

HMO Platinum \$20

Available with the following networks: Full Network HMO, Wholecare HMO, Smartcare HMO, and Salud HMO y Más. Salud HMO y Más plans include the additional SIMNSA provider tier benefits.

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage (EOC)* should be consulted for a detailed description of coverage benefits and limitations.

Benefit description	Platinum \$20
Unlimited lifetime maximum	✓
Plan maximums	
Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	\$3,000 / \$6,000
Professional services¹	
Office visit copay	\$20
Specialist visit	\$40
Telehealth services through Teladoc ²	\$0
MinuteClinic ³	\$20
Rehabilitation and habilitation therapy	\$20
X-ray / Laboratory procedures	\$10 / \$10
Complex radiology services (MRI, CT, PET)	\$150
Outpatient services	
Outpatient surgery (ambulatory surgery center / hospital)	\$200 / \$500
Hospital services	
Inpatient hospital	\$350 per day (3 day max copayment per admission)
Skilled nursing facility	\$25 per day
Emergency services	
Emergency room (copay waived if admitted)	\$150
Urgent care	\$40
Mental/Behavioral health / Substance use disorder services⁴	
Mental/Behavioral health / Substance use disorder (inpatient)	\$350 per day (3 day max copayment per admission)
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$20
Other services	
Durable medical equipment	20%
Acupuncture (medically necessary) ⁵	\$10
Prescription drug coverage^{7,8}	
Prescription drug deductible (single / family)	\$0
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁶ (up to a 30-day supply obtained through a participating pharmacy)	\$5 / \$30 / \$50
Tier 4 Specialty drugs ⁹	30%
Pediatric dental¹⁰	
Diagnostic and preventive services	\$0
Pediatric vision¹¹	
Routine eye exam	\$0
Glasses (limitations apply)	\$0

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Salud HMO y Más – SIMNSA network

SIMNSA NETWORK BENEFITS ARE AVAILABLE WITH ANY OF THE SALUD HMO Y MÁS PLANS.

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Benefit description	SIMNSA ¹²
Unlimited lifetime maximum	✓
Plan maximums	
Calendar year deductible (single / family)	N/A
Out-of-pocket maximum (single / family)	\$1,500 / \$4,500 ¹³
Professional services¹	
Office visit copay	\$5
Specialist visit	\$5
Telehealth services through Teladoc ²	Not covered
MinuteClinic ³	Not covered
Rehabilitation and habilitation therapy	\$5
X-ray / Laboratory procedures	\$0 / \$0
Complex radiology services (MRI, CT, PET)	\$0
Outpatient services	
Outpatient surgery (ambulatory surgery center / hospital)	\$0 / \$0
Hospital services	
Inpatient hospital	\$0
Skilled nursing facility	\$0
Emergency services	
Emergency room (copay waived if admitted)	\$10
Urgent care	\$10
Mental/Behavioral health / Substance use disorder services⁴	
Mental/Behavioral health / Substance use disorder (inpatient)	\$0 ¹⁴
Mental/Behavioral health / Substance use disorder (outpatient office visit)	\$5
Other services	
Durable medical equipment	\$0
Acupuncture (medically necessary) ⁵	Not covered
Prescription drug coverage^{7,8}	
Prescription drug deductible (single / family)	\$0
Prescription drugs Tier 1 / Tier 2 / Tier 3 ⁶ (up to a 30-day supply obtained through a participating pharmacy)	\$5 / \$5 / \$5
Tier 4 Specialty drugs ⁹	\$5
Pediatric dental¹⁰	
Diagnostic and preventive services	Not covered
Pediatric vision¹¹	
Routine eye exam	Not covered
Glasses (limitations apply)	Not covered

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