SIMNSA health plan

SUMMARY OF PS-10-20-250

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 $4,500
Pre-Existing Conditions:	Covered	Out of pocket maximum family $9,000
Lifetime Maximum:	None	

TYPE OF SERVICE	**PATIENT CO-PAY (U.S. DOLLARS)**
PHYSICIAN SERVICES	
Office Visits – IPA Facility	100% Covered After $10.00 Copayment
Specialist Office Visit	100% Covered After $20.00 Copayment
Surgical Services	100% Covered, No Copayment
Assistant Surgeon Anesthesiologist	100% Covered, No Copayment
Annual Physical Examinations	100% Covered, No Copayment
OUTPATIENT SERVICES	
Laboratory Services	100% Covered After $5.00 Copayment
X-rays and diagnostic imaging	100% Covered After $5.00 Copayment
Imaging (CT/PET Scans, MRI)	100% Covered After $100.00 Copayment
Home Health Care – If required, available for post-operative care only	100% Covered, No Copayment
Speech, Physical and Occupational Therapy	100% Covered After $20.00 Copayment
Acupuncture	100% Covered After $10.00 Copayment
Massage Therapy	100% Covered After $10.00 Copayment
Prosthesis	20% Coinsurance

HOSPITAL SERVICES	
Hospital Room and Board	100% Covered After $100.00/day up to 5 days
Intensive Care Unit	100% Covered After $100.00/day up to 5 days
Operating Room and Recovery	100% Covered After $100.00/day up to 5 days
Ancillary Services	100% Covered, No Copayment
URGENT CARE SERVICES	
From a Provider in Mexico Urgent Care Services	100% Covered After $40.00 Copayment
Supplies and Treatment Room	100% Covered, No Copayment
From a Provider outside Mexico Urgent Care Services	100% Covered After $40.00 Copayment
EMERGENCY SERVICES[i]	
In and Out of Plan's Area	100% Covered After $250.00 Copayment (Waived if Member is Admitted)
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 $20.00 Copayment/ Medication

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (including equipment and supplies for the management and treatment of diabetes)	20% Coinsurance

BEHAVIORAL HEALTH TREATMENT, MENTAL HEALTH AND SUBSTANCE ABUSE

Outpatient (In-Network)

Office Visits

Mental Health – Office Visits	100% Covered After $10.00 Copayment
Chemical Dependency Services - Office Visits	100% Covered After $10.00 Copayment
Group Therapy – MH/SUD disorder conditions	100% Covered After $10.00 Copayment

Other Items and Services

Mental Health - Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	100% Covered After $20 Copayment
Intensive Outpatient Program (usually less than 5 hours/day) – MH/SUD disorder conditions	100% Covered After $20 Copayment
Partial Hospitalization Program (generally greater than 5 hours/day) – MH/SUD conditions	100% Covered After $100.00/day up to 5 days
Nonemergency ambulance and psychiatric transportation	100% Covered, No Copayment

Inpatient (In-Network)

Mental Health Services - Inpatient	100% Covered After $100.00/day up to 5 days
Chemical Dependency Services – Inpatient	100% Covered After $100.00/day up to 5 days
Inpatient detoxification - Hospitalization for medical management of withdrawal symptoms, including room and board, physician services,	100% Covered After $100.00/day up to 5 days

drugs, dependency recovery services, education, and counseling	
MATERNITY CARE (At Participating Facility)	
Prenatal and Postnatal Visits	100% Covered, No 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	100% Covered After $20.00 Copayment
Eye Examinations	100% Covered After $20.00 Copayment
Eye Surgery	100% Covered, No Copayment

PEDIATRIC DENTAL SERVICES

Diagnostic and preventive*	No charge
Resin filling – one surface	$24.00 Copayment
Root canal	$30.00 Copayment
Gingivectomy per quad	$25.00 Copayment
Extraction – single tooth, exposed root or erupted	$8.00 Copayment
Extraction – complete bony	$50.00 Copayment
Crown – porcelain with metal	$50.00 Copayment
Medically Necessary Orthodontia	$1,000.00 Case rate

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.