

## Traditional: Summary of Benefits *Plans: D10, E10, F10*

This Summary of Benefits is intended to give an overview of the Plan benefits. In the event that this summary and the Policy differ, the Policy, or the associated benefit Riders will govern. Authorization may be required on some services/procedures. Limitations may exist for some benefits.

**For a complete description of benefits, including exclusions and limitations, review the Policy.**

### NETWORK BENEFITS

|   |   |
|---|---|
| Annual Deductible<br><i>(Note: This is a Calendar Year Deductible)</i>              | \$500, per Covered Person, not to exceed \$1,500 for all Covered Persons in a family OR \$1,000, per Covered Person, not to exceed \$3,000 for all Covered Persons in a family OR \$2,500, per Covered Person, not to exceed \$7,500 for all Covered Persons in a family  |
| Out-of-Pocket Maximum<br><i>(Note: This does NOT include the Annual Deductible)</i> | \$2,000 per Covered Person, not to exceed \$6,000 for all Covered Persons in a family   |
| Maximum Policy Benefit  | No Maximum Policy Benefit   |
| <b>SERVICES (as outlined in Policy)</b>   | <b>YOUR COPAYMENT AMOUNT</b>  |
| Physician's Office Services   | \$20 per visit to a PCP and \$40 per visit to a Specialist  |
| Outpatient Surgery, Diagnostic and Therapeutic                                      | 20% after Deductible (*Certain Preventive Health Services are Covered in Full)  |
| Outpatient Laboratory Services  | Covered in Full   |
| Eye Examinations  | Specialist Copayment applies  |
| Urgent Care Center Services   | \$50 per visit  |
| Emergency Health Services   | \$150 per visit   |
| Inpatient Hospital Stay   | 20% after Deductible  |
| Outpatient Prescription Drug<br><i>(Note: Mandatory Generic Substitution)</i>       | \$10 Copayment for Generic Drugs<br>\$40 Copayment for Preferred Brand Drugs<br>\$65 Copayment for Non-Preferred Brand Drugs<br>\$100 Copayment per 30 days for certain Specialty Pharmaceuticals<br>Mail Order 2.5x Copayment  |
| Ambulance   | 20% after Deductible  |
| Maternity Services<br><i>(Must select maternity coverage)</i>                       | Maternity Benefits are Available for Applicant or Spouse after coverage has been in effect for 12 consecutive months<br>Office Visit Specialist Copayment Applies<br>No Copayment applies to Physician office visits for prenatal care after the first visit<br>Inpatient: 20% after Deductible<br>Outpatient: 20% after Deductible |
| Mental Health Services  | Office Visit: Specialist Copayment applies<br>Inpatient: 20% after Deductible<br>Outpatient: 20% after Deductible   |
| Chemical Dependency Services  | Office Visit: Specialist Copayment applies<br>Inpatient: 20% after Deductible<br>Outpatient: 20% after Deductible   |
| Durable Medical Equipment   | 20% after Deductible  |
| Prosthetic Devices  | 20% after Deductible  |
| Home Health Care  | 20% after Deductible  |
| Hospice Care  | 20% after Deductible  |
| Injections received in Physician's Office   | 20% after Deductible per injection  |
| Professional Fees for Surgical and Medical Services                                 | 20% after Deductible  |
| Rehabilitation Services – Outpatient Therapy  | 20% after Deductible  |
| Skilled Nursing Facility / Inpatient Rehabilitation Facility Services               | 20% after Deductible  |
| Transplantation Services  | 20% after Deductible  |

\* Preventive Health Services: Cholesterol Tests, Colon Screening, Colonoscopy, Double-contrast Barium Enema, Fecal Occult Blood Test, Flexible Sigmoidoscopy, Mammography, Pap Test, Pelvic Exam, Prostate Exam, PSA Test

### NON-NETWORK BENEFITS

|   |   |
|---|---|
| Annual Deductible<br><i>(Note: This is a Calendar Year Deductible)</i>  | \$1,000, per Covered Person, not to exceed \$3,000 for all Covered Persons in a family OR \$2,000, per Covered Person, not to exceed \$6,000 for all Covered Persons in a family OR \$5,000, per Covered Person, not to exceed \$15,000 for all Covered Persons in a family |
| Out-of-Pocket Maximum<br><i>(Note: This does NOT include the Annual Deductible)</i>                                 | \$4,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family  |
| Maximum Policy Benefit  | \$5,000,000 per Covered Person per Lifetime   |
| Covered Services<br><i>(Note: Please see the Policy for a description of benefits that are covered non-network)</i> | 40% after non-network Deductible<br><i>(Note: Covered Benefits performed by non-network providers are subject to Usual and Customary Limits and the non-network providers may balance bill the member)</i>  |