#1083B – CROWN HILL RANCHES, INC. BENEFITS
Locations: 01 & 01A

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

#1083B CROWN HILL RANCHES, INC. BENEFITS
Locations: 01 & 01A

	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 (Mandatory Generic)	$10.00 co-pay
Brand Formulary	$50.00 co-pay
Brand Non-Formulary	Not Covered
Specialty	Not Covered

Locations: 01 & 01A

US - VISION CARE BENEFITS

Examination (Every 12 Months)……..$ 40.00
Frames (Every 24 Months)……$ 45.00
Lenses (Every 12 Months)…….. Per Pair
Single Vision……..$ 30.00
Bifocals……$ 50.00
Trifocals……..$ 65.00
Lenticular……$ 125.00
Contacts- Medically Necessary
Contacts……..……$ 160.00

Contact lenses will be covered up to $160.00 per paid if medically necessary is substantiated by a report from the prescribing ophthalmologist. Medical necessity will include (but not limited to): treatment following cataract surgery, treatment for anisometropia or keratoconus (unequal refraction or norneal protrusion, respectively) or treatment for extreme myopia when conventional lenses cannot restore sufficient visual acuity for normal activity, usually 20/70 or better for primary care.

Locations: 01 & 01A

MEXICO PANEL VISION BENEFITS

Examination – every 12 Months .....$ 15.00
Frames – every 12 Months .....$ 20.00
Lenses – Every 12 Months ..... Per Pair
Single Vision .....$ 20.00
Bifocals .....$ 35.00
Trifocals .....$ 45.00
Lenticular .....$ 50.00

Locations: 01 & 01A

LIFE INSURANCE

TYPE OF COVERAGE ***BENEFIT***

Employee Life ..... $ 10,000.00
Benefits reduce 50% at age 65, 75% at age 70, and 90% at age 75; Terminates at retirement.
Accidental Death & Dismemberment ..... $ 10,000.00
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

Location: 01A

MEXICO DENTAL PANEL BENEFITS

Services provided by panel dentist will be paid in full according to schedule. Panel providers are those dental providers contracted with Transwestern Insurance Administrators. THE EMPLOYEE WILL BE RESPONSIBLE FOR CHARGES WHEN TREATMENT IS RENDERED BY A NON-PANEL PROVIDER.

Annual Maximum (per family)..... $ 500.00

Description	***Co-pay***	***Benefit***
Initial Oral Examination	5.00	10.00
Periodic Oral Examination	5.00	10.00
Visits after Hours	5.00	20.00
Emergency Palliative Treatment	5.00	20.00
Consultation by Specialist, Requested by the attending dentist	5.00	25.00
Dental Prophylaxis, ADULT	5.00	25.00
Dental Prophylaxis, UNDER AGE 19	5.00	15.00
Topical Stannous Fluoride, One Treatment, In addition to Prophylaxis (Under age 19 only)	5.00	15.00
Topical Application of Sealant (per quad)	5.00	30.00
Per Tooth	5.00	12.00
X-Rays		
Full Mouth Films (Intraoral)	5.00	40.00
Intraoral – Single, First Film	5.00	7.00
Intraoral – Each additional Firm	5.00	6.00
Bitewings – Two Films	5.00	10.00
Four Films	5.00	20.00
Panorex-Maxilla-Mandible Single Film	5.00	30.00
Restorative Dentistry		
Amalgam Filling, Primary Teeth-One Surface	5.00	20.00
Two Surfaces	5.00	30.00
Three Surfaces	5.00	35.00
Amalgam Filling, Permanent Teeth One Surface	5.00	25.00
Two Surfaces	5.00	35.00
Three Surfaces	5.00	40.00
Crowns		
Plastic Acrylic Crown	5.00	60.00
Plastic with Metal Crown	5.00	120.00
Stainless Steel-Primary Tooth	5.00	50.00
Permanent Tooth	5.00	40.00
Recementation of Crown	5.00	15.00
Endodontics		
Pulp Capping	5.00	18.00
Recalcification, Per Tooth	5.00	25.00
Vital Pulpotomy	5.00	35.00
Therapeutic Pulpotomy, In addition to Restoration	5.00	35.00
Removable Dentures and Bridges (PROSTHESTICS)		
Complete Dentures - Upper	5.00	220.00
Lower	5.00	220.00
Upper and Lower Partial Denture	5.00	160.00
Partial (Metal Frame) Lower	5.00	250.00
Upper	5.00	250.00
Extractions		
Extraction single tooth	5.00	30.00
Each additional tooth	5.00	30.00
Surgical removal of erupted tooth	5.00	40.00
Removal of tooth, soft tussue impaction	5.00	60.00

ADDITIONAL MEXICO DENTAL INFORMATION

To obtain a better Dental Service only a Maximum of 3 dependents per visits will be seen per day, preferably with previous appointment. Dental treatment will be given in various phases and in the scheduling that the dentist indicates according to the diagnosis. There are no complete treatments in one single session.

This program consists of 4 phases of Dental Treatment, during the first 4 months of benefits with Transwestern Insurance Administrators.
1st Phase – (1st month) includes initial Oral examination, Medical History, X-rays, Diagnosis and Scheduled treatment.

2nd Phase – (2nd month) restorative, includes Amalgams, fillings, extractions, sealants, fotocurables.

3rd Phase – (3rd month) Removable prothesis, includes partial dentures and complete dentures

4th Phase – (4th month) Fixed prothesis includes crowns of acrylic material

Exclusions:
There is no coverage in the following procedures
Endodoncy
Dental Implants
Orthodontics
Paradoncy
Fixed prothesis – porcelain, metal like gold
Maxilofacial Surgery
General Anesthesia
Dental Whitening
Any Dental procedure that involves dental, anesthetics
No dental service under Cobra plan

Limitations:
In case of accident with dental lesions, there will be coverage only if the insured has benefits or is eligible and the lesion is no more than 6 months old. Maximum Benefit of $500.00 per Family.