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 Healthsmart Network. The benefit schedule listed reflects an EPO plan (Exclusive Provider Network) if a member seeks services from a provider outside the network, benefits will not be covered.
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	Plan pays 75% (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	
Urgent Care (Annual Deductible Waived)	$50 co-pay – Limit of 2 visits per calendar year
Emergency Room	$250 co-pay (2 ER visit per calendar year)
Ambulance*	75% after Deductible (Maximum Benefit $1,500)
Hospital Benefits	
Inpatient*	75% after Deductible (2 day inpatient stay maximum for calendar year)
Additional Outpatient Services	
Skilled Nursing*	75% - $1,000 per calendar year maximum
Chiropractic Services*	$50.00 maximum benefit per visit – Maximum of 10 visits per calendar year
Acupuncture Services*	$50.00 maximum benefit per visit – Maximum of 10 visits per calendar year
Rehabilitation Services (Physical, Speech & Occupational Therapy)*	$50.00 maximum benefit 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	ACA Required Benefit
Prescriptions	
Generic	$15 co-pay
Brand Formulary (only if generic drug is not available)	$25 co-pay (5 per calendar year maximum – Formulary and non-Formulary combined)
Brand Non-Formulary	$40 co-pay (5 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	$200.00
Per Family	$400.00
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	$5.00 co-pay
Brand Formulary	$30.00 co-pay
Brand Non-Formulary	Not Covered
Specialty	Not Covered

***Subject to deductible**

USA - VISION CARE BENEFITS

Examination (Every 12 Months)……..	$60.00
Deductible (**applies towards all other vision benefits**)……	$25.00
Frames (Every 24 Months)……..	$120.00
Lenses (Every 12 Months)……..	Per Pair
Single Vision……..	$65.00
Bifocals……..	$90.00
Trifocals……..	$100.00
Lenticular……..	$120.00
Tint……..	$16.00
Contact Lenses……..	$125.00

MEXICO PANEL VISION BENEFITS

Exam (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 - DENTAL BENEFITS

Deductible per Covered Individual……..	$	50.00
Maximum per family……..	$	150.00
Annual Maximum per Covered Individual……..	$	1,000.00

Preventative
Type 1 Services –Applicable dental Schedule (deductible waived)…… 100%
Routine
Type II Services- Applicable dental Schedule..... 80%
Major
Type III Services – Applicable dental Schedule..... 50%

Pre-Authorization is required for any treatment which will exceed $200.00 in charges. Please refer to the back of the dental claim form for pre-authorization instructions. The Plan will pay for procedures performed for you/covered dependents up to the maximum dollar amount allowed provided you meet the following conditions. 1. The work is performed by a licensed dentist or denturist, except for cleaning and x-rays, which may be done by qualified technicians. 2. Procedures are the least expensive appropriate repair. 3. Your coverage is in force at time the work is performed. There are no deductibles for Type I, exams, cleaning, fluoride application and x-rays. One set of full mouth x-rays every 36 months, bitewings every 12 months fluoride applications up to age 18 only. You must meet a $50.00 cash deductible for Types II & III fillings, crowns, bridgework, etc. There is separate cash deductible for you/eligible dependents, but no more than 3 per family per calendar year. Certain dental services are limited to particular time intervals two exams/cleaning per calendar year per covered person.

LIFE INSURANCE

TYPE OF COVERAGE		**BENEFIT**
Employee Life.....	$	10,000.00
Benefits reduce 65% at age 65, 50% at age 70, and terminates at retirement.		
Dependent Life		
Spouse.....	$	5,000.00
Six months and older	$	5,000.00
14 days to less than six months	$	500.00
Less than 14 days.....	$	500.00
Accidental Death & Dismemberment		
Maximum Employee Benefits.....	$	10,000.00

MEXICO PANEL DENTAL

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