HMO HIGH DEDUCTIBLE HEALTH PLAN — $1,500 INDIVIDUAL/$3,000 FAMILY

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.

	MEMBER COST:
PLAN DEDUCTIBLES	
Individual Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	$1,500
Family Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	$3,000
Individual Out-of-Pocket Maximum (includes Plan Deductible and prescription drugs)	$3,000
Family Out-of-Pocket Maximum (includes Plan Deductible and prescription drugs)	$6,000
DAILY HOSPITAL ROOM AND BOARD	
Hospitalization for Maternity, Illness or Injury (includes semi-private room and board)	No Member cost after Plan Deductible
Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES	
Emergency Room	No Member cost after Plan Deductible
Walk-In/Urgent Care Centers	No Member cost after Plan Deductible
SURGICAL SERVICES	
Ambulatory Services (Outpatient) (includes services performed in a Hospital or ambulatory facility)	No Member cost after Plan Deductible
ANESTHESIA SERVICES	
Anesthesia and oxygen services	Included in Hospital Services

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $1,500 INDIVIDUAL/$3,000 FAMILY, CONT.

	MEMBER COST:
IN-HOSPITAL MEDICAL SERVICES	
■ **Inpatient medical services**	Included in Hospital Services
OUT-OF-HOSPITAL CARE	
■ **Primary Care Physician Office Services** (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some preventive care services. Refer to Plan Deductible Information for details.)	No Member cost after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per year)	No Member cost
■ **Maternity Care Office Services**	No Member cost after Plan Deductible
OTHER BENEFITS	
■ **Ambulance Services**	No Member cost after Plan Deductible
■ **Home Health Services** (up to 100 visits)	No Member cost after Plan Deductible
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible
■ **Non-Advanced Radiology** (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible
■ **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
■ **Chiropractic Services** (up to 10 visits)	No Member cost after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible
■ **Routine Vision Exam** (one per year)	No Member cost
■ **Disposable Medical Supplies** (up to $300)	No Member cost after Plan Deductible
■ **Durable Medical Equipment Including Prosthetics** (up to $1,500)	No Member cost after Plan Deductible
■ **Ostomy Supplies and Equipment** (up to $1,000)	No Member cost after Plan Deductible

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $1,500 INDIVIDUAL/$3,000 FAMILY, CONT.

	MEMBER COST:
PRESCRIPTION DRUGS 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**	$1,500
■ **Family Plan Deductible**	$3,000
The Calendar 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.	
■ **Individual Pharmacy Cost-Share Maximum** (Maximum does not include Deductible)	$1,500
■ **Family Pharmacy Cost-Share Maximum** (Maximum does not include Deductible)	$3,000
■ **Prescription Drug Benefit Limit**	Unlimited
RETAIL PHARMACY (UP TO A 30 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**$15 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 2 drugs**	**$25 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 3 drugs**	**$40 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
MAIL ORDER PHARMACY (UP TO A 90 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**$30 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 2 drugs**	**$50 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 3 drugs**	**$80 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
LIFETIME MAXIMUM	Unlimited

HMO HIGH DEDUCTIBLE HEALTH PLAN — $3,000 INDIVIDUAL/$6,000 FAMILY

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.

	MEMBER COST:
PLAN DEDUCTIBLES	
■ **Individual Plan Deductible** (Plan Deductible is combined for health services and prescription drugs)	$3,000
■ **Family Plan Deductible** (Plan Deductible is combined for health services and prescription drugs)	$6,000
■ **Individual Out-of-Pocket Maximum** (includes Plan Deductible and prescription drugs)	$4,500
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and prescription drugs)	$9,000
DAILY HOSPITAL ROOM AND BOARD	
■ **Hospitalization for Maternity, Illness or Injury** (includes semi-private room and board)	No Member cost after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 90 days)	No Member cost after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES	
■ **Emergency Room**	No Member cost after Plan Deductible
■ **Walk-In/Urgent Care Centers**	No Member cost after Plan Deductible
SURGICAL SERVICES	
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	No Member cost after Plan Deductible
ANESTHESIA SERVICES	
■ **Anesthesia and oxygen services**	Included in Hospital Services

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $3,000 INDIVIDUAL/$6,000 FAMILY, CONT.

	MEMBER COST:
IN-HOSPITAL MEDICAL SERVICES	
■ **Inpatient medical services**	Included in Hospital Services
OUT-OF-HOSPITAL CARE	
■ **Primary Care Physician Office Services** (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some preventive care services. Refer to Plan Deductible Information for details.)	No Member cost after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per year)	No Member cost
■ **Maternity Care Office Services**	No Member cost after Plan Deductible
OTHER BENEFITS	
■ **Ambulance Services**	No Member cost after Plan Deductible
■ **Home Health Services** (up to 100 visits)	No Member cost after Plan Deductible
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible
■ **Non-Advanced Radiology** (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible
■ **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
■ **Chiropractic Services** (up to 10 visits)	No Member cost after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible
■ **Routine Vision Exam** (one per year)	No Member cost
■ **Disposable Medical Supplies** (up to $300)	No Member cost after Plan Deductible
■ **Durable Medical Equipment Including Prosthetics** (up to $1,500)	No Member cost after Plan Deductible
■ **Ostomy Supplies and Equipment** (up to $1,000)	No Member cost after Plan Deductible

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $3,000 INDIVIDUAL/$6,000 FAMILY, CONT.

	MEMBER COST:
PRESCRIPTION DRUGS 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**	$3,000
■ **Family Plan Deductible**	$6,000
The Calendar 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.	
■ **Individual Pharmacy Cost-Share Maximum** (Maximum does not include Deductible)	$1,500
■ **Family Pharmacy Cost-Share Maximum** (Maximum does not include Deductible)	$3,000
■ **Prescription Drug Benefit Limit**	Unlimited
RETAIL PHARMACY (UP TO A 30 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**$15 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 2 drugs**	**$25 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 3 drugs**	**$40 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
MAIL ORDER PHARMACY (UP TO A 90 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**$30 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 2 drugs**	**$50 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
■ **Tier 3 drugs**	**$80 Copayment** after Plan Deductible up to Pharmacy Cost-Share Maximum
LIFETIME MAXIMUM	Unlimited

HMO HIGH DEDUCTIBLE HEALTH PLAN — $5,000 INDIVIDUAL/$10,000 FAMILY

For use with a Health Savings Account (HSA)

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	MEMBER COST:
PLAN DEDUCTIBLES	
■ **Individual Plan Deductible** (Plan Deductible is combined for health services and prescription drugs)	$5,000
■ **Family Plan Deductible** (Plan Deductible is combined for health services and prescription drugs)	$10,000
■ **Individual Out-of-Pocket Maximum** (includes Plan Deductible and prescription drugs)	$5,000
■ **Family Out-of-Pocket Maximum** (includes Plan Deductible and prescription drugs)	$10,000
DAILY HOSPITAL ROOM AND BOARD	
■ **Hospitalization for Maternity, Illness or Injury** (includes semi-private room and board)	No Member cost after Plan Deductible
■ **Skilled Nursing and Rehabilitation Facilities** (up to 90 days)	No Member cost after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES	
■ **Emergency Room**	No Member cost after Plan Deductible
■ **Walk-In/Urgent Care Centers**	No Member cost after Plan Deductible
SURGICAL SERVICES	
■ **Ambulatory Services (Outpatient)** (includes services performed in a Hospital or ambulatory facility)	No Member cost after Plan Deductible
ANESTHESIA SERVICES	
■ **Anesthesia and oxygen services**	Included in Hospital Services

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $5,000 INDIVIDUAL/$10,000 FAMILY, CONT.

	MEMBER COST:
IN-HOSPITAL MEDICAL SERVICES	
■ **Inpatient medical services**	Included in Hospital Services
OUT-OF-HOSPITAL CARE	
■ **Primary Care Physician Office Services** (includes services for illness, injury, sickness, follow-up care and consultations) (The Plan Deductible does not apply to some preventive care services. Refer to Plan Deductible Information for details.)	No Member cost after Plan Deductible
■ **Specialist Office Services** (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible
■ **Gynecological Preventive Exam Office Services** (one per year)	No Member cost
■ **Maternity Care Office Services**	No Member cost after Plan Deductible
OTHER BENEFITS	
■ **Ambulance Services**	No Member cost after Plan Deductible
■ **Home Health Services** (up to 100 visits)	No Member cost after Plan Deductible
■ **Laboratory Services** (includes services performed in a Hospital or laboratory facility)	No Member cost after Plan Deductible
■ **Non-Advanced Radiology** (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible
■ **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
■ **Chiropractic Services** (up to 10 visits)	No Member cost after Plan Deductible
■ **Outpatient Rehabilitative Therapy** (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible
■ **Routine Vision Exam** (one per year)	No Member cost
■ **Disposable Medical Supplies** (up to $300)	No Member cost after Plan Deductible
■ **Durable Medical Equipment Including Prosthetics** (up to $1,500)	No Member cost after Plan Deductible
■ **Ostomy Supplies and Equipment** (up to $1,000)	No Member cost after Plan Deductible

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HMO HIGH DEDUCTIBLE HEALTH PLAN — $5,000 INDIVIDUAL/$10,000 FAMILY, CONT.

	MEMBER COST:
PRESCRIPTION DRUGS 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**	$5,000
■ **Family Plan Deductible**	$10,000
The Calendar 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.	
■ **Prescription Drug Benefit Limit**	Unlimited
RETAIL PHARMACY (UP TO A 30 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**No Member Cost** after Plan Deductible
■ **Tier 2 drugs**	**No Member Cost** after Plan Deductible
■ **Tier 3 drugs**	**No Member Cost** after Plan Deductible
MAIL ORDER PHARMACY (UP TO A 90 DAY SUPPLY PER PRESCRIPTION)	
■ **Tier 1 drugs**	**No Member Cost** after Plan Deductible
■ **Tier 2 drugs**	**No Member Cost** after Plan Deductible
■ **Tier 3 drugs**	**No Member Cost** after Plan Deductible
LIFETIME MAXIMUM	Unlimited

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