out-of-Network Reimbursement	Not Applicable	Plan will reimburse the coinsurance percentage of the Maximum Allowable Amount.

	Tier One	Tier Two	Tier Three
30-Day supply through participating retail pharmacies	20% after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible
90-Day supply through participating Mail Order Vendor	20% after Plan Deductible	20% after Plan Deductible	20% after Plan Deductible