	SIMNSA HMO
Deductible *(individual/family)*	None
Medical Plan Out-of-Pocket Maximum (individual/family)	$6,350/$12,700
RX Plan Out-of-Pocket Maximum (individual/ family)	N/A
Health Reimbursement Account	None
PCP Office Visit	$5 copay
Specialist Office Visit	$5 copay
Preventive Care	No charge
Inpatient Hospital Care	No charge
Mental Health Services *(outpatient/inpatient)*	$5 copay/ No charge
Substance Abuse Services *(outpatient/inpatient)*	$5 copay/ No charge
Infertility	Not covered
Outpatient Diagnostic Laboratory and Radiology *(standard procedures)*	No charge
Complex Radiology (PET, MRI)	No charge
Outpatient Surgery	No charge
Outpatient Physical/Rehabilitation Therapy	$10 copay
Urgent Care *(your medical group/other medical group)*	$25 copay/ $50 copay
Emergency Room *(Copay waived if admitted)*	$100 copay (in or out of plan area)
Retail Prescription Drugs[1] *(generic/preferred/ non-preferred)*	$5 copay
Mail Order Prescription Drugs *(generic/ preferred/non-preferred)*	Not available
Chiropractor Service	Not covered

[1]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.

Disclaimer: *This summary is merely a brief description of the major benefits of the plan(s) and is not intended to alter or expand benefits, rights, or liabilities as set forth in the official plan documents and contracts. Limitations may apply. See the Certificate/Evidence of Coverage for details.*