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
Growth Hormone Therapy Calendar Year Maximum Benefit (Benefit Area D)	$25,000**
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 all policies as of Ju1y 1, 2010**

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.