Transwestern Insurance Administrators, Inc.

Petroff Ag Services, Inc. Benefits

Calendar Year Deductible		**None**
Out-of-pocket limit on expenses		**$1,500.00 (Medical & Rx Combined)**
Provider Network		**Interplan/Healthsmart Network**
Common Medical Event	**Service Type**	**Member Cost Share**
(outpatient services – office visit, lab, x-ray, urgent care visits and Free Standing Facilities for MRI, CT and PET scans) ****Services provided outside of the Interplan/Healthsmart network for outpatient services are not covered by this plan**		
Health care provider's visit	Primary care visit to treat an injury or illness	$10 co-pay- member Plan pays 100% of allowed
	Specialist visit	$20 co-pay – member Plan pays 100% of allowed
	Urgent Care Facility/Service	$20 co-pay – member Plan pays 100% of allowed
	Preventive care/screening/immunization	No cost share – member Plan pays 100% of allowed
Tests	Diagnostic test (x-ray, blood work) Free Standing Facilities	$20 co-pay – member Plan pays 100% of allowed
	Imaging (CT/PET scans, MRIs) at a Free Standing Imaging Center, if performed in a hospital on an outpatient basis not covered	Not Covered
Outpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health outpatient services	Not Covered
	Substance use disorder outpatient services	Not Covered
Outpatient surgery	Facility fee (e.g., ASC)	Not Covered
	Physician/Surgeon fees	Not Covered
Need immediate attention	Emergency room services (waived if admitted)	Not Covered
	Emergency medical transportation	Not Covered
Hospital stay	Facility fee (e.g., hospital room)	Not Covered
	Physician/surgeon fee	Not Covered
Inpatient Mental health, Behavioral Health, or Substance abuse needs	Mental/Behavioral health inpatient services	Not Covered
	Substance use disorder inpatient services	Not Covered
Pregnancy	Delivery and all Inpatient Services — Professional Hospital	Not Covered
Help recovering or other special health needs	Home health care (60 days per calendar year)	Not Covered
	Rehabilitation services	$20 co-pay – member Plan pays 100% of allowed
	Habilitation services	Not Covered
	Skilled nursing facility (60 days per calendar year) Immediately following an in-patient stay.	Not Covered
	Chemotherapy/Radiation	Not Covered
	Dialysis	Not Covered
	Durable medical equipment ($2500 per benefit period)	Not Covered
	Hospice service ($2,500 calendar year max benefit)	Not Covered
Child needs **Child oral care Ages 0-11 mos, 1-4yrs, 5-10 yrs.**	Eye Exam	No cost share
	Glasses ($150 max benefit)	Not Covered
	Dental check-up – Preventive and Diagnostic Services	Not Covered
	Dental Basic Services ($1,000 calendar year max)	Not Covered
Drugs to treat illness or condition	Generic Drugs – Mandatory Generic	$5 co-pay
	Brand Subject to deductible Available only when generic is not available	Not Covered
	Specialty Medication	Not Covered
	Mail Order Rx - up to 90 Day Supply	$10 co-pay (Generics Only)