

Calendar Year Deductible			\$250.00	\$0.00
Out-of-pocket limit on expenses			\$500.00	\$0.00
Common Medical Event	Service Type		Member Cost Share	Member Cost Share
	Benefits		Interplan/Healthsmart Network (outpatient services – office visit, lab, x-ray, urgent care visits and Free Standing Facilities for MRI, CT and PET scans) **Services provided outside of the Interplan/Healthsmart network for outpatient services are not covered by this plan	Mexicali, B.C., Mexico San Luis, R.C., Sonora Mexico Tijuana, B.C., Mexico
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		\$10 co-pay- member Plan pays 100% of allowed	\$5 co-pay
	Specialist visit		\$20 co-pay – member Plan pays 100% of allowed	\$10 co-pay
	Urgent Care Facility/Service		\$20 co-pay – member Plan pays 100% of allowed	\$5 co-pay
	Preventive care/screening/immunization		No cost share – member Plan pays 100% of allowed	No cost share – member Plan pays 100% of allowed
Tests	Diagnostic test (x-ray, blood work) Free Standing Facilities Subject to Deductible		Plan pays 75% of allowed	Plan pays 80% of allowed
	Imaging (CT/PET scans, MRIs) at a Free Standing Imaging Center, if performed in a hospital on an outpatient basis not covered Subject to Deductible		Plan pays 75% of allowed	Plan pays 80% of allowed
Outpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health outpatient services		Not Covered	Not Covered
	Substance use disorder outpatient services Subject to Deductible 12 visit maximum		75% of allowed	Not Covered
Outpatient surgery	Facility fee (e.g., ASC)		Not Covered	Plan pays 80%
	Physician/surgeon fees		Not Covered	Plan pays 80%
Need immediate attention	Emergency room services (waived if admitted)		Not Covered	Plan pays 80%
	Emergency medical transportation		Not Covered	Plan pays 80%
Hospital stay	Facility fee (e.g., hospital room)		Not Covered	\$100 co-pay Plan pays 80%
	Physician/surgeon fee		Not Covered	Plan pays 80%
Inpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health inpatient Services		Not Covered	Not Covered
	Substance use disorder inpatient Services		Not Covered	Not Covered
Pregnancy	Delivery and all Inpatient services	Professional Hospital	Not Covered	Same as any other illness
Help recovering or other special health needs	Home health care (60 days per calendar year)		Not Covered	Not Covered
	Rehabilitation services		\$20 co-pay – member Plan pays 100% of allowed	Not Covered
	Habilitation services		Not Covered	Not Covered
	Skilled nursing facility (60 days per calendar year) Immediately following an in-patient stay.		Not Covered	Not Covered
	Chemotherapy/Radiation		Not Covered	Not Covered
	Dialysis		Not Covered	Not Covered
	Durable medical equipment (\$2500 per benefit period)		Not Covered	Not Covered
	Hospice service (\$2,500 calendar year max benefit)		Not Covered	Not Covered
Child needs	Eye Exam		No cost share	No cost share
Child oral care Ages 0-11 mos, 1-4yrs, 5-10 yrs.	Glasses (\$150 max benefit)		Not Covered	Not Covered
	Dental check-up – Preventive and Diagnostic Services		Not Covered	Not Covered
	Dental Basic Services (\$1,000 calendar year max)		Not Covered	Not Covered
Drugs to treat illness or condition	Generic Drugs – Mandatory Generic		\$5 co-pay	\$10 co-pay
	Brand Subject to deductible		\$20 co-pay Formulary	\$20 co-pay Formulary
	Available only when generic is not available		\$40 Non-Formulary	\$30 Non-Formulary
	Specialty Medication		Not Covered	Not Covered