

Benefit	Choice Care 15 (HHG10002)		Choice Care 30 (HHG10006)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible (Deductible must be met before payments are made)	None	\$750 x3 family	None	\$1,000 x3 family
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum (Does not include Deductible)	2x annual premium	\$2,500 x3 family	2x annual premium	\$5,000 x3 family
Physician Services				
Office Visit (OV) (Primary Care or Specialists)	\$15	50%	\$30	50%
Outpatient Surgery	Inc in OV copay	50%	Inc in OV copay	50%
Hospital and Skilled Nursing Visits	No copay	50%	No copay	50%
Specialty Pharmaceuticals ⁽¹⁾ (Injectable forms administered in Physician's office)	15% up to a max of \$250 per injection and \$1,500 per Calendar Year	Not Covered	15% up to a max of \$250 per injection and \$1,500 per Calendar Year	Not Covered
Allergy Services				
Testing	20%	60%	20%	60%
Serum (allergy extracts)	20%	60%	20%	60%
Injections (Copay waived if nursing visit only)	Inc in OV copay	50%	Inc in OV copay	50%
Injections such as insulin, heparin, and antibiotics	Inc in OV copay	50%	Inc in OV copay	50%
Infertility Services including drugs and injections	50%	Not Covered	50%	Not Covered
On-Campus Student Health Center	\$15	\$15	\$30	\$30
Hospital Inpatient Services ⁽¹⁾				
Room and Board	\$250	50% ⁽²⁾	\$1,000	50% ⁽²⁾
Inpatient Physician Care	No copay	50%	No copay	50%
Hospital Outpatient Services				
Surgeries ⁽¹⁾	\$100	50% ⁽²⁾	\$200	50% ⁽²⁾
Lab and X-Ray	No copay	50%	No copay	50%
Diagnostic Services				
Lab and X-Ray	No copay	50%	No copay	50%
Magnetic Resonance Imaging (MRI) ⁽¹⁾	\$50	50% ⁽²⁾	\$50	50% ⁽²⁾
Accidental Injury / Urgent / Emergency Care				
Emergency Care including trauma services	\$50	\$50	\$100	\$100
Urgent Care	\$15	\$15	\$30	\$30
Ambulance Services				
Ground / Air	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100
Diabetes Services				
Diabetes Education and Office Visit	\$15	Not Covered	\$30	Not Covered

⁽¹⁾ Benefit Certification is required ⁽²⁾ If Benefit Certification is not obtained penalty amounts will apply.

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Benefit	Choice Care 15 (HHG10002)		Choice Care 30 (HHG10006)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Clinical Preventive Services				
Well Child Care	\$15	Not Covered	\$30	Not Covered
Preventive Physical Exam	\$15	Not Covered	\$30	Not Covered
Adult and Child Immunizations	Inc in OV copay	Not Covered	Inc in OV copay	Not Covered
Mammography/Pap Smear	No copay	Not Covered	No copay	Not Covered
Prescription Drugs				
Generic (Preferred)	\$7	Not Covered (Must use participating pharmacy)	\$10	Not Covered (Must use participating pharmacy)
Brand (Preferred)	\$17		\$20	
Brand when generic is available	Generic copay + cost difference		Generic copay + cost difference	
Non-Preferred	\$37		\$40	
Specialty Pharmaceuticals ⁽¹⁾	15% up to a max of \$250 per injection and \$1,500 per Calendar Year		15% up to a max of \$250 per injection and \$1,500 per Calendar Year	
Women's Health Care				
Gynecological Care	\$15	50%	\$30	50%
In Office Obstetrical/Maternity Care	\$15 to \$150 max	50%	\$30 to \$300 max	50%
Mental Health Services ⁽¹⁾				
Outpatient	\$15	50% ⁽²⁾	\$30	50% ⁽²⁾
Inpatient or Partial Hospitalization	\$250	50% ⁽²⁾	\$1,000	50% ⁽²⁾
Alcoholism / Substance Abuse ⁽¹⁾				
Detox-Inpatient (IP)/Outpatient (OP)	\$250/\$15	50% ⁽²⁾	\$1,000/\$30	50% ⁽²⁾
Additional Rehabilitation IP/OP	Not Covered	Not Covered	Not Covered	Not Covered
Complementary Therapies ⁽¹⁾				
Acupuncture (20 visits per calendar year)	\$25	Not Covered	\$35	Not Covered
Chiropractic (up to 18 visits per calendar year)	\$25	Not Covered	\$35	Not Covered
Rehabilitation Services ⁽¹⁾				
Cardiac Rehabilitation	\$15	Not Covered	\$30	Not Covered
Dialysis/Plasmapheresis/ Photopheresis	20%	50%	20%	50%
Pulmonary Rehabilitation ⁽¹⁾	\$15	Not Covered	\$30	Not Covered
Short-term Rehabilitation ⁽¹⁾ (Physical and Occupational up to 2 months per condition)				
Inpatient	\$250	50% ⁽²⁾	\$1,000	50% ⁽²⁾
Outpatient	\$25	50% ⁽²⁾	\$35	50% ⁽²⁾
Speech ⁽¹⁾ and Hearing ⁽¹⁾ (up to 2 months per condition)	\$25	50% ⁽²⁾	\$35	50% ⁽²⁾
Hospice Care ⁽¹⁾				
Inpatient	\$250	50% ⁽²⁾	\$1,000	50% ⁽²⁾
In-home	No copay	50% ⁽²⁾	No copay	50% ⁽²⁾
Skilled Nursing Facility ⁽¹⁾				
(up to 60 days per year)	\$250	50% ⁽²⁾	\$1,000	50% ⁽²⁾
Transplants ⁽¹⁾	\$250	Not Covered	\$1,000	Not Covered
Durable Medical Equipment ⁽¹⁾	50%	Not Covered	50%	Not Covered
Dental and Vision Services	Please refer to Optional Benefit Rider Materials			

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