

SUMMARY OF P-5-5-250

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

TYPE OF SERVICE

PATIENT CO-PAY (U.S. DOLLARS)

PHYSICIAN SERVICES

Office Visits – IPA Facility	100% Covered After \$5.00 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% Covered, No 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>	100% Covered After \$25.00 Copayment
Urgent Care Services	
Supplies and Treatment Room	100% Covered, No Copayment

From a Provider outside Mexico

Urgent Care Services	100% Covered After \$50.00 Copayment
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EMERGENCY SERVICESⁱ

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
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AMBULANCE SERVICE

Ambulance Service	100% Covered, No Copayment
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PRESCRIPTION DRUGSⁱⁱ

Prescription Drugs	100% Covered After \$5.00 Copayment
(including insulin, glucagon and prescription medications for treating diabetes)	

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

Outpatient (In-Network)

Office Visits

Mental Health – Office Visits	100% Covered After \$5.00 Copayment
Chemical Dependency Services - Office Visits	100% Covered After \$5.00 Copayment
Group Therapy – MH/SUD disorder conditions	100% Covered After \$5.00 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/SUD disorder conditions	100% Covered, No Copayment
Partial Hospitalization Program (generally greater than 5 hours/day) – MH/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,	100% Covered, No Copayment

drugs, dependency recovery services,
education, and counseling

MATERNITY CARE (At Participating Facility)

Prenatal and Postnatal Visits	100% Covered After \$5.00 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	100% Covered After \$5.00 Copayment
Eye Examinations	100% Covered After \$5.00 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.

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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.

TIJUANA

AV PASEO TIJUANA #406
THIRD FLOOR – SIMNSA BUILDING
TIJUANA B.C.
Tel: (664) 231-4739
Monday – Friday: 8 A.M. – 8 P.M.
Saturday: 8 A.M. – 4 P.M.
Sunday: 10 A.M. – 2 P.M.

MEXICALI

CALLE E #123 COL
SEGUNDA SECCION C.P. 21100
MEXICALI B.C.
Tel: (686) 555-6322
Monday – Friday: 8 A.M. – 8 P.M.
Saturday: 8 A.M. – 4 P.M.
Sunday: 10 A.M. – 2 P.M.

COVERED SERVICES

**DIAGNOSTIC AND PREVENTATIVE
SERVICES:**

CO-PAY

01100	Oral examination, diagnostic, consultation	No Charge
01120	Office visit & periodic oral examinations	No Charge
01130	Emergency oral examinations	No Charge
01210	Complete series x-rays	No Charge
	Infection control - per visit	No Charge
00220	Single periapical film	No Charge
00230	Each additional film	No Charge
00460	Pulp vitality tests	No Charge
	Teeth cleaning (prophylaxis-treatment to include basic scaling and polishing/eligible every six months):	No Charge
01110	Adult	No Charge
01120	Child	No Charge
01203	Topical fluoride (up to age 18)	No Charge

SPACE MAINTAINERS:

01510	Unilateral fixed	\$20.00
01520	Unilateral	25.00
08210	Removable appliance therapy (thumb-sucking appliance)	25.00

RESIN RESTORATIONS:

2330	Acrylic or plastic restoration (Anterior teeth)	\$15.00
2391	Resin-one surface	24.00
2392	Resin-two surfaces	30.00
2393	Resin-three surfaces	34.00
2394	Resin-four or more surfaces	37.00
1351	Silicate cement- per restoration	15.00

CROWNS - PER UNIT: PLUS ADDITIONAL COST OF NOBLE METAL (GOLD):

02740	Porcelain (molars not included)	\$50.00
02751	Porcelain with non-precious metal (molars not included)	50.00
02753	Acrylic	45.00
02754	Acrylic with metal	45.00
02791	Full cast non-precious metal	15.00
02810	3/4 Crown	50.00
02910	Recement inlay	5.00
02920	Recement crown	5.00
02930	Prefabricated stainless steel crown - primary	15.00
02931	Prefabricated stainless steel crown - permanent	15.00
02950	Pin build-up	45.00
02952	Cast metal post	45.00

ENDODONTICS:

03110	Pulp capping direct (no final restoration)	\$5.00
03120	Pulp cap indirect (no final restoration)	10.00
03220	Vital pulpotomy	10.00
03310	1 canal	30.00
03320	2 canals	40.00

03330	3 canals	50.00
03410	Apicoectomy/anterior (per root) (periapical)	50.00
03411	Apicoectomy/per tooth, each additional root	50.00
03940	Recalcification	5.00
03999	Culturing canal	5.00

PERIODONTICS:

09110	Palliative (emergency) treatment	\$7.00
04210	Gingivectomy/gingivoplasty - per quadrant	25.00
04211	Gingival or gingivoplasty, per tooth	8.00
04220	Gingival curettage - per quad	18.00
04250	Mucogingival surgery - per quad	36.00
04260	Osseous surgery - per quad	36.00

PROSTHETICS:

05110	Complete upper	\$63.00
05120	Complete lower	63.00
05211	Upper partial - resin base (including any conventional clasps, rests and teeth)	63.00
05212	Lower partial - resin base (including any conventional clasps, rests and teeth)	63.00
05213	Partial upper - cast metal with resin saddles (include any conventional clasps, rests and teeth)	63.00
05214	Partial lower - cast metal base with resin saddles (include any conventional clasps, rests & teeth)	63.00
05410	Adjust complete denture - upper	10.00
05411	Adjust complete denture - lower	10.00
05421	Adjust partial denture - upper	10.00
05422	Adjust partial denture - lower	10.00
05510	Repair broken complete denture base	15.00
05520	Replace missing or broken teeth	10.00
05610	Repair resin acrylic saddle or base	20.00
05630	Repair or replace broken clasp	20.00
05640	Replace broken teeth - per tooth	10.00
05650	Add tooth to existing partial denture (first tooth)	15.00
	Each additional tooth	5.00
05660	Add clasp to existing partial denture	5.00
05730	Reline complete upper denture (Chairside)	15.00

05731	Reline complete lower denture (Chairside)	15.00
05740	Reline upper partial denture (Chairside)	15.00
05741	Reline lower partial denture (Chairside)	15.00
05750	Reline complete upper denture (Laboratory)	18.00
05751	Reline complete lower denture (Laboratory)	18.00
05760	Reline upper partial denture (Laboratory)	18.00
05761	Reline lower partial denture (Laboratory)	18.00
	Reconstruction (jump per denture, including impression)	35.00
05820	Stayplate - upper or lower	10.00
06940	Stressbreakers	15.00

BRIDGES - PER UNIT (PLUS ADDITIONAL COST OF NOBLE METAL):

06211	Pontic - Cast predominantly base metal	\$60.00
06241	Pontic - Porcelain fused to predominantly base metal	70.00
06251	Pontic - Resin with predominantly base metal	60.00
06930	Recement bridge	10.00
05281	Removable (unilateral) bridges:	
	One piece casting, per unit	15.00
	Steelfacing	50.00

ORAL SURGERY:

07110	Single tooth	\$8.00
07120	Each additional tooth	8.00
07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone/or section of tooth	15.00
07220	Removal of impacted tooth - Soft tissue	30.00
07230	Removal of impacted tooth - Partially bony	35.00
07240	Removal of impacted tooth - Completely bony	50.00
07285	Biopsy of oral tissue - Hard	No Charge
07286	Biopsy of oral tissue - Soft	No Charge
07310	Alveoplasty in conjunction with extractions per quadrant	15.00
07960	Frenulectomy (Frenectomy or Frenotomy) - separate procedure	25.00
07510	Incision and drainage of abscess-intraoral soft tissue	No Charge

ADJUNCTIVE GENERAL SERVICES:

09110	Palliative (Emergency) treatment of dental pain	\$5.00
09215	Local anesthesia	No Charge
09241	Sedative base	No Charge

09310	Consultation (Diagnostic service provided by dentist other than practitioner providing treatment)	No Charge
09430	Post-operative visit	No Charge
09440	Office visit – after regularly scheduled hours	10.00
09999	Broken appointment (Less than 24-hour notice)	10.00

ORTHODONTICS:

03000	Full banded case - adult	\$50.00 copay/visit*
03001	Full banded case - child	\$50.00 copay/visit*

* Orthodontic lengths of treatment are normally 24 months; however, some may extend or conclude sooner, the copayment shall be paid each time the patient is required to receive service for the orthodontic treatment which is usually once a month. Initial deposit is applicable to cover cost of materials. Additional charges may apply in case of patient negligence with installed braces. Metal brackets included. Cosmetic brackets not covered.

Exclusions & Limitations

- a. Services which, in the opinion of the attending dentist are not necessary for the patient's dental health. In all cases where the patient selects a plan of treatment that is considered unnecessary by the attending dentist, any additional cost is the responsibility of the patient;
- b. Implants;
- c. Aesthetics - services for appearance only, or to correct congenital conditions;
- d. Myofunctional therapy - procedures for training, treating or developing muscles in and around the jaw or mouth;
- e. Treatment for malignancies or neoplasms (tumors);
- f. Dispensing of drugs not normally supplied in dental office;
- g. Any dental procedure or service rendered while patient is hospitalized;
- h. Prosthodontics - replacement will be made of an existing appliance (dentures, etc.) only if it is unsatisfactory. Prosthodontic appliances will be replaced only after five years have elapsed from the time of delivery. Lost or stolen appliances are the responsibility of the member;
- i. Service compensable under Worker's Compensation or Employer's Liability Laws may be subject to reimbursement;
- j. Services provided or paid by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. The exception extends to any benefits provided under the U.S. Social Security Act and its Amendments;
- k. Charges for services provided for temporomandibular joint (TMJ) dysfunctions;
- l. Charges for services prior to the date the person became covered and was eligible for benefits under this plan, or for charges "incurred" following termination of coverage;
- m. Non-emergency services rendered by any nonparticipating dentist;
- n. Procedures, appliances, or restoration that are necessary to alter occlusion, or a full mouth rehabilitation.