#1083A – PETER RABBIT FARMS 02, 02A, 02B, 02C

Benefits	
Service	**Stateside Plan**
Annual Deductible	
Per Person	$500
Per Family	$1,000
Percentage Payable	75%
Professional Services	Services must be provided by Providers within the PHCS Network
Office visit	$25 co-pay (Maximum of 3 office visits per calendar year)
Specialist Office Visit	$25 co-pay (Maximums are combined with office visits – 3 visits per calendar year)
Additional Services/Lab & X-ray in office	20% - member Plan pays 80%
Preventative Services - Child & Adult	100%
Outpatient Lab & X-Ray*	Plan pays 75% (3 procedures/tests per calendar year)
Specialty Testing/Scans	130% of Medicare Pricing (Procedures/tests are combined with Lab & X-Ray – 3 per calendar year)
Outpatient Services Facility*	75% after Deductible (1 per calendar year)
Outpatient Services Physician*	75% after Deductible (1 per calendar year)
Emergency Services	
Emergency Room	$250 co-pay 130% of Medicare Pricing (1 ER visit per calendar year)
Ambulance*	75% after Deductible (1 use per year)
Hospital Benefits	
Inpatient	130% of Medicare Pricing (2 day inpatient stay maximum for calendar year)
Additional Outpatient Services	
Skilled Nursing*	75% - $1,000 per calendar year maximum
Chiropractic Services*	$25.00 per visit – Maximum of 10 visits per calendar year
Acupuncture Services*	$25.00 per visit – Maximum of 10 visits per calendar year
Rehabilitation Services (Physical, Speech & Occupational Therapy)*	$50 per visit – Maximum of 10 visits per calendar year
Mental Outpatient	$25 co-pay; 10 visits per year
Substance Abuse Outpatient	75% - 10 visits calendar year max
Pediatric Dental & Vision	Not Covered
Prescriptions	
Generic	$15 co-pay
Brand Formulary (only if generic drug is not available)	$25 co-pay
Brand Non-Formulary	$40 co-pay
Specialty Medication	Not Covered
(5 per calendar year maximum – Formulary and Non-Formulary combined)	

*Subject to deductible

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	Mexico Benefits
	Services must be performed at Hospital San Andres. A reciprocal agreement is in place with Hospital Almater for the services not provided by Hospital San Andres.
Annual Deductible	
Per Person	$500.00
Per Family	$1,000.00
Maximum out of pocket	$6,350.00
Emergency Services	
Emergency Room	$150 co-pay, Plan pays 80%
Ambulance	$150 co-pay, Plan pays 80%
Hospital Benefits	
Inpatient*	Plan pays 80%
Inpatient Professional Services*	Plan pays 80%
Maternity & Newborn Care 48 hours following a vaginal delivery 96 hours following a cesarean delivery	Same as any other illness
Mental Inpatient	Not Covered
Professional Services	
Medical Treatment (Office)	$10 co-pay
Specialist (Office)	$20 co-pay
Urgent Care Facility/Service	$20 co-pay
Preventative Services – Child & Adult	100%
Outpatient Lab & X-Ray	Plan pays 80% of Maximum Allowable Charge
MRI/PET/CT Scan	$50 co-pay, Plan pays 80% of Maximum Allowable Charge
Outpatient Services	
Outpatient Surgeon Benefits*	Plan pays 80% of Maximum Allowable Charge
Outpatient Surgical Facility*	$150 co-pay, Plan pays 80% of Maximum Allowable Charge
Anesthesiologist*	Plan pays 80% of Maximum Allowable Charge
Additional Outpatient Services	
Skilled Nursing	Not Covered
Chiropractic/Acupuncture Services	Not Covered
Physical/Occupational Services – Medical Necessity	Not Covered
Mental Outpatient/Substance Abuse Outpatient	Not Covered
Durable Medical Equipment ($2,500 per benefit period)	Plan pays 80% of Maximum Allowable Charge
Pediatric Dental & Vision	Not Covered
Prescriptions	
Generic	$10.00 co-pay
Brand Formulary	$50.00 co-pay
Brand Non-Formulary	Not Covered
Specialty	Not Covered

LIFE INSURANCE – 01, 01A, 02, 02A, 02B, 02C

TYPE OF COVERAGE	BENEFIT
Employee Life	$ 10,000.00
Benefits reduce 35% at age 65 25% at age 70, 15% at age 75, Terminates at retirement.	
Spouse	$ 5,000.00
Spouse insurance terminates at age70.	
Children	
Six months and older	$ 5,000.00
14 days to less than six months	$ 5,000.00
Less than 14 days	$ 5,000.00