Group Health Benefit Handout
for
Employees and Dependents
Of

Hadley Date Gardens, Inc.

Group No: 1119

Provided By:
George Ekizian

Through:
Transwestern Insurance Administrators, Inc.

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Insurance Administrators, Inc.

Benefits	
Service	**Stateside Plan**
Annual Deductible	
Per Person	$300
Per Family	$600
Percentage Payable	75%
Professional Services	Services must be provided by Providers within the PHCS Network
Office visit	$25 co-pay (Maximum of 10 office visits per calendar year)
Specialist Office Visit	$25 co-pay (Maximums are combined with office visits – 10 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
Prescriptions	
Generic	$15 co-pay
Brand Formulary (only if generic drug is not available)	$25 co-pay (8 per calendar year maximum – Formulary and non-Formulary combined)
Brand Non-Formulary	$40 co-pay (8 per calendar year maximum – Formulary and non-Formulary combined)
Specialty Medication	Not Covered

***Subject to deductible**

	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**
Prescriptions	
Generic	**$10.00 co-pay**
Brand Formulary	**$50.00 co-pay**
Brand Non-Formulary	**Not Covered**
Specialty	**Not Covered**

***Subject to deductible**

USA - VISION CARE BENEFITS

Deductible - per Covered Individual per Calendar Year…..$		20.00
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 - every 12 months		
Medically Necessary…….. $		250.00
Cosmetic……...……. $		130.00

MEXICO PANEL - VISION CARE BENEFITS

Examination - every 12 month……...$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	

LIFE INSURANCE

TYPE OF COVERAGE	**BENEFIT**
Employee Life ……..	$5,000.00
Benefits reduce 65% at age 65; 45% at age 70; 30% at age 75; and 10% at age 90. Terminates at retirement.	
Accidental Death & Dismemberment – Employee Only	
Maximum Employee Benefit……..	$5,000.00
Spouse……	$2,500.00
Spouse Insurance terminates at age 70.	
Children	
Six months and older……...	$2,500.00
14 days to less than six months……...	$2,500.00
Less than 14 days…….	$2,500.00