

# Benefit Package HMO Saver 5/5/10

## 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
<b>PHYSICIAN SERVICES</b>	
Office Visits	\$5/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

<b>OUTPATIENT SERVICES</b>	
Laboratory Services	100% Covered, No Copayment
Radiology Services	100% Covered, No Copayment
Home Health Care – If medically necessary; available for post-operative care only	\$20/visit
Speech, Physical and Occupational Therapy	\$20/visit

<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>	
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

<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)	
Generic medications	\$5/prescription
Brand-name medications	\$10/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.	

<b>DURABLE MEDICAL EQUIPMENT</b>	
Durable Medical Equipment (including equipment and supplies for the management and treatment of diabetes)	50% of allowed charges No maximum.

<b>MENTAL HEALTH AND SUBSTANCE ABUSE</b>	
(Outpatient)	\$5/visit
(Inpatient) .....	100% Covered, No Copayment
††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.	

<b>MATERNITY CARE (At Participating Facility)</b>	
Prenatal and Postnatal Visits (for all necessary inpatient hospital services, see "Hospital Services")	\$5/visit

<b>PREVENTIVE CARE SERVICES</b>	
Pap Smears	100% Covered, No Copayment
Mammogram	100% Covered, No Copayment
Immunizations	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

<b>EYE CARE SERVICES</b>	
Office Visits	100% Covered After \$5.00 Copayment
Eye Examinations	100% Covered After \$5.00 Copayment
Eye Surgery	100% Covered, No Copayment

<b>DENTAL SERVICES</b>	
Examinations	100% Covered, No Copayment
Prophylaxis (Dental Cleanings)	\$5.00
Fillings (amalgam)	\$10/filling

<b>FAMILY PLANNING</b>	
Tubal ligation	\$100
Vasectomy	\$50

**EXCLUSIONS AND LIMITATIONS**

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