

POS 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.

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
CALENDAR YEAR COST SHARE		
■ Individual Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	\$1,500	\$3,000
■ Family Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	\$3,000	\$6,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$3,000	\$4,500
■ Family Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$6,000	\$9,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to the Maximum Allowable Amount
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	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ Walk-In/Urgent Care Centers	No Member cost after Plan Deductible	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	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to Plan Deductible Information for details.)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services (one per year)	No Member cost	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	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost after Plan Deductible	25% 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 (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per year)	No Member cost	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	No Member cost after Plan Deductible	30% after Plan Deductible

POS 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 (Combined in-network and out-of-network Benefit Limit)	\$1,500
■ Family Plan Deductible (Combined in-network and out-of-network Benefit Limit)	\$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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY PER PRESCRIPTION)		
■ Tier 1 drugs	\$15 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
■ Tier 2 drugs	\$25 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
■ Tier 3 drugs	\$40 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
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	Not a covered benefit
■ Tier 2 drugs	\$50 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	Not a covered benefit
■ Tier 3 drugs	\$80 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	Not a covered benefit
LIFETIME MAXIMUM	Unlimited	\$1,000,000

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

For use with a Health Savings Account (HSA)

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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
CALENDAR 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 Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$4,500	\$9,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$9,000	\$18,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to the Maximum Allowable Amount
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	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ Walk-In/Urgent Care Centers	No Member cost after Plan Deductible	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	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to Plan Deductible Information for details.)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services (one per year)	No Member cost	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	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost after Plan Deductible	25% 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 (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per year)	No Member cost	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	No Member cost after Plan Deductible	30% after Plan Deductible

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POS 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
(Combined in-network and out-of-network Benefit Limit)

■ **Family Plan Deductible** \$6,000
(Combined in-network and out-of-network Benefit Limit)

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** \$1,500
(Maximum does not include Deductible)

■ **Family Pharmacy Cost-Share Maximum** \$3,000
(Maximum does not include Deductible)

■ **Prescription Drug Benefit Limit** Unlimited

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY PER PRESCRIPTION)		
■ Tier 1 drugs	\$15 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
■ Tier 2 drugs	\$25 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
■ Tier 3 drugs	\$40 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	30% Coinsurance after Plan Deductible
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	Not a covered benefit
■ Tier 2 drugs	\$50 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	Not a covered benefit
■ Tier 3 drugs	\$80 Copayment after Plan Deductible up to Pharmacy Cost-Share maximum	Not a covered benefit
LIFETIME MAXIMUM	Unlimited	\$1,000,000

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

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	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
PLAN DEDUCTIBLES		
■ Individual Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	\$5,000	\$7,000
■ Family Plan Deductible (Plan Deductible is combined for health services and prescription drugs)	\$10,000	\$14,000
■ Individual Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$5,000	\$10,000
■ Family Out-of-Pocket Maximum (includes Plan Deductible, Coinsurance and Prescription Drugs)	\$10,000	\$20,000
■ Out-of-Network Reimbursement	None	Plan will reimburse up to the Maximum Allowable Amount
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	30% after Plan Deductible
■ Skilled Nursing and Rehabilitation Facilities (up to 90 days)	No Member cost after Plan Deductible	30% after Plan Deductible
MISCELLANEOUS HOSPITAL SERVICES		
■ Emergency Room	No Member cost after Plan Deductible	No Member cost after Plan Deductible
■ Walk-In/Urgent Care Centers	No Member cost after Plan Deductible	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	30% after Plan Deductible
ANESTHESIA SERVICES		
■ Anesthesia and oxygen services	Included in Hospital Services	Included in Hospital Services

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

	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER COST
IN-HOSPITAL MEDICAL SERVICES		
■ Inpatient medical services	Included in Hospital 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 in-network preventive care services. Refer to the Plan Deductible Information for details.)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Specialist Office Services (includes services for illness, injury, sickness, follow-up care and consultations)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Gynecological Preventive Exam Office Services (one per year)	No Member cost	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	No Member cost after Plan Deductible
■ Home Health Services (up to 100 visits)	No Member cost after Plan Deductible	25% 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 (includes services performed in a Hospital or radiology facility)	No Member cost after Plan Deductible	30% 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	30% after Plan Deductible
■ Chiropractic Services (up to 10 visits)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Outpatient Rehabilitative Therapy (up to 20 visits combined for physical, speech, and occupational therapy)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Routine Vision Exam (one per year)	No Member cost	30% after Plan Deductible
■ Disposable Medical Supplies (up to \$300)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Durable Medical Equipment Including Prosthetics (up to \$1,500)	No Member cost after Plan Deductible	30% after Plan Deductible
■ Ostomy Supplies and Equipment (up to \$1,000)	No Member cost after Plan Deductible	30% after Plan Deductible

POS 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
(Combined in-network and out-of-network Benefit Limit)

■ **Family Plan Deductible** \$10,000
(Combined in-network and out-of-network Benefit Limit)

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

**IN-NETWORK
MEMBER COST**

**OUT-OF-NETWORK
MEMBER COST**

RETAIL PHARMACY (UP TO A 30-DAY SUPPLY PER PRESCRIPTION)

■ Tier 1 drugs	No Member Cost after Plan Deductible	30% Coinsurance after Plan Deductible
■ Tier 2 drugs	No Member Cost after Plan Deductible	30% Coinsurance after Plan Deductible
■ Tier 3 drugs	No Member Cost after Plan Deductible	30% Coinsurance after Plan Deductible

MAIL ORDER PHARMACY (UP TO A 90-DAY SUPPLY PER PRESCRIPTION)

■ Tier 1 drugs	No Member Cost after Plan Deductible	Not a covered benefit
■ Tier 2 drugs	No Member Cost after Plan Deductible	Not a covered benefit
■ Tier 3 drugs	No Member Cost after Plan Deductible	Not a covered benefit

LIFETIME MAXIMUM Unlimited \$1,000,000