

This chart only summarizes covered benefits.
Please refer to the Policy for coverage details including exclusions and limitations.

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
POLICY YEAR: CALENDAR		
DEDUCTIBLE¹ (Applies toward Out-of-Pocket Maximum)	\$3,000 per Insured \$6,000 per Family	\$6,000 per Insured \$12,000 per Family
OUT-OF-POCKET MAXIMUM²	\$3,000 per Insured \$6,000 per Family	\$12,000 per Insured \$24,000 per Family
AGGREGATE LIFETIME MAXIMUM	\$2,000,000	
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize reduces benefits by 50% or \$500, whichever is less.	
INPATIENT SERVICES Inpatient Services include: <ul style="list-style-type: none"> Semi-Private Room and Board Charges Surgical Procedures Pre-Admission Testing Physician Hospital Visits Intensive Care & Coronary Care Units Operating/Recovering Room Acquired Brain Injury Laboratory Tests and X-ray Reconstructive Surgery Observation Unit Physician Services Skilled Nursing Facility - <i>Limited to a combined 30 In-/Out-of-Network days per Policy Year</i> 	100% after Deductible	70% after Deductible
OUTPATIENT SERVICES Outpatient Services/Surgery include: <ul style="list-style-type: none"> Facility Charges Surgical Procedures Physician Services Laboratory Tests and X-ray in an Outpatient Setting MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan	100% after Deductible 100% after Deductible 100% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible

¹ *Embedded Deductible* is when the Individual Deductible amount must be met by every Insured covered, each Policy Year. If Dependents are covered, all charges applied to the Individual Deductible amount will be applied towards the Family Deductible amount. When the Family Deductible is reached, no further Individual Deductibles will have to be met for the remainder of that Policy Year. No Insured will contribute more than the Individual Deductible amount to the Family Deductible amount.

² *Out-of-Pocket Maximum* is the total amount that must be paid each Policy Year before benefits are covered at 100%, up to the Usual, Customary and Reasonable (UCR) amount. Coinsurance amounts count towards the Out-of-Pocket Maximum. Deductibles do not count towards the Out-of-Pocket Maximum.

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
<p>PHYSICIAN OFFICE SERVICES</p> <p>Physician Office Services Include:</p> <ul style="list-style-type: none"> • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion <p>Laboratory Tests and X-Ray</p> <p>MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office</p> <p>Allergy Services:</p> <ul style="list-style-type: none"> • Office Visit • Allergy Testing • Serum • Injection Administration <p>Surgical Procedures performed in the Physician's Office</p>	<p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p>	<p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p>
<p>PREVENTIVE SERVICES</p> <p><i>*Limited to a combined \$500 In-/Out-of-Network benefit per Insured per Policy Year.</i></p> <p>Preventive Services include*:</p> <ul style="list-style-type: none"> • Annual Routine Physicals* • Well Baby and Well Child Care* • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit* • Routine Labs and X-Rays* • Routine Immunizations (ages 6 and older)* • Examinations and testing for the detection of Prostate Cancer* • Well Woman Exam including Routine Annual Physicals and low-dose mammography screenings* <p>Immunizations for Newborns (<i>birth to 6-years of age</i>)</p> <p>Newborn Child Hearing Screenings (birth to 30-days old)</p> <p>Preventive Diagnostics and Testing:</p> <ul style="list-style-type: none"> • Non-routine mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer (<i>If other procedures are done during screening, additional copays, deductibles, and/or coinsurance will apply</i>) • Bone Mass Measurement 	<p>\$30 Copayment - Deductible waived</p> <p>Covered in full</p> <p>\$30 Copayment - Deductible waived</p> <p>\$30 Copayment - Deductible waived</p>	<p>70% after Deductible</p> <p>Covered in full</p> <p>70% after Deductible</p> <p>70% after Deductible</p>

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
<p>FAMILY PLANNING</p> <p>Family Planning and Counseling</p> <p>Contraceptive Devices, Implants and Injections including:</p> <ul style="list-style-type: none"> • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections <p>Sterilization Procedures: (Vasectomy & Tubal Ligation)</p> <ul style="list-style-type: none"> • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility 	<p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p>	<p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p>
<p>DIABETIC SERVICES</p> <p>Diabetic Self-Management Education</p> <p>Insulin and Diabetic Medication:</p> <ul style="list-style-type: none"> • 30-day Supply • Mail Order (up to 90-day supply) <p>Test Strips:</p> <ul style="list-style-type: none"> • Level 1 Strips • Level 2 Strips <p>Other Diabetic Supplies and Equipment (30-day Supply)</p>	<p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p> <p>100% after Deductible</p>	<p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p> <p>70% after Deductible</p>
<p>OUTPATIENT PHARMACY</p> <p><i>Limited to a combined \$4,000 In-/Out-of-Network, Policy Year Maximum</i></p> <p>30-Day Supply</p> <p>Mail Order (up to 90-Day Supply)</p>	<p>100% after Deductible</p> <p>100% after Deductible</p>	<p>The claim is paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication.</p>
<p>SPECIALTY SERVICES/PHARMACY</p> <p>Specialty Services/Pharmacy includes:</p> <ul style="list-style-type: none"> • Medical Injectable Drugs (<i>excluding Depo-Provera™ injectables</i>) • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-Rejection Therapy • Specified Cancer Chemotherapy • Defined Associated Agents 	<ul style="list-style-type: none"> • When Covered Service cost is \$500 or less: No additional Coinsurance taken after Deductible. <i>See the office visit, outpatient surgery or inpatient hospital section(s) for applicable charges.</i> • When Covered Service cost is more than \$500: 30% coinsurance after Deductible, not to exceed \$3,000 Out-of-Pocket Maximum for these specific 	<p>70% after Deductible</p> <p>70% after Deductible</p>

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Organ Transplant Services (<i>Inpatient & Outpatient</i>) – <i>Limited to a combined \$300,000 In-/Out of Network Lifetime Maximum</i>	100% after Deductible	70% after Deductible
Home Health Care Services include: <i>Limited to a combined 20 In-/Out-of-Network visits per Covered Service per Policy Year</i> <ul style="list-style-type: none"> • Skilled nursing services provided by a registered nurse or vocational nurse; supervised by one registered nurse and one physician • Home health aide services; supervised by a registered nurse • Medical equipment/supplies other than drugs and medicines: <i>Limited to the combined dollar amount listed under Durable Medical Equipment (DME) for both Outpatient & Home Health DME services.</i> 	100% after Deductible	70% after Deductible
ALL OTHER COVERED SERVICES	100% after Deductible	70% after Deductible