

Benefit	Flex Care 10 (HHG10004)		Flex Care 15 (HHG10005)		Flex Care 30 (HHG10006)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Annual Calendar Year Deductible</b> (Deductible must be met before payments are made)	None	\$500 x3 family	None	\$500 x3 family	None	\$1,000 x3 family
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>Annual Out-of-Pocket Maximum</b> (Does <b>not</b> include Deductible)	2x annual premium	\$2,000 x3 family	2x annual premium	\$2,500 x3 family	2x annual premium	\$5,000 x3 family
<b>Physician Services</b>						
Office Visit (OV) (Primary Care or Specialists)	\$10	35%	\$15	50%	\$30	50%
Outpatient Surgery	Inc in OV copay	35%	Inc in OV copay	50%	Inc in OV copay	50%
Hospital and Skilled Nursing Visits	No copay	35%	No copay	50%	No copay	50%
Specialty Pharmaceuticals <sup>(1)</sup> (Injectable forms administered in Physician's office)	15% up to a max of \$250 per injection and \$1,500 per Calendar Year	<b>Not Covered</b>	15% up to a max of \$250 per injection and \$1,500 per Calendar Year	<b>Not Covered</b>	15% up to a max of \$250 per injection and \$1,500 per Calendar Year	<b>Not Covered</b>
Allergy Services						
Testing	20%	60%	20%	60%	20%	60%
Serum (allergy extracts)	20%	60%	20%	60%	20%	60%
Injections (Copay waived if nursing visit only)	Inc in OV copay	35%	Inc in OV copay	50%	Inc in OV copay	50%
Injections such as insulin, heparin, and antibiotics	Inc in OV copay	35%	Inc in OV copay	50%	Inc in OV copay	50%
Infertility Services including drugs and injections	50%	<b>Not Covered</b>	50%	<b>Not Covered</b>	50%	<b>Not Covered</b>
On-Campus Student Health Center	\$10	\$10	\$15	\$15	\$30	\$30
<b>Hospital Inpatient Services</b> <sup>(1)</sup>						
Room and Board	\$250	35% <sup>(2)</sup>	\$250	50% <sup>(2)</sup>	\$1,000	50% <sup>(2)</sup>
Inpatient Physician Care	No copay	35%	No copay	50%	No copay	50%
<b>Hospital Outpatient Services</b>						
Surgeries <sup>(1)</sup>	\$100	35% <sup>(2)</sup>	\$100	50% <sup>(2)</sup>	\$200	50% <sup>(2)</sup>
Lab and X-Ray	No copay	35%	No copay	50%	No copay	50%
<b>Diagnostic Services</b>						
Lab and X-Ray	No copay	35%	No copay	50%	No copay	50%
Magnetic Resonance Imaging (MRI)	\$50	35% <sup>(2)</sup>	\$50	50% <sup>(2)</sup>	\$50	50% <sup>(2)</sup>
<b>Accidental Injury / Urgent / Emergency Care</b>						
Emergency Care including trauma services	\$50	\$50	\$50	\$50	\$100	\$100
Urgent Care	\$10	\$10	\$15	\$15	\$30	\$30
<b>Ambulance Services</b>						
Ground / Air	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100	\$50 / \$100
<b>Diabetes Services</b>						
Diabetes Education and Office Visit	\$10	<b>Not Covered</b>	\$15	<b>Not Covered</b>	\$30	<b>Not Covered</b>

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

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Benefit	Flex Care 10 (HHG10004)		Flex Care 15 (HHG10005)		Flex Care 30 (HHG10006)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Clinical Preventive Services</b>						
Well Child Care	\$10	<b>Not Covered</b>	\$15	<b>Not Covered</b>	\$30	<b>Not Covered</b>
Preventive Physical Exam	\$10	<b>Not Covered</b>	\$15	<b>Not Covered</b>	\$30	<b>Not Covered</b>
Adult and Child Immunizations	Inc in OV copay	<b>Not Covered</b>	Inc in OV copay	<b>Not Covered</b>	Inc in OV copay	<b>Not Covered</b>
Mammography/Pap Smear	No copay	<b>Not Covered</b>	No copay	<b>Not Covered</b>	No copay	<b>Not Covered</b>
<b>Women's Health Care</b>						
Gynecological Care	\$10	35%	\$15	50%	\$30	50%
In Office Obstetrical/Maternity Care	\$10 to \$100 max	35%	\$15 to \$150 max	50%	\$30 to \$300 max	50%
<b>Mental Health Services</b> <sup>(1)</sup>						
Outpatient	\$10	35% <sup>(2)</sup>	\$15	50% <sup>(2)</sup>	\$30	50% <sup>(2)</sup>
Inpatient or Partial Hospitalization	\$250	35% <sup>(2)</sup>	\$250	50% <sup>(2)</sup>	\$1,000	50% <sup>(2)</sup>
<b>Alcoholism / Substance Abuse</b> <sup>(1)</sup>						
Detox-Inpatient (IP)/Outpatient (OP)	\$250/\$10	35% <sup>(2)</sup>	\$250/\$15	50% <sup>(2)</sup>	\$1,000/\$30	50% <sup>(2)</sup>
Additional Rehabilitation	<b>Not Covered</b> unless Optional Substance Abuse Rider is purchased					
<b>Complementary Therapies</b> <sup>(1)</sup>						
Acupuncture (20 visits per calendar year)	\$15	<b>Not Covered</b>	\$25	<b>Not Covered</b>	\$35	<b>Not Covered</b>
Chiropractic (up to 18 visits per calendar year)	\$15	<b>Not Covered</b>	\$25	<b>Not Covered</b>	\$35	<b>Not Covered</b>
<b>Rehabilitation Services</b> <sup>(1)</sup>						
Cardiac Rehabilitation	\$10	<b>Not Covered</b>	\$15	<b>Not Covered</b>	\$30	<b>Not Covered</b>
Dialysis/Plasmapheresis/ Photopheresis	20%	35% <sup>(2)</sup>	20%	50% <sup>(2)</sup>	20%	50% <sup>(2)</sup>
Pulmonary Rehabilitation <sup>(1)</sup>	\$10	<b>Not Covered</b>	\$15	<b>Not Covered</b>	\$30	<b>Not Covered</b>
Short-term Rehabilitation <sup>(1)</sup> (Physical and Occupational up to 2 months per condition)						
Inpatient	\$250	35% <sup>(2)</sup>	\$250	50% <sup>(2)</sup>	\$1,000	50% <sup>(2)</sup>
Outpatient	\$15	35% <sup>(2)</sup>	\$25	50% <sup>(2)</sup>	\$35	50% <sup>(2)</sup>
Speech <sup>(1)</sup> and Hearing <sup>(1)</sup> (up to 2 months per condition)	\$15	35% <sup>(2)</sup>	\$25	50% <sup>(2)</sup>	\$35	50% <sup>(2)</sup>
<b>Home Health Care Services</b> <sup>(1)</sup>	No copay	35% <sup>(2)</sup>	No copay	50% <sup>(2)</sup>	No copay	50% <sup>(2)</sup>
<b>Hospice Care</b> <sup>(1)</sup>						
Inpatient	\$250	35% <sup>(2)</sup>	\$250	50% <sup>(2)</sup>	\$1,000	50% <sup>(2)</sup>
In-home	No copay	35% <sup>(2)</sup>	No copay	50% <sup>(2)</sup>	No copay	50% <sup>(2)</sup>
<b>Skilled Nursing Facility</b> <sup>(1)</sup> (up to 60 days per year)	\$250	35% <sup>(2)</sup>	\$250	50% <sup>(2)</sup>	\$1,000	50% <sup>(2)</sup>
<b>Transplants</b> <sup>(1)</sup>	\$250	<b>Not Covered</b>	\$250	<b>Not Covered</b>	\$1,000	<b>Not Covered</b>
<b>Durable Medical Equipment</b> <sup>(1)</sup>	50%	<b>Not Covered</b>	50%	<b>Not Covered</b>	50%	<b>Not Covered</b>
<b>Prescription Drugs, Dental and Vision Services</b>	<b>Please refer to Optional Rider Materials</b>					

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