MEXICO SCHEDULE OF BENEFITS

Mexicali, B.C., Mexico
San Luis, R.C., Sonora Mexico
Tijuana, B.C., Mexico

***Services must be provided by a Mexico Panel Provider. Services received from a non-participating doctor or facility will not be covered.**

Coinsurance……80%

Basic Benefits:	**Co-pay**	***Benefit Maximum**
Doctor Office Visits	$ 5.00	$10.00
Specialist Office Visits (included in office visit – 5 maximum)	$ 10.00	$10.00
Combined Annual Maximum benefit		
Laboratory and X-Ray – 3 test maximum per calendar year	20%	80%
Outpatient Hospital Charges/Emergency room – 1 surgery per calendar year	20%	80%
Outpatient Surgical Facility Fees – 1 per calendar year	20%	80%
Family Planning		
Consultation		100%
Tubal Ligation (No reversals)		100%
Vasectomy (No reversals)		100%
Inpatient Care		
Hospital Confinement of 18 hours or more – 2 inpatient day maximum	$ 100.00	
Hospital Miscellaneous	20%	80%
* All scheduled surgeries require pre-authorization. Surgery for Hysterectomy, Hernia and Deviated Septum		
Surgeon, Assistant Surgeon, Anesthesiologist		
Surgeon – 1 surgery per calendar year maximum	20%	80%
Assistant Surgeon – 1 surgery per calendar year maximum	20%	80%
Anesthesiologist – 1 surgery per calendar year maximum	20%	80%
Preventative Health Care		
Consultation and Office Visit		100%
Mammogram		100%
Pap Test		100%
Prostate Test		100%
Prescriptions		
Generic Drugs	$ 10.00	
Brand Name Drugs (only if generic is not available)	$ 20.00	
** Maximum benefit per calendar year**		
* Drugs considered “Over the Counter” are not covered under the Plan.		
* Generic drugs will be dispensed at all times except in the event that there is no Generic available, then the Brand name drugs will be dispensed. Maximum of 10 medications per year.		

MEXICO PANEL DENTAL 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		**Benefit**
Initial Oral Examination		$10.00
Periodic Oral Examination		$10.00
Visits after Hours		$20.00
Emergency Palliative Treatment		$20.00
Consultation by Specialist, Requested by the attending dentist		$25.00
Topical Stannous Fluoride, One Treatment, In addition to Prophylaxis (Under age 19 only)		
Topical Application of Sealant (per quad)		$30.00
Per Tooth		$12.00
X-Rays		
Full Mouth Films (Intraoral)		$40.00
Intraoral – Single, First Film		$7.00
Intraoral – Each additional Film		$6.00
Bitewings – Two Films		$10.00
Four Films		$20.00
Panorex- Maxilla-Mandible Single Film		$30.00
Restorative Dentistry		
Amalgam Filling, Primary Teeth – One Surface		$20.00
Two Surfaces		$30.00
Tree Surfaces		$35.00
Amalgam Filling, Permanent Teeth One Surface		$25.00
Two Surfaces		$35.00
Three Surfaces		$40.00
Crowns		
Plastic Acrylic Crown		$60.00
Plastic with Metal Crown		$120.00
Stainless Steel – Primary Tooth		$50.00
Permanent Tooth		$40.00
Re-cementation of Crown		$15.00
Porcelain		$150.00
Porcelain with Metal Crown		$180.00
Endodontics		
Root Canal One Root		$50.00
Two Roots		$120.00
Three Roots		$150.00
Pulp Capping		$18.00
Recalcification, Per Tooth		$25.00
Vital Pulpotomy		$35.00
Therapeutic Pulpotomy, In addition to Resoration		$35.00
Extractions		
Extraction – Single Tooth		$30.00
Each Additional Tooth		$30.00
Surgical Removal of Erupted Tooth		$40.00
Removal of tooth, soft tissue impaction		$60.00
Removable Dentures and Bridges (Prosthestics)		
Complete Dentures - Upper		$220.00
- Lower		$220.00
Upper and Lower Partial Denture		$160.00
Partial (Metal Frame) Lower		$250.00
- Upper		$250.00

MEXICO PANEL VISION BENEFIT

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

USA SCHEDULE OF BENEFITS

Co-insurance……..60% R & C
Calendar Year Deductible……$250 Individual/$750 Family

Basic Benefits:	Member Pays:	Plan Pays:
PPO Network is Interplan/Healthsmart		
Doctor Office Visits – Limit of 5 visits per calendar year per person	$20.00 co-pay	$25.00
Diagnostic Lab & X-ray – Limit of 4 test per calendar year per person	40% co-insurance	60% co-insurance
Preventative Services Includes: office visits, lab, pap smear, mammogram, prostate screening, gynecological exam and routine physical	No cost share	Plan pays 100%
Services Applied to Deductible		
Medical Procedure performed in Doctors office only	40% co-insurance	60% co-insurance of R&C
Prescription Benefits		
$100.00 calendar year deductible applies to Brand name drugs. Maximum of 15 medications (combined generic and brand) per calendar year. **PBM Vendor: IPM**	40% - Generic 40% Brand after deductible Specialty Meds not Covered	60% - Generic 60% Brand after deductible Specialty Meds not Covered