Benefit Package HMO Saver 10/10/20

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	$10/visit
Surgical Services	100% Covered, No Copayment
Assistant Surgeon	100% Covered, No Copayment
Anesthesiologist	100% Covered, No Copayment
Annual Physical Examinations	100% Covered, No Copayment

OUTPATIENT SERVICES	
Laboratory Services	100% Covered, No Copayment
Radiology Services	100% Covered, No Copayment
Home Health Care –If medically necessary; available for post-operative care only	$25/visit
Speech, Physical and Occupational Therapy	$10/visit

HOSPITAL SERVICES	
Hospital Room and Board	$100/per day
Intensive Care Unit	100% Covered, No Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment

EMERGENCY SERVICES & URGENT CARE	
Emergency Services provided in Mexico	$25/visit (paid according to usual and customary charges)
Emergency Services provided outside of Mexico	$50/visit
Urgent Care outside Plan’s Service Area, but within Mexico	$25/visit
Urgent Care outside of Mexico	$50/visit

AMBULANCE SERVICE	
Ambulance Service	$50

PRESCRIPTION DRUGS†	
Prescription Drugs (including insulin, glucagon and prescription medications for treating diabetes) Generic medications Brand-name medications	 $10/prescription $20/prescription

†Coverage is provided for all medically necessary medications, as determined by a Plan Provider. Medications obtained from a non-participating pharmacy are not covered unless medically necessary for a covered emergency.

DURABLE MEDICAL EQUIPMENT	
Durable Medical Equipment (includes home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies, and equipment for the management and treatment of diabetes)	50% of allowed charges No maximum.

MENTAL HEALTH AND SUBSTANCE ABUSE	
(Outpatient) Limited to 20 visits per year No limit on outpatient visits for severe mental illnesses or serious emotional disturbances of a child or adolescent.††	$10/visit
(Inpatient) Limited to 20 days per year	$100/day

††Please refer to the Combined Evidence of Coverage/Disclosure Form and Plan Contract for the definition of severe mental illness and serious emotional disturbances of a child or adolescent.

MATERNITY CARE (At Participating Facility)	
Prenatal and Postnatal Visits (for all necessary inpatient hospital services, see "Hospital Services")	$10/visit

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 $10.00 Copayment
Eye Examinations	100% Covered After $10.00 Copayment
Eye Surgery	100% Covered, No Copayment

DENTAL SERVICES	
Examinations	100% Covered, No Copayment
Prophylaxis (Dental Cleanings)	$5.00
Fillings (amalgram)	$10/filling

FAMILY PLANNING	
Tubal ligation	$100
Vasectomy	$50.00

EXCLUSIONS AND LIMITATIONS

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