

Benefits Service	MEC Plus Plan	
	Stateside Benefits	Mexico Benefits
	<b>Interplan/Healthsmart Network (outpatient services – office visit, lab, x-ray, urgent care visits and Free Standing Facilities for MRI, CT and PET scans)</b>  <b>**Services provided outside of the Interplan/Healthsmart network for outpatient services are not covered by this plan</b>	<b>Mexicali, B.C., México San Luis, R.C., Sonora México Tijuana, B.C., México</b>
<b>Calendar Year Deductible</b>		
<b>Per Person</b>	<b>\$250.00</b>	<b>\$0.00</b>
<b>Per Family</b>	<b>\$500.00</b>	<b>\$0.00</b>
<b>Maximum Out-of-Pocket on Expenses</b>		
<b>Per Person</b>	<b>\$500.00</b>	<b>\$0.00</b>
<b>Per Family</b>	<b>\$1,000.00</b>	<b>\$0.00</b>
<b>Professional Services</b>		
<b>Office visit</b>	<b>\$20 co-pay</b>	<b>\$5 co-pay</b>
<b>Specialist visit</b>	<b>\$35 co-pay</b>	<b>\$10 co-pay</b>
<b>Urgent care</b>	<b>\$35 co-pay</b>	<b>\$5 co-pay</b>
<b>Preventative Services - Child &amp; Adult</b>	<b>No cost share – member Plan pays 100% of allowed</b>	<b>No cost share – member Plan pays 100% of allowed</b>
<b>Outpatient Lab &amp; X-Ray</b>	<b>Plan pays 75% of allowed*</b>	<b>Plan pays 80% of allowed</b>
<b>Specialty Testing/Scans (CT/PET scans, MRIs)</b>	<b>Plan pays 75% of allowed*</b>	<b>Plan pays 80% of allowed</b>
<b>Outpatient Services Facility</b>	<b>Not covered</b>	<b>Plan pays 80% of allowed</b>
<b>Outpatient Services Physician</b>	<b>Not covered</b>	<b>Plan pays 80% of allowed</b>
<b>Emergency Services</b>		
<b>Emergency Room</b>	<b>Not covered</b>	<b>Plan pays 80%</b>
<b>Ambulance</b>	<b>Not covered</b>	<b>Plan pays 80%</b>
<b>Hospital Benefits</b>		
<b>Inpatient</b>	<b>Not covered</b>	<b>\$100 co-pay Plan pays 80% of allowed</b>
<b>Additional Outpatient Services</b>		
<b>Skilled Nursing</b>	<b>Not covered</b>	<b>Not Covered</b>
<b>Chiropractic Services</b>	<b>Not covered</b>	<b>Not Covered</b>
<b>Acupuncture Services</b>	<b>Not covered</b>	<b>Not Covered</b>
<b>Rehabilitation Services</b>	<b>\$20 co-pay Plan pays 100% of allowed</b>	<b>Not Covered</b>
<b>Mental Outpatient</b>	<b>Not covered</b>	<b>Not Covered</b>
<b>Durable Medical Equipment</b>	<b>Not covered</b>	<b>Not Covered</b>
<b>Substance Abuse Outpatient – 12 visit maximum</b>	<b>Plan pays 75% of allowed*</b>	<b>Not Covered</b>
<b>Pediatric Dental &amp; Vision</b>	<b>Covered (ACA required benefits)</b>	<b>Not Covered</b>
<b>Prescriptions</b>		
<b>Generic – Mandatory Generic</b>	<b>\$10 co-pay</b>	<b>\$10 co-pay</b>
<b>Brand Formulary – Available only when generic is not available</b>	<b>\$40 co-pay</b>	<b>\$20 co-pay</b>
<b>Brand Non-Formulary</b>	<b>\$75 co-pay</b>	<b>\$30 co-pay</b>
<b>Specialty Medication</b>	<b>Not Covered</b>	<b>Not Covered</b>

**\*Subject to deductible**