

<b>Benefit</b>	<b>Smart Care HMO Plans (HHG: 10039, 10040)</b>	<b>Smart Care HMO Plans (HHG: 10038, 10041, 10073, 10074)</b>
<b>Annual Calendar Year Deductible</b>	HHG10039 - Individual: \$500 HHG10040 - Individual: \$750 Family: x3 (Individual)	HHG10038 - Individual: \$1,250 HHG10041 - Individual: \$2,000 HHG10073 - Individual: \$2,500 HHG10074 - Individual: \$5,000 Family: x3 (Individual)
<b>Annual Out-of-Pocket Maximum</b> (Includes % Copayments which are subject to Deductible only - does <b>not</b> include Deductible, all other Copayments, or non-covered charges.)	Individual: \$2,000 Family: x3 (Individual)	Individual: \$4,500 Family: x3 (Individual)
<b>Maximum Lifetime Benefit</b>	Unlimited	Unlimited
<b>Physician Services</b> 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 <sup>(1)</sup> (Injectable forms administered in Physician's office)  Allergy Services Testing Serum (extracts) Injections (Copoly waived if nursing visit only) Injections such as insulin, heparin, and injectable antibiotics Infertility Services including drugs and injections On-Campus Student Health Center	Unlimited  \$30 \$40 <b>Not Covered</b> Included in OV copay 30% <sup>(2)</sup> 15% copay up to a maximum of \$250 per injection and \$1,500 per Calendar Year  30% 30% Included in OV copay Included in OV copay  50% \$30	Unlimited  \$30 \$40 <b>Not Covered</b> Included in OV copay 30% <sup>(2)</sup> 15% copay up to a maximum of \$250 per injection and \$1,500 per Calendar Year  30% 30% Included in OV copay Included in OV copay  50% \$30
<b>Hospital Inpatient Services</b> <sup>(1)</sup> Room & Board Inpatient Physician Care	30% <sup>(2)</sup> 30% <sup>(2)</sup>	30% <sup>(2)</sup> 30% <sup>(2)</sup>
<b>Hospital Outpatient Services</b> Surgeries <sup>(1)</sup> (at facility)	30% <sup>(2)</sup>	30% <sup>(2)</sup>
<b>Diagnostic Tests:</b> X-Ray / MRI <sup>(1)</sup> / PET <sup>(1)</sup> CAT <sup>(1)</sup> Scans, Cardiac Cath/GI Lab	30% <sup>(2)</sup>	30% <sup>(2)</sup>
<b>Diagnostic Tests:</b> Lab	0%	0%
<b>Emergency Room Care</b> (Including trauma services)	\$100	\$100
<b>Urgent Care</b> Participating and Non-Participating Provider/ Practitioner (In or out of the Service Area)	\$40	\$40
<b>Ambulance Services including:</b> Emergency Ground/Air High-risk Inter-Facility Transfer Services Ground/Air	\$50/\$100 \$0 /\$100	\$50/\$100 \$0 /\$100

<sup>(1)</sup> Benefit Certification may be required. <sup>(2)</sup> Subject to Deductible.

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Benefit	Smart Care HMO Plans (HHG: 10039, 10040)	Smart Care HMO Plans (HHG: 10038, 10041, 10073, 10074)
<b>Clinical Preventive Services</b> Well Child Care Preventive Physical Exam Adult and Child Immunizations Pap Smear Mammography Colonoscopy	\$30 \$30 Included in OV copay Included in OV copay \$0 \$0	\$30 \$30 Included in OV copay Included in OV copay \$0 \$0
<b>Diabetes Services</b> Diabetes Education and Office Visit (OV)	Included in OV copay	Included in OV copay
<b>Women's Health Care</b> Gynecological Care In office Obstetrical/Maternity Care Specialist (Perinatologist) Delivery <sup>(1)</sup>	\$30 \$30 to \$300 copay maximum \$40 per visit 30% <sup>(2)</sup>	\$30 \$30 to \$300 copay maximum \$40 per visit 30% <sup>(2)</sup>
<b>Mental Health Services</b> <sup>(1)</sup> Outpatient Inpatient and partial hospitalization	\$40 30% <sup>(2)</sup>	\$40 30% <sup>(2)</sup>
<b>Substance Abuse Services</b> <sup>(1)</sup> Detoxification only - Inpatient / Outpatient Additional rehabilitation coverage	30% <sup>(2)</sup> / \$40 <b>Not Covered unless the Optional Alcohol/Substance Abuse Rider is purchased</b>	30% <sup>(2)</sup> / \$40
<b>Complementary Therapies (Limited)</b> Acupuncture (20 sessions per Calendar Year) Chiropractic (18 sessions per Calendar Year)	30% <sup>(2)</sup> 30% <sup>(2)</sup>	30% <sup>(2)</sup> 30% <sup>(2)</sup>
<b>Rehabilitation and Therapy Services</b> Cardiac Rehabilitation Dialysis/Plasmapheresis/Photophoresis Pulmonary Rehabilitation Short-term Rehabilitation <sup>(1)</sup> (Physical and Occupational Therapy up to 2 months per condition) Inpatient Outpatient Speech <sup>(1)</sup> and Hearing Therapy <sup>(1)</sup> (up to 2 months per condition)	30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup>	30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup> 30% <sup>(2)</sup>
<b>Hospice Care</b> <sup>(1)</sup> Inpatient In-home	30% <sup>(2)</sup> 30% <sup>(2)</sup>	30% <sup>(2)</sup> 30% <sup>(2)</sup>
<b>Skilled Nursing Facility</b> <sup>(1)</sup> (up to 60 days per Calendar Year)	30% <sup>(2)</sup>	30% <sup>(2)</sup>
<b>Transplants</b> <sup>(1)</sup>	30% <sup>(2)</sup> (Standard Coverage)	30% <sup>(2)</sup> (Standard Coverage)
<b>Durable Medical Equipment</b> <sup>(1)</sup>	50% copay <sup>(2)</sup> (\$2,000 per Calendar Year Maximum) – Diabetic supplies do not count toward the Calendar Year Maximum Benefit	50% copay <sup>(2)</sup> (\$2,000 per Calendar Year Maximum) – Diabetic supplies do not count toward the Calendar Year Maximum Benefit
<b>Prescription Drugs and Vision Services</b>	<b>Please refer to the Optional Benefit Rider Materials</b>	

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