

Family Ranch, Inc. Benefits

Benefits	PLAN 1		
Service	MEC+ PLAN	Mexico Panel	
Annual Deductible			
Per Person/Per Family	\$250/\$500	\$0/\$0	
Maximum Out of Pocket	\$0.00	\$0.00	
Percentage Payable	80%	80%	
1 croomage r ayabic	Services must be provided by	Mexicali, B.C, Mexico	
	Providers within the PHCS	San Luis, R.C. Sonora,	
Professional Services	Network	Mexico Tijuana B.C., Mexico	
Physician office visits, services must be			
provided by Providers within the PHCS		\$5 co-pay	
Network	\$10 co-pay then 100% of PHCS	Plan pays 100% of Allowed	
Procedures performed during an office			
visit	80% after Deductible	Included in Office visit co-pay	
Our salellet office whether	\$40 4000/ -f DUO	\$10 co-pay	
Specialist office visit only Procedures performed during an office	\$40 co-pay then 100% of PHCS	Plan pays 100% of Allowed	
visit	80% after Deductible	Included in Specialist visit co-	
VISIL	00 % after Deductible	pay \$10 co-pay	
Urgent Care	\$40 co-pay then 80% of PHCS	Plan pays 80%of Allowed	
Additional Services/Lab & X-ray in office	80% after Deductible	Plan pays 80% of Allowed	
Preventative Services - Child & Adult	100%	100%	
Outpatient Lab & X-Ray	80% after Deductible	Plan pays 80% of Allowed	
Outpatient Services Facility	Not covered	Plan pays 80% of Allowed	
Outpatient Services			
Physician	Not covered	Plan pays 80% of Allowed	
Emergency Services			
Emergency Room	Not covered	Plan pays 80% of Allowed	
Ambulance	Not covered	Plan pays 80% of Allowed	
Hospital Benefits			
		\$100 co-pay, Plan pays 80%	
Inpatient	Not covered	of Allowed	
Inpatient Professional Services	Not covered	Plan pays 80% of Allowed	
Mental Inpatient	Not covered	Not Covered	
Additional Outpatient Services			
Skilled Nursing	Not covered	Not Covered	
Chiropractic/Acupuncture	Not covered	Not Covered	
Physical/Occupational	Not covered	Not Covered	
Mental Outpatient	Not covered	Not Covered	
Substance Abuse Outpatient	Not covered	Not Covered	
Pediatric Dental & Vision	ACA Required benefits	Not Covered	
Prescriptions	Non Required beliefits	Tiot Covered	
Generic	\$5 co-pay	\$10 co-pay	
Brand Formulary	Not covered	\$40 co-pay Formulary	
Brand Non-Formulary	Not covered	\$75 co-pay Non-Formulary	
Specialty Medication	Not covered	Not Covered	
Mail Order (90 Days)			
Generic	Not covered	Not covered	
Preferred	Not covered	Not covered	
Non-Preferred	Not covered	Not covered	
Specialty Medication	Not covered	Not covered	

Benefits	PLAN 2		
Service	MV PLAN	Mexico Panel	
Annual Deductible			
Per Person/Per Family	\$1,250/\$2,500	\$0/\$0	
Maximum Out of Pocket	\$7,150/\$14,300	\$0/\$0	
Percentage Payable	140% of Medicare Allowed	80%	
1 Crocinage i ayabic	140 / Of Medicale Allowed	Mexicali, B.C, Mexico	
		San Luis, R.C. Sonora,	
Professional Services	PHCS Network	Mexico Tijuana B.C., Mexico	
Physician office visits, services must be	\$25 co-pay first 10 visits, after		
provided by Providers within the PHCS	which subject to deductible then	\$5 co-pay	
Network	100% of PHCS*	Plan pays 100% of Allowed	
Procedures performed during an office			
visit	140% of Medicare Allowed*	Included in Office visit co-pay	
	\$50 co-pay first 5 visits, after	, , ,	
	which subject to deductible then	\$10 co-pay	
Specialist office visit only	100% of PHCS*	Plan pays 100% of Allowed	
Procedures performed during an office		Included in Specialist visit co-	
visit	140% of Medicare Allowed*	pay	
	\$50 co-pay then the plan pays	\$10 co-pay	
Urgent Care	140% Medicare Allowed	Plan pays 80%of Allowed	
Additional Services/Lab & X-ray in office	140% Medicare Allowed*	Plan pays 80% of Allowed	
Preventative Services - Child & Adult	100%	100%	
Outpatient Lab & X-Ray	140% Medicare Allowed*	Plan pays 80% of Allowed	
Outpatient Services Facility	140% Medicare Allowed*	Plan pays 80% of Allowed	
Outpatient Services Physician	140% Medicare Allowed*	Plan pays 80% of Allowed	
	140 /0 Miculcule Allowed	I lan pays 60 % of Allowed	
Emergency Services	\$200 co-pay Waived if admitted		
	Subject to the deductible*		
Emergency Room	Then 140% Medicare Allowed	Plan pays 80% of Allowed	
Ambulance	140% Medicare Allowed*	Plan pays 80% of Allowed	
Hospital Benefits	140 /0 Wiedicale Allowed	I lan pays 00 % of Allowed	
Hospital Belletits		\$100 co-pay, Plan pays 80%	
Inpatient	140% Medicare Allowed*	of Allowed	
Inpatient Professional Services	140% Medicare Allowed*	Plan pays 80% of Allowed	
Mental Inpatient	140% Medicare Allowed*	Not covered	
	140% Medicare Allowed	Not covered	
Additional Outpatient Services	4400/11 11 111	N. d	
Skilled Nursing	140% Medicare Allowed*	Not covered	
Chiropractic/Acupuncture	140% Medicare Allowed*	Not covered	
Physical/Occupational	140% Medicare Allowed*	Not covered	
Mental Outpatient	140% Medicare Allowed*	Not covered	
Substance Abuse Outpatient	140% Medicare Allowed*	Not covered	
Pediatric Dental & Vision	ACA Required Benefits	Not covered	
Prescriptions			
Generic	\$25 co-pay	\$10 co-pay	
Brand Formulary	\$50 co-pay	\$40 co-pay Formulary	
Brand Non-Formulary	\$75 co-pay	\$75 co-pay Non-Formulary	
Specialty Medication	Not covered	Not covered	
Mail Order (90 Days)			
Generic	\$50 co-pay	Not covered	
Preferred	\$100 co-pay	Not covered	
Non-Preferred	\$150 co-pay	Not covered	
Specialty Medication	Not covered	Not covered	
*Subject to Deductible			

^{*}Subject to Deductible

Benefits	PLAN 3		
Service	MV PLA	N	Mexico Panel
Annual Deductible	In-Network	Out-of-Network	
Per Person/Per Family	\$500/\$1,000	\$5,000/\$10,000	\$0/\$0
Maximum Out of Pocket	\$5,000/\$10,000	\$15,000/\$30,000	\$0/\$0
Percentage Payable	80%	50%	80%
1 010011tage 1 ayabio	3070	0070	Mexicali, B.C, Mexico
			San Luis, R.C. Sonora, Mexico
Professional Services	PHCS Network		Tijuana B.C., Mexico
T TOTOGOTOTIAL COTTIOGO	T HOO HOUNGIN		\$5 co-pay
Physician office visits	\$20 co-pay	50% co-insurance	Plan pays 100% of Allowed
Procedures performed during an	, ,		
office visit	Included in Office visit co-pay		Included in Office visit co-pay
			\$10 co-pay
Specialist office visit only	\$50 co-pay	50% co-insurance	Plan pays 100% of Allowed
Procedures performed during an	Included in Specialist visit co-		Included in Specialist visit co-
office visit	pay		pay
			\$10 co-pay
Urgent Care	\$75 co-pay	50% co-insurance	Plan pays 80%of Allowed
Preventative Services - Child &			. ,
Adult	100%	100%	100%
Outpatient Lab & X-Ray*	80% of PHCS negotiated fee	50% after deductible	Plan pays 80% of Allowed
Outpatient Services Facility*	80% of PHCS negotiated fee	50% after deductible	Plan pays 80% of Allowed
Outpatient Services Physician*	80% of PHCS negotiated fee	50% after deductible	Plan pays 80% of Allowed
Emergency Services			
Emergency Room*	80% after deductible	50% after deductible	Plan pays 80% of Allowed
Ambulance*	80% of PHCS negotiated fee	50% after deductible	Plan pays 80% of Allowed
Hospital Benefits	00 % OF FIES Hegotiated fee	30 % arter deductible	Fian pays 60 % of Anowed
Hospital Belletits			\$100 co-pay, Plan pays 80% of
Inpatient*	80% of PHCS negotiated fee	50% after deductible	Allowed
Inpatient Professional Services*	80% of PHCS negotiated fee	50% after deductible	Plan pays 80% of Allowed
Mental Inpatient*	80% of PHCS negotiated fee	50% after deductible	Not covered
	00 % of 1 1100 negotiated fee	30 % after deductible	Not covered
Additional Outpatient Services	000/ 15 PUIO	500/ - 5/ - 1 - 1 - 1 - 1	No. 1
Skilled Nursing*	80% of PHCS negotiated fee	50% after deductible	Not covered
Chiropractic/Acupuncture*	80% of PHCS negotiated fee	50% after deductible	Not covered
Physical/Occupational Services	000/ of DUCC magatists of fac	FOO/ often deductible	Not sovered
(Medical Necessity)*	80% of PHCS negotiated fee	50% after deductible	Not covered
Rehabilitation Services*	80% of PHCS negotiated fee	50% after deductible	Not severed
Mental Outpatient*	80% of PHCS negotiated fee	50% after deductible	Not covered
Substance Abuse Outpatient (12 visit maximum)*	80% of PHCS negotiated fee	50% after deductible	Not severed
			Not covered
Durable Medical Equipment*	80% of PHCS negotiated fee	50% after deductible	Not occurred
Pediatric Dental & Vision	ACA Required Benefits	ACA Required Benefits	Not covered
Prescriptions	\$10 co nov	Not occurred	\$10 oc nov
Generic	\$10 co-pay	Not covered	\$10 co-pay
Brand Non Formulary	\$25 co-pay	Not covered	\$40 co-pay Formulary
Brand Non-Formulary	\$40 co-pay	Not covered	\$75 co-pay Non-Formulary
Mail Order (90 Days)	\$20 a	Not occurred	Not occurred
Generic	\$20 co-pay	Not covered	Not covered
Preferred	\$50 co-pay	Not covered	Not covered
Non-Preferred	\$80 co-pay	Not covered	Not covered

^{*}Subject to Deductible