

INDIVIDUAL HIGH RISK POOL PLAN COMPARISON TABLE

Benefit Areas*	Basic Plan	Standard Plan	Catastrophic A Plan	Catastrophic B Plan
Lifetime Maximum Benefit Per Carrier (ALL Benefit Areas)	\$500,000	\$1,000,000	\$1,000,000	\$1,000,000
Calendar Year Deductible Amount Per Individual (Benefit Areas A, C, D, E and F; Benefit Areas B and G have separate Deductibles)	\$500	\$1,000	\$2,000	\$5,000
Normal Maternity Benefit Deductible (Benefit Area B)	\$5,000	\$5,000	\$5,000	\$5,000
Outpatient Prescription Drugs Calendar Year Deductible per Individual (50% Benefit Percentage/ 50% Coinsurance Percentage; Does not apply to Out-of-Pocket Expense Maximum) (Benefit Area G)	\$250	\$250	\$500	\$500
Benefit/Coinsurance Percentage (ALL Benefit Areas except Benefit Area G)	50% / 50%	70% / 30%	70% / 30%	80% / 20%
Individual Out-of-Pocket Expense Calendar Year Maximum (Does NOT include Deductible or Copayments; includes Coinsurance) (ALL Benefit Areas except Benefit Area G)	\$20,000	\$10,000	\$10,000	\$10,000

HSA COMPATIBLE PLAN

Benefit Areas	HSA Compatible Plan
Lifetime Maximum Benefit Per Carrier (ALL Benefit Areas)	\$1,000,000
Calendar Year Deductible Amount (ALL Benefit Areas)	\$3,000 per individual \$6,000 per family
Normal Maternity Benefit (Benefit Area B)	EXCLUDED
Benefit/Coinsurance Percentage (ALL Benefit Areas)	60% / 40%
Out-of-Pocket Expense Calendar Year Maximum (INCLUDES Deductible, Copayments, and Coinsurance)	\$5,000 per individual \$10,000 per family
Outpatient Prescription Drugs Calendar Year Maximum (Benefit Area G)	\$6,000

Benefit Areas *	All Plans
Preventive Services Calendar Year Maximum Benefit (Benefit Area A)	\$200
Organ Transplant Lifetime Maximum Benefit (Benefit Area C)	\$250,000**
Skilled Nursing Facility Calendar Year Maximum Benefit (Benefit Area C)	45 Days
Rehabilitation Therapy Calendar Year Maximum Benefits	\$25,000 Inpatient (Benefit Area C) \$2,000 Combined Outpatient (Benefit Area D)
Home Health Care Calendar Year Maximum Benefit (Benefit Area D)	\$5,000
Hospice Care Calendar Year Maximum Benefit (Benefit Area D)	\$5,000
Ambulance Service Calendar Year Maximum Benefit (Benefit Area E)	\$2,000
Durable Medical Equipment Calendar Year Maximum Benefit (Benefit Area E)	\$10,000
Psychiatric & Substance Abuse Services Calendar Year Benefit Maximum (Benefit Area F)	\$5,000

* See the sample Policy of Insurance for a description of the Benefit Area covered services

** For policies issued or renewed on and after January 1, 2008

HSA COMPATIBLE PLAN

Key Differences from the other Four Plans:

1. This plan has both an individual calendar year deductible (\$3,000) AND a family aggregate calendar year deductible (\$6,000).
2. No coverage for normal maternity expenses (Benefit Area B). The other 4 plans cover normal maternity after a separate \$5,000 deductible. (Complications of pregnancy are covered the same as any other illness, as with all plans.)
3. Out-of-Pocket (OOP) Expense:
 - a. The plan has an individual (\$5,000) AND a family aggregate (\$10,000) per calendar year.
 - b. The OOP includes the calendar year deductible, any copayments, and coinsurance. The OOP for the other 4 plans does not include the deductible or any copayments, but includes coinsurance.
4. Outpatient prescription drugs (Benefit Area G):
 - a. Expenses under this plan are subject to the same deductible and coinsurance as any other eligible expense. The other 4 plans have a separate deductible and are paid at 50%.
 - b. This plan includes a separate calendar year maximum benefit of \$6,000. The other plans do not have a calendar year maximum benefit.