Transwestern
Insurance Administrators, Inc.

Sarah Farms Benefits

Mexico Supplemental Benefit Schedule

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..... 70%

Basic Benefits:	**Co-pay**	**Plan Pays**
Doctor Office Visits	$20.00	$0
Specialist Office Visits	$20.00	$0
Combined Annual Maximum benefit		
Laboratory and X-Ray	30%	70%
Outpatient Hospital Charges/Emergency room	30%	70%
Outpatient Surgical Facility Fees	30%	70%
Family Planning		
Consultation	$20.00	70%
Tubal Ligation (No reversals)	$50.00	70%
Vasectomy (No reversals)	$75.00	70%
Inpatient Care		
Hospital Confinement of 18 hours or more	$100.00	
Hospital Miscellaneous	30%	70%
All scheduled surgeries require pre-authorization. Surgery for Hysterectomy, Hernia and Deviated Septum		
Surgeon, Assistant Surgeon, Anesthesiologist		
Surgeon	30%	70%
Assistant Surgeon	30%	70%
Anesthesiologist	30%	70%
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	$40.00	
Specity Drugs and 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.		

U.S. Minimum Essential/MEC (Preventative Services) included.

DENTAL
SCHEDULE OF BENEFITS

Dental Benefits and Copayment Requirements:
The Plan will pay 100% of Covered Expenses for the Dental Services stated below, subject to applicable copayments also stated below.

	Dr. Raúl Héctor Payan Garcia **Centro Médico del Noroeste** Ave. Kino y Calle 12 #1203 Colonia Residencias 83448 San Luis Rio Colorado, Sonoras MX Mexico Telephone No.: 52 653 534 1245 USA Telephone No.: (928) 487-2209
BENEFIT	**Co-Payment Requirements**
ORAL EXAMS: (effective upon enrollment)	$10
Examination (intial episode)	
Office Visit for medication, observation and temporary correction of accidental injuries to natural teeth or supporting structures (post operative visits and visits where a permanent correction procedure is performed are not applicable).	$5
CLEANINGS-ROUTINE PROPHYLAXIS: (effective upon enrollment)	
Children to age 14 (each treatment)	$12
Adults and children over age 14 (treatment to include scaling and polishing) (each treatment)	$15
Topical application of sodium fluoride-Includes cleaning (only children under age 14 years)	$20
X-RAYS AND PATHOLOGY: (effective upon enrollment)	
Single film	$5
Additional film (up to and including a total of 13 films each)	$2 per film
Entire denture series consisting of at least 14 films (including bite wings if indicated).	$30
Intraoral, occlusal vies, maxillary or mandibular, each	$10
Superrior or inferior maxillary, extraoral, one film	$15
Superior or inferior maxillary, extraoral, two films	$25
Biopsy of Oral Tissue	$15
Microscopic Examinations	$25
EXTRACTIONS: (effective after 4 months continuous enrollment)	
Uncomplicated (single extraction includes routine post operative visits)	$15
Each additional tooth (includes routine post-operative visits)	$15
Surgical removal of erupted teeth	$50
Post-Operative visit (sutures and complication)	$5
IMPACTED TEETH: (effective after 4 months continuous enrollment)	
Removal of tooth (soft tissue)	$30
Removal of tooth (partially bony)	$45
Removal of tooth (completely bony)	$55

DENTAL SCHEDULE OF BENEFITS (cont'd)

Benefit	Co-Payment Requirements
RESTORATIVE DENTISTRY: (effective after 4 months of continuous enrollment	
Amalgam Restorations Primary Teeth:	
Cavities involving one tooth surface	$10
Cavities involving two tooth surface	$15
Cavities involving three or more tooth surfaces	$20
Amalgam Restorations Permanent Teeth:	
Cavities involving one tooth surface	$10
Cavities involving two tooth surface	$15
Cavities involving three or more tooth surfaces	$20
ENDODONTICS-ROOT CANALS: (effective after 4 months continuous enrollment)	
Pulp Capping	$10
Therapeutic Pulpotomay (in addition to restoration each treatment)	$10
Vital Pulpotomy	$20
Remineralization (each, temporary restoration) each tooth	$15
ROOT CANALS	
Single rooted canal therapy	$65
Bi-rooted canal therapy	$85
Tri-rooted canal therapy	$125
PERIODONTIC: (effective after 4 months continuous enrollment)	
Emergency treatment (periodontal abscess, acute Periodontitis, etc.)	$20
Subgingival curettage, root planning (each quadrant)	$45
Correction of occlusion	$25
Gingivectomy each quadrant (includes post surgical visits)	$100
Gingivectomy, osseous or muco-gingival surgery each quadrant (includes post-surgical visits)	$100
PROSTHETICS: (effective after 8 months of continuous enrollment)	
Complete maxillary denture	$225
Partial maxillary denture	$150
Compelte mandibular denture	$150
Partial mandibular denture	$150
MISCELLANEOUS: (effective after 4 months continuous enrollment)	
Incision and removal of foreign body from soft tissue	$15
Suture of solft tissue wound or injury	$20
Drugs-antibiotic injection	$10

DENTAL EXPENSE LIMITATIONS

The following limitations apply to Dental Benefits:

1. Diagnostic/preventative procedures are covered expenses from the effective date of coverage.

2. Basic procedures are covered expenses after the fourth month of ***continuous*** coverage starting from the effective date of coverage.

3. Major procedures are covered expenses after the eighth month of ***continuous*** coverage starting from the effective date of coverage.

4. Covered topical fluoride treatment is limited to children under age 14. Only one treatment of topical fluoride is allowed in any six-month period, per covered person.

DENTAL EXCLUSIONS

The following services and charges are not covered under this Plan:

1. Treatment by other than a dentist, oral surgeon, or a licensed dental hygienist.

2. Treatment at any other facility than the Mexico Dental Facility selected by the covered person from the provider directory or assigned by the Plan Administrator or the employer.

3. Any procedure, which is not listed in the section "Covered Dental Services" or in the "Benefit" column of the section. "Dental Benefits and Co-payment Requirements"

4. A procedure that is not considered Medically Necessary or that does not meet professionally recognized standards.

5. Charges for dental care rendered or supplied by a dentist employed by a government.

6. Any disability covered by a Worker's Compensation or Occupational Disease Law; or injury occurring in the course of employment.

7. Prescribed drugs outside of the Dental Office and used during treatment.

8. Services and supplies for **Orthodontics, Crowns, Bridges, and Inlays**.

9. Any procedure that is performed mainly to improve the appearance of the covered person.

10. Replacement of any dental item which, in the opinion of the attending dentist, is or can be made satisfactory.

11. The following items and services: (a) an athletic mouth-guard; (b) a specialized appliance; (c) a precision or semi-precision attachment; (d) a denture duplication; (e) oral hygiene instruction.

12. Experimental procedures.

LIFE INSURANCE

TYPE OF COVERAGE	BENEFIT
Employee Life	$10,000.00
Benefits reduce 65% at age 65; 45% at age 70; 30% at age 75; Coverage terminates at retirement.	
Accidental Death & Dismemberment	
Maximum Employee Benefit	$10,000.00
Dependent Life	
Spouse	$2,000.00
Children	
Six months and older	$1,000.00
14 days to less than six months	$500.00
Less than 14 days	$0.00