

SALUD CON HEALTH NET PORTFOLIO (continued)

BENEFIT DESCRIPTION ¹	SALUD MEXICO HMO (35W)	SALUD EPO PRIMERO (9U2)	
	SIMNSA NETWORK ONLY ⁶	SIMNSA NETWORK ⁵	SALUD NETWORK
PLAN MAXIMUMS			
Out-of-pocket maximum	\$1,500 single \$3,000 two-party \$4,500 family	Not applicable	\$1,500 single \$4,500 family
Lifetime medical benefit maximum	No maximum	No maximum	\$5,000,000
PROFESSIONAL SERVICES			
Office visit	\$5 copayment	\$5 copayment	\$15 copayment
Periodic health evaluation including newborn, well-baby care and immunizations (birth through age 17)	Covered in full	Covered in full	Covered in full
Adult preventive care (age 18 and older)	Covered in full	Covered in full	\$15 copayment
Specialist consultation	\$5 copayment	\$5 copayment	\$35 copayment
X-ray and laboratory procedures (includes mammograms)	Covered in full	Covered in full ⁵	Covered in full ⁵
Rehabilitation therapy	\$5 copayment ³	\$5 copayment ²	\$15 copayment ²
Self-injectable drugs	Covered in full	Covered in full	See Specialty drugs
HOSPITAL SERVICES			
Inpatient care	Covered in full	Covered in full ⁵	\$250 per admission deductible ⁵
Outpatient facility services	Covered in full	Covered in full	20%
Outpatient surgery (hospital or outpatient surgery center charges only)	Covered in full	Covered in full	20%
Skilled nursing facility	Covered in full (100 days per calendar year)	Not covered	20% (100 days per calendar year)
EMERGENCY SERVICES			
Professional services	Covered in full	Covered in full	Covered in full
Emergency room facility (copayment waived if admitted)	\$10 copayment (in Mexico), \$50 copayment (outside Mexico)	\$10 copayment	\$100 copayment
Urgent care facility	\$10 copayment	\$10 copayment	\$15 copayment
Ambulance services (ground and air)	Covered in full (air ambulance not covered)	Covered in full ⁵ (air ambulance not covered)	\$50 copayment ⁵
BEHAVIORAL HEALTH SERVICES			
Severe mental health (outpatient/inpatient)	\$5 copayment/ Covered in full ⁵	\$5 copayment/ Covered in full ⁵	\$15 copayment/\$250 per admit deductible ⁵
Non-severe mental health (outpatient/inpatient)	\$5 copayment (20 days)/ Covered in full ⁵	\$5 copayment/ Covered in full ^{5,6} (20 days per calendar year maximum combined with SIMNSA and Salud)	\$15 copayment/ \$250 per admit deductible ⁵
Chemical dependency (outpatient/inpatient)	\$5 copayment (20 days)/ Covered in full (30 days) ⁵	\$5 copayment/ Covered in full ^{5,6} (20 days per calendar year maximum combined with SIMNSA and Salud)	\$15 copayment/ \$250 per admit deductible ⁵
Acute care detoxification	20% ⁵	Covered in full (3-day maximum per calendar year combined with SIMNSA and Salud)	\$250 per admit deductible ⁵
OTHER SERVICES			
Durable medical equipment	Covered in full	Covered in full ⁵	Covered in full ⁵
Orthotics and prosthetics	Covered in full	Covered in full	Covered in full
Diabetic equipment	Covered in full	Covered in full	Covered in full
Acupuncture, Chiropractic services	Not covered	Not covered	Not covered
PRESCRIPTION DRUG COVERAGE			
Brand name calendar year deductible (per member)	No deductible	No deductible	No deductible
Prescription drugs (up to a 30-day supply)	\$5 copayment	\$5 copayment	\$10/\$35/50% ⁷
Specialty drugs (most self-injectables)	See Self-injectable drugs	See Self-injectable drugs	30% (\$250 copayment maximum per prescription)

Plan footnotes found on pages 34–36.