SUMMARY OF P-10-15-250

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	Out of pocket maximum individual $6,350
Pre-Existing Conditions:	Covered	Out of pocket maximum family $12,700
Lifetime Maximum:	None	

TYPE OF SERVICE	PATIENT CO-PAY (U.S. DOLLARS)
PHYSICIAN SERVICES	
Office Visits – IPA Facility	100% Covered After $10.00 Copayment
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 required, available for post-operative care only	100% Covered, No Copayment
Speech, Physical and Occupational Therapy	100% Covered After $10.00 Copayment
Acupuncture	100% Covered After $10.00 Copayment
Massage Therapy	100% Covered After $10.00 Copayment
Prosthesis	100% Covered, No Copayment

HOSPITAL SERVICES

Hospital Room and Board	$100.00/day Copayment
Intensive Care Unit	100% Covered, No Copayment
Operating Room and Recovery	100% Covered, No Copayment
Ancillary Services	100% Covered, No Copayment

URGENT CARE SERVICES

<u>From a Provider in Mexico</u>	
Urgent Care Services	100% Covered After $25.00 Copayment
Supplies and Treatment Room	100% Covered, No Copayment
<u>From a Provider outside Mexico</u>	
Urgent Care Services	100% Covered After $50.00 Copayment

EMERGENCY SERVICES[i]

In and Out of Plan's Area	100% Covered After $250.00 Copayment (Waived if Member is Admitted) Payment based on usual and customary charges

AMBULANCE SERVICE

Ambulance Service	100% Covered, No Copayment

PRESCRIPTION DRUGS[ii]

Prescription Drugs (including insulin, glucagon and prescription medications for treating diabetes	100% Covered After $15.00 Copayment

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment	100% Covered, No copayment

(including equipment and supplies for the management and treatment of diabetes)

BEHAVIORAL HEALTH TREATMENT, MENTAL HEALTH AND SUBSTANCE ABUSE (MH/SUD)

Outpatient (In-Network)

Office Visits

Mental Health – Office Visits	100% Covered After $10.00 Copayment
Chemical Dependency Services– Office Visits (including Outpatient evaluation and treatment for chemical dependency)	100% Covered After $10.00 Copayment
SUD Day treatment	100% Covered After $10.00 Copayment
SUD Individual and Group Counseling	100% Covered After $10.00 Copayment
MH Individual and Group Evaluation and Therapy	100% Covered After $10.00 Copayment
Outpatient monitoring of drug therapy	100% Covered After $10.00 Copayment
Psychological Testing (when necessary to evaluate a mental disorder)	100% Covered, No Copayment

Other Items and Services

Mental Health – Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	100% Covered, No Copayment
Intensive Outpatient Program (usually less than 5 hours/day) – MH or SUD conditions	100% Covered, No Copayment

Partial Hospitalization Program (generally greater than 5 hours/day) – MH or SUD conditions	100% Covered, No Copayment
Nonemergency ambulance and psychiatric transportation	100% Covered, No Copayment

Inpatient (In-Network)

Mental Health Services - Inpatient	100% Covered, No Copayment
Chemical Dependency Services – Inpatient	100% Covered, No Copayment
Inpatient detoxification - Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling	100% Covered, No Copayment
Treatment for Withdrawal Symptoms	100% Covered, No Copayment
Psychiatric Observation	100% Covered, No Copayment

MATERNITY CARE (At Participating Facility)

Prenatal and Postnatal Visits	100% Covered, After $10.00 Copayment
Delivery Including Cesarean Section	100% Covered, No Copayment
Newborn Including Well Baby Care	100% Covered, No Copayment

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 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

EYE CARE SERVICES

Office Visits Eye	100% Covered After $10.00 Copayment
Examinations	100% Covered After $10.00 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.

i. For emergency services received outside the Plan's Network, the Member must notify the Plan within 48 hours after care is received, unless it is not reasonably possible to do so. The services will be reviewed retrospectively by the Plan to determine whether services are eligible for coverage.

ii. 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.