Transwestern
Insurance Administrators, Inc.

The Peterson Family Benefits

	Plan 1	Plan 2	Plan 3
Benefits	**MEC**	**MEC VALUE**	**MEC PLUS**
Annual Deductible Per Person/Per Family	$0	$0	$0
Maximum Out of Pocket	$0	$6,350/$12,700	$6,350/$12,700
Percentage Payable	100%	100%	80%
Professional Services		**Services must be provided by providers within the PHCS Network**	
Physician office visits	Not Covered	$10 co-pay (limit to 3 annual visits)	$15 co-pay then 100% of negotiated fee
Specialist office visit (Referral needed)	Not Covered	$10 co-pay (combined with 3 annual Physician office visits)	$25 co-pay then 100% of negotiated fee
Procedures performed during an office/ specialist visit	Not Covered	Not Covered	80% of Negotiated Fee
Lab & X-ray in office	Not Covered	$10 co-pay (limit to 3 annual visits)	$50 co-pay, then 100% of Negotiated Fee
Lab & X-Ray Outpatient Complex Imaging – CAT, MRI, MRA/MRI & PET SCANS	Not Covered	Not Covered	$400 co-pay, then 80% of Negotiated Fee
Preventative Services - Child & Adult	100%	100%	100%
Outpatient Services			
Facility	Not Covered	Not Covered	Not Covered
Physician	Not Covered	Not Covered	Not Covered
Emergency Services			
Emergency Room – Facility and Physician	Not Covered	Not Covered	$400 co-pay, then 80% of Negotiated Fee
Ambulance	Not Covered	Not Covered	Not Covered
Hospital Benefits			
Facility	Not Covered	Not Covered	Not Covered
Physician	Not Covered	Not Covered	Not Covered
Mental Health	Not Covered	Not Covered	Not Covered
Substance Abuse	Not Covered	Not Covered	Not Covered
Additional Services			
Chemotherapy/Radiation Therapy	Not Covered	Not Covered	Not Covered
Skilled Nursing	Not Covered	Not Covered	Not Covered
Chiropractic/Acupuncture	Not Covered	Not Covered	Not Covered
Physical/Occupational/Speech	Not Covered	Not Covered	Not Covered
Mental Outpatient	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	Not Covered	Not Covered	Not Covered
Sleep Disorder – Medically Necessary	Not Covered	Not Covered	Not covered
Substance Abuse Outpatient	Not Covered	Not Covered	Not Covered
Pediatric Dental & Vision	ACA Required Benefits	ACA Required Benefits	ACA Required Benefits
Prescriptions			
Generic	Not Covered	Not Covered	$25.00 co-pay
Brand Formulary	Not Covered	Not Covered	$50.00 co-pay
Brand Non-Formulary	Not Covered	Not Covered	$75.00 co-pay
Mail Order (90 Days)			
Generic	Not Covered	Not Covered	Not Covered
Preferred	Not Covered	Not Covered	Not Covered
Non-Preferred	Not Covered	Not Covered	Not Covered
Specialty Medication	Not Covered	Not Covered	Not Covered

24/7 CALL A DOC **You must activate your account to access this benefit.**	$0 co-pay	$0 co-pay	$0 co-pay
	https://www.247calladoc.com/activation or call 844-362-2447		