Transwestern
Insurance Administrators, Inc.

Vessey & Company, Inc. Benefits
October 1, 2023 – September 30, 2024

	Plan I Mexico	Plan II MEC Plus Plan	Plan III Buy Up
Annual Deductible			
Per Person	N/A	N/A	$1,000
Per Family	N/A	N/A	$2,000
Maximum out of pocket	N/A	N/A	$4,000/$8,000
Calendar Year Maximum Benefit	$25,000	$25,000 (Mexico)	$25,000 (Mexico) Unlimited
			Network-PHCS Provider/Facility Non network physicians/facilities payable at 140% of Medicare
Professional Services			
Medical Treatment (Office) *9 visits maximum any combination, not to exceed 3 Specialist visits	$5 co-pay	$20 co-pay*	$25 co-pay
Specialist (Office) Benefit includes lab & x-ray in office	$10 co-pay	$40 co-pay* 3 visit maximum	$45 co-pay
Urgent Care Facility/Service	$20 co-pay	$50 co-pay*	$45 co-pay
Outpatient Lab & X-Ray	$10 co-pay	Plan pays 80% 3 visit maximum	$45 co-pay
Preventative Services – Child & Adult	100%	100%	100%
Pediatric Dental & Vision	N/A	ACA Required	ACA Required
			Benefits Below are Subject to Deductible
Outpatient Services			
Outpatient Surgeon Benefits	Plan pays 80%	Not Covered	Plan pays 80%
MRI/PET/CT Scan Free Standing Facility Only	Plan pays 80%	Plan pays 80% 1 test maximum	Plan pays 80%
Ultrasound/mammogram	$25 co-pay		
Emergency Services		$25,000 Calendar Year Max Benefit Emergency Only	
Emergency Room	$25 co-pay Plan pays 80%		140% of Medicare Allowed
Ambulance	Plan pays 80%		140% of Medicare Allowed
Hospital Benefits			
Inpatient	$75 co-pay, Plan pays 80%		140% of Medicare Allowed
Inpatient Professional Services	Plan pays 80%	$1,000 Ded + 140% of Medicare Allowed	140% of Medicare Allowed
Maternity & Newborn Care 48 hours following a vaginal delivery 96 hours following a cesarean delivery	Same as any other illness		140% of Medicare Allowed
Mental Inpatient	N/A	N/A	140% of Medicare Allowed
Additional Outpatient Services			
Skilled Nursing	N/A	N/A	140% of Medicare Allowed
Chiropractic/Acupuncture Services	N/A	N/A	140% of Medicare Allowed
Physical/Occupational Services (Medical Necessity)	N/A	N/A	140% of Medicare Allowed
Rehabilitation Services	N/A	N/A	140% of Medicare Allowed
Mental Outpatient	N/A	N/A	140% of Medicare Allowed
Substance Abuse Outpatient (12 visit maximum)	N/A	N/A	140% of Medicare Allowed
Durable Medical Equipment	N/A	N/A	140% of Medicare Allowed
Prescriptions			
Generic **10 Rx maximum, not to exceed 5 Brand	$5.00 co-pay	$5.00 co-pay**	$10.00 co-pay
Brand Formulary	$10.00 co-pay	$30.00 co-pay** 5 Rx Max	$25.00 co-pay
Brand Non-Formulary	50%	N/A	$65.00 co-pay
Maintenance Meds	$15 co-pay	$15 co-pay	$15 co-pay
Specialty	N/A	N/A	N/A

24/7 CALL A DOC You must activate your account to access this benefit.	Not covered	Not covered	$0 co-pay https://www.247calladoc.com/activation or call 844-362-2447

Minimum Essential Coverage & Mexico Panel included in all plans. Panel offered in Mexicali, B.C., San Luis, R.C., Sonora and Tijuana, B.C.

LIFE INSURANCE

TYPE OF COVERAGE	BENEFIT
Employee Life	$5,000.00
Benefits reduce 65% at age 65; 45% at age 70; 30% at age 75; Terminates at retirement.	
Accidental Death & Dismemberment	
Maximum Employee Benefit	$5,000.00

Vessey & Company, Inc.
Dental Plan
Summary of Benefits
Open Network

Deductible Amount	Mexico	U.S.
Individual/Family	$10/$30	$50/$150
Preventative	100%	100%
Basic	80%	80%
Major	60%	60%
Annual Maximum	$1,000 per Family Member	
Percentage Payable	Refers to the percentage of "Reasonable & Customary" as noted below	

Remember – This is an Open Network Plan, meaning you can obtain services from a Provider of Choice but claims will be paid as noted under Percentage Payable & per Plan Design.

Description	Percentage Payable
Visits and Examinations……	100%
X-Rays ……	100%
Prophylaxis / Cleanings ……...	100%
Restorative Dentistry ……	80%
Crowns ……...	60%
Endodontics ……..	80%
Periodontics ……...	80%
Dentures & Bridges ……..	60%
Extraction / Oral Surgery ……..…	80%
General Anesthesia ……..……	80%
Orthodontia ……	Not Covered

Pre-Existing Condition

A pre-existing dental condition is any planned "treatment program", which was proposed, or teeth which were missing prior to the date the person became eligible under the Plan.

Dental Benefits Extension

If your eligibility ends after a "treatment program" has begun for you or one of your eligible dependents, benefits will be extended for a maximum of 90 days to allow completion of any dental work which was part of that "treatment program" only.

Covered Dental Expense

Unless specifically excluded or limited by the Plan provisions, covered expense includes charges made by a:

Dentist for diagnostic x-rays, cleanings, fluoride treatments for children under age 19, routine exams and emergency palliative treatment.
Dental Hygienist for cleaning, if the hygienist is working under the supervision of a dentist.
Technician or Laboratory for materials or X-rays ordered by a dentist as long as they do not duplicate charges for services billed by the dentist.

Actual payment for covered expenses listed above is limited to customary & reasonable or contracted fees for the services performed, subject to any deductible, percentage payable and benefits maximums shown on the "schedule of dental plan benefits".

Dental Expense Limitations

Covered Expense for the following services is limited as shown below:

1. **Examinations and/or Prophylaxis** – limited to 2 routine exams and 2 prophylaxes (with or without fluoride) in any 1 Calendar year.
2. **Topical Fluoride** – limited to children under age 19. Only 1 treatment of topical fluoride is allowed in any 6 month period.
3. **Diagnostic X-rays** – limited to 1 full mouth X-ray series in a 36-month period and 2 supplemental bitewings in any 12 consecutive months.
4. **Dentures or Dental Appliances** – limited as follows:
    1. Benefit payment for any denture or bridge includes all repair or adjustments within 6 months of the date of placement.
    2. Services necessary to replace teeth extracted prior to your effective date under the Plan will be paid at 50% of the regular plan benefits.

Dental Expense Not Covered

The following services are not covered under the Dental Plan:

1. Services performed for correction of congenital malformations or solely for Cosmetic reasons.
2. Replacement of a bridge or denture within 5 years of the originals date of installation for any reason, including loss or theft, unless:
    a) Necessary because of placement of a new opposing appliance;
    b) Due to extraction of additional natural teeth; or,
    c) The appliance, while in a patient's mouth was damaged beyond repair by an Accidental injury which occurred while covered by the Plan.
3. Replacement of any bridge or denture which is satisfactory or can be made satisfactory.
4. Any appliance or restoration, except full dentures, where the primary purpose is to change position of the teeth, stabilize teeth involved in periodontal or restore occlusion.
5. Duplicate dentures or appliance, dental implants, regardless of the diagnosis, or protective mouth guards.
6. Experimental procedures, training in plaque control or oral hygiene, or dietary instruction.
7. Charges for a patient's failure to keep a scheduled appointment or for completion of claim forms.
8. Orthodontic services, except space maintainers, regardless of the diagnosis.

Nothing in this section of the plan affects coverage under any medical or vision care benefits included in your health package.

Please call your TWIA customer service department at (800) 221-8942 for further information.

Note: This outline is for use as a reference only and is a summary of available benefits. It is not a contract. All benefits referenced are subject to ay applicable exclusions and/or limitations in your Transwestern Insurance Summary Benefits Description and member eligibility at the time services are rendered.

Vessey & Company, Inc.
Vision Plan
Summary of Benefits
Open Network

BENEFIT	DESCRIPTION	U.S. COPAY	Mexico COPAY
Well Vision Exam	• Focuses on your eyes and overall wellness • Every 12 months	**$10**	**$5**
Prescription Glasses		**$25**	**$10**
Frames	• $130 allowance for wide selection of frames • 20% savings on the amount over your allowance • $70 Costco frame allowance • Every 24 months	**Included in prescription Glasses**	**Included in prescription Glasses**
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	**Included in prescription Glasses**	**Included in prescription Glasses**
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Every 12 months	**$50** **$90** **$160**	**$50** **$80** **$120**
Contacts (Instead of glasses	• $130 allowance for contacts; copays does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	**Up to $60**	**Up to $60**
Extra Savings	**Retinal Screening** • No more than $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off		

Coverage/Frequency	Stateside	Mexico
Prescription Frames/Contacts (Every 24 Months)	$130.00 Allowance & 20% off Balance	$135.00 Allowance & 20% off Balance
Examination (Every 12 Months)	$10 co-pay	$5 co-pay
Lenses (1 Pair/Every 12 Months)	$25 co-pay	$10 co-pay
Contact Fitting	$60 Co-Pay	$60 Co-Pay
Single Vision, Bifocal, Trifocal, Lenticular	Included	Included
Additional Benefit	LASIK Discounts & Lens Enhancement Discounts	LASIK Discounts & Lens Enhancement Discounts

This is an Open Network Plan, meaning you can obtain services from Provider of Choice but claims will be paid according to the above Benefits.

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