

Benefit	Value Care 10 (HHH10021)	Value Care 15 (HHH10027)	Value Care 20 (HHH10029)	Value Care 30 (HHH10031)	Value Care 40 (HHH10053)
Annual Calendar Year Deductible	None	None	None	None	None
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services					
Primary Care Physician (PCP) office visit (OV)	\$10	\$15	\$20	\$30	\$40
Specialist Office Visit	\$20	\$25	\$30	\$40	\$50
Outpatient Surgery (In Physician's office)	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Hospital and Skilled Nursing Visits	\$0	\$0	\$0	\$0	\$0
Specialty Pharmaceuticals ⁽¹⁾ (Injectable forms administered in Physician's office)	15% copay up to maximum of \$250 per injection and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per injection and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per injection and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per injection and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per injection and \$1,500 per Calendar Year
Allergy Services					
Testing	20%	20%	20%	20%	20%
Serum (extracts)	20%	20%	20%	20%	20%
Injections (Copay waived if nursing visit only)	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Injections such as insulin, heparin, and injectable antibiotics	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Infertility Services including drugs and injections	50%	50%	50%	50%	50%
On-Campus Student Health Center	\$10	\$15	\$20	\$30	\$40
Hospital Inpatient Services ⁽¹⁾					
Room and Board	\$250	\$250	\$500	\$1,000	\$1,500
Inpatient Physician Care	\$0	\$0	\$0	\$0	\$0
Hospital Outpatient Services					
Surgeries ⁽¹⁾ (at facility)	10% up to \$150 per visit	10% up to \$150 per visit	15% up to \$250 per visit	15% up to \$300 per visit	20% up to a maximum of \$400 per visit
Diagnostic Tests:					
Lab / X-Ray	\$0	\$0	\$0	\$0	\$0
MRI ⁽¹⁾ / PET ⁽¹⁾ and CAT ⁽¹⁾ Scans	10% up to \$150 per test	10% up to \$150 per test	15% up to \$250 per test	15% up to \$300 per test	20% up to \$400 per test
Cardiac Cath / GI Lab	10% up to \$150 per visit	10% up to \$150 per visit	15% up to \$250 per visit	15% up to \$300 per visit	20% up to \$400 per visit
Emergency Room Care (including trauma services)	\$75	\$100	\$100	\$150	\$150
Urgent Care					
Participating Provider/Practitioner	\$20	\$25	\$30	\$40	\$50
Non-Participating Provider/Practitioner (In or out of the Service Area)	\$30	\$35	\$40	\$50	\$60
Ambulance Services including:					
Emergency - Ground / Air	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100
High-Risk Inter-Facility Transfer Services Ground / Air	\$0 / \$100	\$0 / \$100	\$0 / \$100	\$0 / \$100	\$0 / \$100
Clinical Preventive Services					
Well Child Care	\$10	\$15	\$20	\$30	\$40
Preventive Physical Exam	\$10	\$15	\$20	\$30	\$40
Adult and Child Immunizations	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Pap Smear	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Mammography	\$0	\$0	\$0	\$0	\$0
Colonoscopy	\$0	\$0	\$0	\$0	\$0

⁽¹⁾ Benefit Certification may be required

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Benefit	Value Care 10 (HHH10021)	Value Care 15 (HHH10027)	Value Care 20 (HHH10029)	Value Care 30 (HHH10031)	Value Care 40 (HHH10053)
Diabetes Services					
Diabetes Education and Office Visit (OV)	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay	Included in OV copay
Prescription Drugs (Retail/Mail Order)					
Generic (Preferred)	\$5 / 2x	\$7 / 2x	\$10 / 2x	\$10 / 2x	\$10 / 2x
Brand (Preferred)	\$15 / 2.5x	\$17 / 2.5x	\$20 / 2.5x	\$35 / 2.5x	\$35 / 2.5x
Non-Preferred	\$35 / 3x	\$37 / 3x	\$40 / 3x	\$55 / 3x	\$55 / 3x
Specialty Pharmaceuticals ⁽¹⁾	15% copay up to maximum of \$250 per prescription and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per prescription and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per prescription and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per prescription and \$1,500 per Calendar Year	15% copay up to maximum of \$250 per prescription and \$1,500 per Calendar Year
Women's Health Care					
Gynecological Care	\$10	\$15	\$20	\$30	\$40
In Office Obstetrical/Maternity Care	\$10 to \$100 maximum	\$15 to \$150 maximum	\$20 to \$200 maximum	\$30 to \$300 maximum	\$40 to \$400 maximum
Specialist (Perinatologist)	\$20 per visit	\$25 per visit	\$30 per visit	\$40 per visit	\$50 per visit
Delivery ⁽¹⁾	\$250	\$250	\$500	\$1,000	\$1,500
Mental Health Services ⁽¹⁾					
Outpatient	\$20	\$25	\$30	\$40	\$50
Inpatient and partial hospitalization	\$250	\$250	\$500	\$1,000	\$1,500
Substance Abuse Services ⁽¹⁾					
Outpatient	\$25	\$25 Detox only	\$30 Detox only	\$40 Detox only	\$50 Detox only
Inpatient	50%	\$250 Detox only	\$500 Detox only	\$1,000 Detox only	\$1,500 Detox only
Complementary Therapies (Limited)					
Acupuncture (20 sessions per Calendar Year)	\$20	\$25	\$30	\$40	\$50
Chiropractic (18 sessions per Calendar Year)	\$20	\$25	\$30	\$40	\$50
Rehabilitation and Therapy Services					
Cardiac Rehabilitation	\$10	\$15	\$20	\$30	\$40
Dialysis/Plasmapheresis/Photopheresis	20%	20%	20%	20%	20%
Pulmonary Rehabilitation	\$10	\$15	\$20	\$30	\$40
Short-term Rehabilitation ⁽¹⁾ (Physical and Occupational Therapy up to 2 months per condition)					
Inpatient	\$250	\$250	\$500	\$1,000	\$1,500
Outpatient	\$15	\$25	\$25	\$35	\$45
Speech ⁽¹⁾ and Hearing Therapy ⁽¹⁾ (up to 2 months per condition)	\$15	\$25	\$25	\$35	\$45
Hospice Care ⁽¹⁾					
Inpatient	\$250	\$250	\$500	\$1,000	\$1,500
In-home	\$0	\$0	\$0	\$0	\$0
Skilled Nursing Facility ⁽¹⁾ (up to 60 days per Calendar Year)	\$250	\$250	\$500	\$1,000	\$1,500
Transplants ⁽¹⁾	\$250	\$250	\$500	\$1,000	\$1,500
Durable Medical Equipment ⁽¹⁾	50%	50%	50%	50%	50%
Dental and Vision Services	Please refer to the Optional Benefit Rider Materials				

⁽¹⁾ Benefit Certification may be required

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