

# Benefit Package HMO Saver 5/5

## 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.

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

**SIMNSA HMO Saver 5/5**

TYPE OF SERVICE	PATIENT CO-PAY (U.S. DOLLARS) SIMNSA HMO SAVER NETWORK
<b>PHYSICIAN SERVICES</b>	
Office Visits – IPA Facility	100% Covered After \$5.00 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 \$5.00 Copayment

<b>OUTPATIENT SERVICES</b>	
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

<b>HOSPITAL SERVICES</b>	
Hospital Room and Board	100% Covered, No Copayment
Intensive Care Unit	100% Covered, No Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment

<b>EMERGENCY SERVICES</b>	
In Plan's Area	100% Covered After \$25.00 Copayment (Waived if Member is Admitted)
Supplies and Treatment Room	100% Covered, No Copayment

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

<b>AMBULANCE SERVICE</b>	
Ambulance Service	100% Covered, No Copayment

<b>PRESCRIPTION DRUGS</b>	
Prescription Drugs (including insulin, glucagon and prescription medications for treating diabetes)	100% Covered After \$5.00 Copayment

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

<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>	
(Outpatient)	100% Covered After \$5.00 Copayment
(Inpatient)	100% Covered, No Copayment

<b>MATERNITY CARE (At Participating Facility)</b>	
Prenatal and Postnatal Visits	100% Covered After \$5.00 Copayment
Delivery Including Cesarean Section	100% Covered, No Copayment
Newborn Including Well Baby Care	100% Covered, No Copayment

<b>PREVENTIVE CARE SERVICES</b>	
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

<b>EYE CARE SERVICES</b>	
Office Visits	100% Covered After \$5.00 Copayment
Eye Examinations	100% Covered After \$5.00 Copayment
Eye Surgery	100% Covered, No Copayment

<b>DENTAL SERVICES</b>	
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.