

**The most affordable
Healthcare is now here!**



Let us introduce you to our

***AFFORDABLE HMO
PREMIER***

THIS BENEFIT SUMMARY 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. YOU CAN CONTACT THE PLAN AT 1-800-424-4652.

Out-of-Pocket Maximum: Individual - \$3,000 Family - \$6,000

Pre-Existing Conditions: Covered

Lifetime Maximum: None

If a member of a family reaches the individual yearly out-of-pocket maximum, s/he will have no more co-pays that year (for services that apply to the yearly out-of-pocket maximum).

TYPE OF SERVICE

PATIENT CO-PAY (U.S. DOLLARS)

PHYSICIAN SERVICES

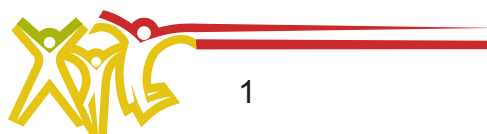
Office Visits – IPA Facility	100% Covered After \$15.00 Copayment
Specialist Visits	100% Covered After \$20.00 Copayment
Anesthesiologist	100% Covered, No Copayment
Annual Physical Examinations	
(After 90 days of Participation)	100% Covered After \$15.00 Copayment

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 \$15.00 Copayment
Orthotics	100% Covered, No Copayment
Prosthetics	100% Covered, No Copayment
Surgical Services (facility charges)	100% Covered After \$300 Copayment

HOSPITAL SERVICES

Hospital Room and Board	100% Covered After \$200/day Copayment
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Intensive Care Unit	100% Covered After \$300/day Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment
Surgical Services (Surgeon/Assistant Surgeon)	100% Covered After \$500 Copayment

EMERGENCY SERVICESⁱ

In Plan's Area

Emergency/Urgent Care Services	100% Covered After \$50.00 Copayment (Waived if Member is Admitted)
Supplies and Treatment Room	100% Covered, No Copayment

Out-of-Area

Urgent Care Services	100% Covered After \$100.00 Copayment
Emergency Services	50% Coinsurance (of cost to health plan)

AMBULANCE SERVICE

Ambulance Service	100% Covered After \$50 Copayment
Air Ambulance	50% Coinsurance (of cost to health plan)

PRESCRIPTION DRUGSⁱⁱ

Prescription Drugs	100% Covered After \$20.00 Copayment
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(including insulin, glucagon and prescription medications for treating diabetes)

ⁱ For emergency services received outside the Plan's Network, the Member must notify the Plan within 48 hours after care is received, unless it is not reasonably possible to do so. The services will be reviewed retrospectively by the Plan to determine whether services are eligible for coverage.

ⁱⁱ Coverage is provided for drugs determined by the Participating Physician to be medically necessary. Drugs obtained at non-participating pharmacies are not covered unless medically necessary for a covered emergency. Copays for Prescription drugs count towards the out of pocket maximum amount. If the OOPM is met during the calendar year, copays are still applicable for this covered benefit.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment 50% Coinsurance (of cost to health plan)
(including equipment and supplies for the management and treatment of diabetes)

MENTAL HEALTH AND SUBSTANCE ABUSE*ⁱⁱⁱ

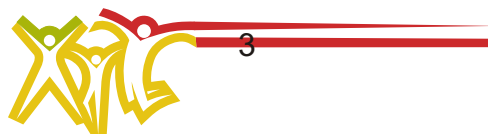
(Outpatient) 100% Covered After \$15.00 Copayment
(Inpatient) 100% Covered, No Copayment

MATERNITY CARE (At Participating Facility)

Prenatal and Postnatal Visits 100% Covered After \$15.00 Copayment
Normal Delivery See "Hospital Room & Board"
Cesarean Section See "Surgical Services"
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 Cancer Screening Tests consistent with professionally recognized standards of practice, including annual screening for cervical cancer and screening for prostate cancer and breast cancer, including mammograms. 100% Covered, No Co-payment

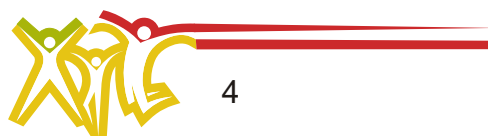
EYE CARE SERVICES

Office Visits 100% Covered After \$15.00 Copayment

Eye Examinations 100% Covered After \$15.00 Copayment

ⁱⁱⁱ For a listing of severe mental illnesses including serious emotional disturbances of a child and other benefit details, please refer to the Combined Evidence of Coverage/Disclosure Form or Group Contract

If you have any questions about how much has been applied to your annual out-of-pocket maximum, please call our member services at 1-800-424-4652.



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