

Benefit	Smart Care HMO Plans (HHH: 10039, 10040)	Smart Care HMO Plans (HHH: 10038, 10041, 10073, 10074)
Annual Calendar Year Deductible	HHH10039 – Individual: \$500 HHH10040 – Individual: \$750 Family: x3 (Individual)	HHH10038 – Individual: \$1,250 HHH10041 – Individual: \$2,000 HHH10073 – Individual: \$2,500 HHH10074 – Individual: \$5,000 Family: x3 (Individual)
Annual Out-of-Pocket Maximum (Includes % Copayments which are subject to Deductible only – does not include Deductible, all other Copayments, or non-Covered charges.)	Individual: \$2,000 Family: x3 (Individual)	Individual: \$4,500 Family: x3 (Individual)
Maximum Lifetime Benefit	Unlimited	Unlimited
Physician Services Primary Care Physician (PCP) office visit (OV) Specialist office visit (OV) Home Visits Outpatient Surgery (In Physician’s office) Hospital and Skilled Nursing Visits Specialty Pharmaceuticals ⁽¹⁾ (Injectable forms administered in Physician’s office) Allergy Services Testing Serum (extracts) Injections (Copay waived if nursing visit only) Injections such as insulin, heparin, and injectable antibiotics Infertility Services including drugs and injections On-Campus Student Health Center	<p style="text-align: center;">Not Covered</p> <p style="text-align: center;">Included in OV copay 30%⁽²⁾</p> <p style="text-align: center;">15% up to a maximum of \$250 per injection and \$1,500 per Calendar Year</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">Included in OV copay Included in OV copay</p> <p style="text-align: center;">50%</p> <p style="text-align: center;">\$30</p>	<p style="text-align: center;">Not Covered</p> <p style="text-align: center;">Included in OV copay 30%⁽²⁾</p> <p style="text-align: center;">15% up to a maximum of \$250 per injection and \$1,500 per Calendar Year</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">30%</p> <p style="text-align: center;">Included in OV copay Included in OV copay</p> <p style="text-align: center;">50%</p> <p style="text-align: center;">\$30</p>
Hospital Inpatient Services ⁽¹⁾ Room and Board Inpatient Physician Care	30% ⁽²⁾ 30% ⁽²⁾	30% ⁽²⁾ 30% ⁽²⁾
Hospital Outpatient Services Surgeries ⁽¹⁾ (at facility)	30% ⁽²⁾	30% ⁽²⁾
Diagnostic Tests: X-Ray / MRI ⁽¹⁾ / PET ⁽¹⁾ / CAT ⁽¹⁾ Scans, Cardiac Cath/GI Lab	30% ⁽²⁾	30% ⁽²⁾
Diagnostic Tests: Lab	0%	0%
Emergency Room Care (Including trauma services)	\$100	\$100
Urgent Care Participating and Non-Participating Provider/ Practitioner (In or out of the Service Area)	\$40	\$40
Ambulance Services including: Emergency Ground/Air High-risk Inter-Facility Transfer Services Ground/Air	\$50/\$100 \$0 /\$100	\$50/\$100 \$0 /\$100
Clinical Preventive Services Well Child Care Preventive Physical Exam Adult and Child Immunizations Pap Smear Mammography Colonoscopy	<p style="text-align: center;">\$30</p> <p style="text-align: center;">\$30</p> <p style="text-align: center;">Included in OV copay</p> <p style="text-align: center;">Included in OV copay</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">\$0</p>	<p style="text-align: center;">\$30</p> <p style="text-align: center;">\$30</p> <p style="text-align: center;">Included in OV copay</p> <p style="text-align: center;">Included in OV copay</p> <p style="text-align: center;">\$0</p> <p style="text-align: center;">\$0</p>

⁽¹⁾ Benefit Certification may be required. ⁽²⁾ Subject to Deductible.

This summary of Covered Benefits and services is subject to the provisions of the Contract and cannot modify or affect the Group Subscriber Agreement in any way, nor shall you accrue any rights because of any statement in or omission from this summary.

Benefit	Smart Care HMO Plans (HHH: 10039, 10040)	Smart Care HMO Plans (HHH: 10038, 10041, 10073, 10074)
Diabetes Services Diabetes Education and Office Visit	\$30 per visit	\$30 per visit
Women's Health Care Gynecological Care In office Obstetrical/Maternity Care Specialist (Perinatologist) Delivery ⁽¹⁾	\$30 \$30 to \$300 maximum \$40 per visit 30% ⁽²⁾	\$30 \$30 to \$300 maximum \$40 per visit 30% ⁽²⁾
Prescription Drugs (Retail/Mail Order) Generic (Preferred) Brand (Preferred) Non-Preferred Specialty Pharmaceuticals ⁽¹⁾	\$10 / 2x \$35 / 2.5x \$55 / 3x 15% up to a maximum of \$250 per prescription and \$1,500 per Calendar Year	\$10 / 2x \$35 / 2.5x \$55 / 3x 15% up to a maximum of \$250 per prescription and \$1,500 per Calendar Year
Mental Health Services ⁽¹⁾ Outpatient Inpatient and partial hospitalization	\$40 30% ⁽²⁾	\$40 30% ⁽²⁾
Substance Abuse Services ⁽¹⁾ Detoxification only - Inpatient and Outpatient Additional rehabilitation coverage	30% ⁽²⁾ Not Covered	30% ⁽²⁾ Not Covered
Complementary Therapies (Limited) Acupuncture (20 sessions/Calendar Year) Chiropractic (18 sessions/Calendar Year)	30% ⁽²⁾ 30% ⁽²⁾	30% ⁽²⁾ 30% ⁽²⁾
Rehabilitation and Therapy Services Cardiac Rehabilitation Dialysis/Plasmapheresis/Photophoresis Pulmonary Rehabilitation Short-term Rehabilitation ⁽¹⁾ (Physical and Occupational Therapy up to 2 months per condition) Inpatient Outpatient Speech ⁽¹⁾ and Hearing Therapy ⁽¹⁾ (up to 2 months per condition)	30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾	30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾ 30% ⁽²⁾
Hospice Care ⁽¹⁾ Inpatient In-home	30% ⁽²⁾ 30% ⁽²⁾	30% ⁽²⁾ 30% ⁽²⁾
Skilled Nursing Facility ⁽¹⁾ (up to 60 days per Calendar Year)	30% ⁽²⁾	30% ⁽²⁾
Transplants ⁽¹⁾	30% ⁽²⁾ (Standard Coverage)	30% ⁽²⁾ (Standard Coverage)
Durable Medical Equipment ⁽¹⁾	50% copay ⁽²⁾ (\$2,000/Calendar Year Maximum) Diabetic supplies do not count toward the Calendar Year Maximum benefit.	50% copay ⁽²⁾ (\$2,000/Calendar Year Maximum) Diabetic supplies do not count toward the Calendar Year Maximum benefit.
Vision Services	Please refer to the Optional Benefit Rider Materials	

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