	Plan 1 (locations 0001 & 0007) *Any medical plan has the option to choose dental and/or vision	
Benefits	**MEC Plus Plan**	**Mexico Panel**
Annual Deductible Per Person/Per Family	$250/$500	$0/$0
Maximum Out of Pocket Per Person/Per Family	$500/$1,000	$0/$0
Percentage Payable	100%	80%
	Professional Services Healthsmart PPO Network *services must be in network or they will not be covered	**Mexicali, B.C., Mexico San Luis, R.C., Mexico Tijuana, B.C., Mexico**
Physician office visits	$20 co-pay	$5 co-pay
Specialist office visit	$40 co-pay	$10 co-pay
Lab & X-ray in office	$40 co-pay	80% co-insurance
Lab & X-Ray Outpatient Complex Imaging – CAT, MRI, MRA/MRI & PET SCANS	$100 co-pay*	80% co-insurance
Preventative Services - Child & Adult	Covered at 100%	Covered at 100%
Urgent Care	$50 co-pay	$5 co-pay
Outpatient Services		
Facility	Not covered	80% co-insurance
Physician	Not covered	80% co-insurance
Emergency Services		
Emergency Room – Facility and Physician	Not covered	80% co-insurance
Ambulance	Not covered	80% co-insurance
Hospital Benefits		
Facility	Not covered	$100 co-pay & 80% co-insurance
Physician	Not covered	80% co-insurance
Pediatric Dental & Vision	ACA Required Benefits	Not covered
Prescriptions		
Generic	$10 co-pay	$10 co-pay
Brand Formulary	$20 co-pay	$20 co-pay
Brand Non-Formulary	$40 co-pay	Not covered
Specialty	Not covered	Not covered

***Subject to deductible**

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

	Plan 3 (locations 0003 & 0009) *Any medical plan has the option to choose dental and/or vision		
Proposed Benefits	**PPO Healthsmart In Network**	**Out of Network**	**Mexico Panel**
Annual Deductible Per Person/Per Family	$1,000/$2,000	$2,000/$4,000	$0/$0
Maximum Out of Pocket Per Person/Per Family	$5,000/$10,000	$12,000/$24,000	$0/$0
Percentage Payable	90%	50%	80%
Professional Services			
Physician office visits	$20 co-pay	50% co-insurance	$5 co-pay
Telemedicine – Through 24/7 Call A Doc	Covered at 100%	Covered under in network benefit	Not covered
Specialist office visit	$30 co-pay	50% co-insurance	$10 co-pay
Preventative Services – Child & Adult	Covered at 100%	Covered at 100%	Covered at 100%
Outpatient Services			
Lab & X-ray Outpatient Complex Imaging – CAT, MRI, MRA/MRI & PET Scans	$100 co-pay*	50% co-insurance*	80% co-insurance
Facility	90% co-insurance*	50% co-insurance*	80% co-insurance
Physician	90% co-insurance*	50% co-insurance*	80% co-insurance
Emergency Services			
Emergency Room – Facility and Physician	90% co-insurance*	50% co-insurance*	80% co-insurance
Ambulance	90% co-insurance*	50% co-insurance*	80% co-insurance
Hospital Benefits			
Facility	90% co-insurance*	50% co-insurance*	$100 co-pay & 80% co-insurance
Physician	90% co-insurance*	50% co-insurance*	80% co-insurance
Mental Health	90% co-insurance*	50% co-insurance*	Not covered
Substance Abuse	90% co-insurance*	50% co-insurance*	Not covered
Pediatric Dental & Vision	ACA Required Benefits	ACA Required Benefits	Not covered
Prescriptions			
Generic	$15 co-pay	$15 co-pay	$10 co-pay
Brand Formulary	$30 co-pay*	$30 co-pay*	$20 co-pay
Brand Non-Formulary	$50 co-pay*	$50 co-pay*	Not covered
Specialty	Not covered	Not covered	Not covered
***$250 RX Deductible applies combined between Brand formulary and non-formulary**			

***Subject to deductible**

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

Plan 4
(locations 0004, 0006, 0010, & 0012)
***Any medical plan has the option to choose dental and/or vision**
Dental Plan
Summary of Benefits

Procedure Type	Calendar Year Deductible
Type I Preventative Services	Not applicable
Type II Basic Services	$50 individual/$150 Family
Type III Major Services	
Type IV Ortho Services	Not covered

Procedure Type	Coinsurance
Type I Preventative Services	100%
Type II Basic Services	80%
Type III Major Services	50%
Type IV Ortho Services	Not covered

Benefit Waiting Periods

- **A late Entrant Benefit Waiting Period of 6 months for Type II Basic Restorations, 12 months for all other Type II Basic Services, and 12 months for Type III Major Services will apply to employees who enroll in this dental plan more than 31 days after becoming eligible**

Procedure Type	Calendar Year Maximum Benefit
Types I, II and III (Preventive, Basic and Major) Services	$1,500 per person

This plan includes Preventative Max Waiver, which makes regular dental checkups easy by not counting Type I Preventive expenses toward the annual plan maximum. This leaves more coverage for employees and their covered dependents when they need it most, encouraging employees to maintain good oral health with routine care.

Covered Dental Expenses

Type I Preventive covered dental expenses	**Coverage limitation**
Oral Evaluations	1in any 6 consecutive months
Dental Prophylaxis (Cleaning)	1 per 6 months – frequency combined with Periodontal Maintenance and is limited to 4 in any 12 months consecutive period
Fluoride Treatments	Covered Persons under age 14 1 in any 6 consecutive months
Sealants	Covered Persons under age 14 Once per tooth per 36 consecutive months on permanent first and second molars
Full Mouth X-Rays	1 in 60 consecutive months
Bite-Wing X-Rays	1 in 12 consecutive months
Intraoral X-Rays	4 Films in any 12 month period
Type II Basic covered dental expenses	**Coverage limitation**
Palliative Treatment	Paid as separate benefit only if no treatment, except x-rays, was rendered during the visit
Simple Extractions	No Limitation
Periodontal Maintenance	Periodontal Maintenance following active Periodontal Therapy – 1 per 6 months. The number of Dental Prophylaxis and Periodontal Maintenance is Combined and is limited to 4 in any 12 consecutive month period.
Amalgam Restorations	Once per tooth surface in any 24 consecutive months
Composite and Silicate Restorations	Once per tooth surface in any 24 consecutive months and excluding posterior teeth
Space Maintainers	Covered Persons under age 19 Once per tooth in any 3 year period
Periodontics (Non-Surgical): Scaling and Root Planning	Once per 24 consecutive months per area of the mouth
Surgical Periodontics	Once per 36 consecutive months per area of the mouth
Endodontics: Root Canal Therapy	Root Canal Therapy is limited to 1 time per tooth in any consecutive 24 months period
Oral Surgery: Surgical Extraction of Erupted and Impacted Teeth	Multiple surgical services on 1 area of the mouth will be based on the most inclusive procedure
General Anesthesia	Benefits payable as a separate expense only when required for the surgical Extraction of an impacted tooth
Type III Major covered Dental expenses	**Coverage limitation**
Inlays and Onlays	Covered if tooth cannot be restored by fillings Once per tooth in any 10 years period
Crowns	Covered if tooth cannot be restored by filling or other means Once per tooth in any 10 years period
Crown Buildup	Once per 10 years
Full or Partial Dentures	Once in any 10 years
Fixed Bridges	Once in any 10 years

Transwestern
Insurance Administrators, Inc.

Plan 5
(locations 0005, 0006, 0011 & 0012)
***Any medical plan has the option to choose dental and/or vision**
Vision Plan
Summary of Benefits

Covered Vision Expenses

Vision Insurance Schedule – Full Service		
BENEFIT	**Frequency**	**Member Cost**
Exam Services **WellVision Exam**	1 per 12 months	$10
Laser Vision Correction Discount	Once per eye per lifetime	• Average 15% off the regular price or 5% off the promotional price. • Discounts only available from contracted facilities.
Lenses **Single Lined** **Bifocal Lined** **Trifocal** **Lenticular** **Necessary Contacts**	1 per 12 months	$10 (lenses and frame)
Lens Enhancements **Standard progressive** **Premium progressive** **Custom progressive**		No cost $95 - $105 copay $150 - $175 copay Average savings of 20-25% On other lens enhancements
Frames **Includes a wide selection of frames at Walmart**	1 per 24 months	• $130 for the frame of your choice and 20% off the amount over your allowance • $70 allowance at Costco
Elective Contact Lenses **Contact lenses are in place of lenses and frame.**	1 per 12 months	• Up to $60 / 15% savings for your contact lens exam (fitting and evaluation) • $130 for contact lenses
Additional Glasses and Sunglasses Discount	20% off additional glasses and sunglasses, including lens options, on the same day as your exam.	
Coverage with Retail Providers	*Coverage with retail providers may be different. Check with Costco and Walmart for member discount. The Costco allowance is equivalent to the allowance at preferred providers and other retail providers.	