

Benefit Package HMO Saver 10/15

SUMMARY OF BENEFITS AND SCHEDULE OF COPAYMENTS

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE COMBINED EVIDENCE OF COVERAGE & DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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| Annual Deductible: | None |
| Pre-Existing Conditions: | Covered |
| Lifetime Maximum: | None |

| TYPE OF SERVICE | PATIENT CO-PAY (U.S. DOLLARS) SIMNSA HMO SAVER NETWORK |
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| PHYSICIAN SERVICES | |
| Office Visits – IPA Facility | 100% Covered After \$10.00 Copayment |
| Surgical Services | 100% Covered, No Copayment |
| Assistant Surgeon | 100% Covered, No Copayment |
| Anesthesiologist | 100% Covered, No Copayment |
| Annual Physical Examinations | |
| (After 90 days of Participation) | 100% Covered After \$10.00 Copayment |

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| OUTPATIENT SERVICES | |
| Laboratory Services | 100% Covered, No Copayment |
| Radiology Services | 100% Covered, No Copayment |
| Home Health Care – If required, available for post-operative care only | 100% Covered, No Copayment |
| Speech, Physical and Occupational Therapy | 100% Covered After \$10.00 Copayment |
| Prosthesis | 100% Covered, No Copayment |

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| HOSPITAL SERVICES | |
| Hospital Room and Board | 100% Covered After \$100/per day Copayment |
| Intensive Care Unit | 100% Covered, No Copayment |
| Operating Room and Recovery | 100% Covered, No Copayment |
| Ancillary Services | 100% Covered, No Copayment |

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| EMERGENCY SERVICES | |
| In Plan's Area | 100% Covered After \$25.00 Copayment (Increases to \$100/day if Admitted) |
| Supplies and Treatment Room | 100% Covered, No Copayment |

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| Out-of-Area | |
| Urgent Care Services | 100% Covered After \$50.00 Copayment |
| Emergency Services | 100% Covered After \$100.00 Copayment (based on usual and customary charges) |

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| AMBULANCE SERVICE | |
| Ambulance Service | 100% Covered, No Copayment |

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| PRESCRIPTION DRUGS | |
| Prescription Drugs (including insulin, glucagon and prescription medications for treating diabetes) | 100% Covered After \$15.00 Copayment |

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| DURABLE MEDICAL EQUIPMENT | |
| Durable Medical Equipment (including equipment and supplies for the management and treatment of diabetes) | 100% Covered, No Copayment |

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| MENTAL HEALTH AND SUBSTANCE ABUSE | |
| (Outpatient) Limited to 20 visits per year | 100% Covered After \$10.00 Copayment |
| (Inpatient) Limited to 20 days per year | 100% Covered, No Copayment |

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| MATERNITY CARE (At Participating Facility) | |
| Prenatal and Postnatal Visits | 100% Covered After \$10.00 Copayment |
| Delivery Including Cesarean Section | 100% Covered, No Copayment |
| Newborn Including Well Baby Care | 100% Covered, No Copayment |

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| PREVENTIVE CARE SERVICES | |
| Pap Smears | 100% Covered, No Copayment |
| Mammogram | 100% Covered, No Copayment |
| Immunizations | 100% Covered, No Copayment |
| Birth Control Methods | 100% Covered, No Copayment |
| Testing and Treatment for Phenylketonuria | 100% Covered, No Copayment |
| All Generally Accepted Cancer Screening Tests, including annual screening for cervical cancer and screening for prostate cancer and breast cancer consistent with generally accepted medical practices and scientific evidence, including mammograms. | 100% Covered, No Copayment |

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| EYE CARE SERVICES | |
| Office Visits | 100% Covered After \$10.00 Copayment |
| Eye Examinations | 100% Covered After \$10.00 Copayment |
| Eye Surgery | 100% Covered, No Copayment |

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| DENTAL SERVICES | |
| Examinations | 100% Covered, No Copayment |
| Prophylaxis (Dental Cleanings) | \$5.00 |
| Fillings (amalgam) | \$10/filling |

EXCLUSIONS AND LIMITATIONS

Please refer to your Evidence of Coverage Booklet for an explanation of what is not covered under the Plan.