

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

TYPE OF SERVICE	PATIENT CO-PAY (U.S. DOLLARS) SIMNSA HMO SAVER NETWORK
PHYSICIAN SERVICES	
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

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

HOSPITAL SERVICES	
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

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

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

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE	
(Outpatient) Limited to 20 visits per year	100% Covered After \$5.00 Copayment
(Inpatient) Limited to 20 days per year	100% Covered, No Copayment

MATERNITY CARE (At Participating Facility)	
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

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

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

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.