Transwestern
Insurance Administrators, Inc.

	Option #1	Option #2
Benefits	**MEC PLAN**	**MV PLAN**
Per Person/Per Family	$0.00	$5,000/$10,000
Maximum Out of Pocket	$0.00	$6,350/$12,700
Percentage Payable	100%	130% of Medicare Allowed
Professional Services	**Preventative Services Only**	**Services must be provided by Providers within the Healthsmart Network**
Physician office visits	Not covered	$25 co-pay
Specialist office visit	Not covered	$50 co-pay
Urgent Care	Not covered	$50 co-pay
Procedures performed during an office/ specialist visit	Not covered	25% of Negotiated Fee
Lab & X-ray in office	Not covered	25% after Deductible*
Lab & X-Ray Outpatient Complex Imaging – CAT, MRI, MRA/MRI & PET SCANS	Not covered	25% after Deductible*
Preventative Services - Child & Adult	**100%**	**100%**
Outpatient Services		**Referenced Based Pricing**
Facility	Not covered	130% Medicare Allowed*
Physician	Not covered	130% Medicare Allowed*
Emergency Services		
Emergency Room – Facility and Physician	Not covered	130% Medicare Allowed*
Ambulance	Not covered	130% Medicare Allowed*
Hospital Benefits		
Facility	Not covered	130% Medicare Allowed*
Physician	Not covered	130% Medicare Allowed*
Mental Health	Not covered	130% Medicare Allowed*
Substance Abuse	Not covered	130% Medicare Allowed*
Additional Services		
Chemotherapy/Radiation Therapy	Not covered	130% Medicare Allowed*
Skilled Nursing	Not covered	130% Medicare Allowed*
Chiropractic/Acupuncture	Not covered	130% Medicare Allowed*
Physical/Occupational/Speech	Not covered	130% Medicare Allowed*
Mental Outpatient	Not covered	130% Medicare Allowed*
Durable Medical Equipment	Not Covered	Not Covered
Sleep Disorder – Medically Necessary	Not covered	130% Medicare Allowed*
Substance Abuse Outpatient	Not covered	130% Medicare Allowed*
Pediatric Dental & Vision	ACA Required Benefits	ACA Required Benefits
Prescriptions		
Generic	Not covered	$25.00 co-pay
Brand Formulary	Not covered	$50.00 co-pay
Brand Non-Formulary	Not covered	$75.00 co-pay
Mail Order (90 Days)		
Generic	Not covered	$55.00 co-pay
Preferred	Not covered	$100.00 co-pay
Non-Preferred	Not covered	$150.00 co-pay
Specialty Medication	Not covered	Not Covered
Monthly Cost		**Mexico Panel (Listed below)**
Option #1 Mec Plan: EE Only $0.00 EE+Spouse $5.40 EE+Child(ren) $4.50 EE+Family $9.00 **Option#2** MV Plan:EE Only $153.81 EE+Spouse $439.42 EE+Child(ren) $332.31 EE+Family $641.71		$5.00 Office Visit Co-pay $10.00 Specialist Visit Co-pay Lab & X-Ray:Plan pays 80% $10.00 Co-pay Generic Medication $20.00 Co-pay Brand Medication $100.00 Co-pay, plan pays 80% of Hospital services

Beneficios	Opción #1	Opción #2
Servicios	**MEC PLAN**	**MV PLAN**
Deducible Anual		
Por Persona/Por Familia	**$0.00**	**$5,000/$10,000***
Límite de gastos de su bolsillo	**$0.00**	**$6,350/$12,700***
Porcentaje Pagable	**100%**	**130% de lo permitido de Medicare**
Servicios Profesionales	**Solamente servicios preventivos**	**Los servicios deben ser hechos por proveedores dentro de la Red de Healthsmart**
Visitas de oficina	No es cubierto	$25 copago
Visita en oficina de Especialista solamente	No es cubierto	$50 copago
Cuidado Urgente	No es cubierto	$50 copago
Procedimientos hechos durante una visita en oficina/visita de especialista	No es cubierto	25% de lo permitido
Laboratorio y Rayos X en oficina	No es cubierto	25% de lo permitido*
Paciente Externo – Laboratorio y Rayos X	No es cubierto	25% de lo permitido*
Servicios Preventivos – Nino y Adulto	**100%**	**100%**
Servicios de Emergencia		
Cuarto de Emergencia	No es cubierto	130% de lo permitido de Medicare*
Ambulancia	No es cubierto	130% de lo permitido de Medicare*
Beneficios de Hospital		
Paciente Internado	No es cubierto	130% de lo permitido de Medicare**
Servicios Profesionales para Pacientes Internado	No es cubierto	130% de lo permitido de Medicare*
Paciente Internado Mental	No es cubierto	130% de lo permitido de Medicare*
Servicios Adicionales de Paciente Externo		
Quimioterapia / Radiacion	No es cubierto	130% de lo permitido de Medicare*
Enfermería Especializada	No es cubierto	130% de lo permitido de Medicare*
Quiropráctica/Acupuntura	No es cubierto	130% de lo permitido de Medicare*
Físico/Ocupacional	No es cubierto	130% de lo permitido de Medicare*
Paciente Externo Mental	No es cubierto	130% de lo permitido de Medicare*
Equipo Duradero	No es cubierto	130% de lo permitido de Medicare*
Desorden del Sueno	No es cubierto	130% de lo permitido de Medicare*
Abuso de Substancias Paciente Externo	No es cubierto	130% de lo permitido de Medicare*
Dental y Visión Pediátrico	Beneficios Requeridos por ACA	Beneficios Requeridos por ACA
Prescripciones/Receta		
Genérico	No es cubierto	$25.00 copago
Marca Formulario	No es cubierto	$50.00 copago
Marca No Formulario	No es cubierto	$75.00 copago
Prescripciones Por Correo (90dias)		
Genérico	No es cubierto	$55.00 copago
Marca Formulario	No es cubierto	$100.00 copago
Marca No Formulario	No es cubierto	$150.00 copago
Costo Mensual		**Los servicios de Mexico Panel**
Option #1 Mec Plan: EE Only $0.00 EE+Spouse $5.40 EE+Child(ren) $4.50 EE+Family $9.00 **Option#2** MV Plan:EE Only $153.81 EE+Spouse $439.42 EE+Child(ren) $332.31 EE+Family $641.71		$5.00 Visita de Oficina Co-pago $10.00 Visita de Oficina Especializada Co-pago Laboratorio & Rayos X: El plan paga el 80% $10.00 Co-pago Medicinas Genérico $20.00 Co-pago Medicinas de Marca $100.00 Co-pago, el plan paga el 80% de servicios en el Hospital

2404 Kern Ridge Growers, LLC

	Mexico Benefits
	Mexicali, B.C., Mexico San Luis, R.C., Sonora Mexico Tijuana, B.C., Mexico
Annual Deductible	
Per Person	$0.00
Per Family	$0.00
Maximum out of pocket	$0.00
Emergency Services	
Emergency Room	Plan pays 80%
Ambulance	Plan pays 80%
Hospital Benefits	
Inpatient	$100 co-pay, 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)	$5 co-pay
Specialist (Office)	$10 co-pay
Urgent Care Facility/Service	$5 co-pay
Preventative Services – Child & Adult	100%
Outpatient Lab & X-Ray	Plan pays 80% of Maximum Allowable Charge
MRI/PET/CT Scan	Plan pays 80% of Maximum Allowable Charge
Outpatient Services	
Outpatient Surgeon Benefits	Plan pays 80% of Maximum Allowable Charge
Outpatient Surgical Facility	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	Not Covered
Pediatric Dental & Vision	Not Covered
Prescriptions	
Generic	$10.00 co-pay
Brand Formulary – Available only when generic is not available	$20.00 co-pay
Brand Non-Formulary	Not Covered
Specialty	Not Covered