

# HMO 7/10 Premier Access

## 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 EVIDENCE OF COVERAGE 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)
<b>PHYSICIAN SERVICES</b>	
Office Visits – IPA Facility	100% Covered After \$7.00 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 \$7.00 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 \$10.00 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 \$7.00 Copayment
(Inpatient)	100% Covered, No Copayment

<b>MATERNITY CARE (At Participating Facility)</b>	
Prenatal and Postnatal Visits	100% Covered After \$7.00 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 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 Copayment

<b>EYE CARE SERVICES</b>	
Office Visits	100% Covered After \$7.00 Copayment
Eye Examinations	100% Covered After \$7.00 Copayment
Eye Surgery	100% Covered, No Copayment

**EXCLUSIONS AND LIMITATIONS**

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