Transwestern
Insurance Administrators, Inc.

#2528 – Fondomonte Arizona, LLC

Benefits	MEC PLUS PLAN
Annual Deductible	
Per Person/Per Family	$0/$0
Maximum Out of Pocket	
Per Person/Per Family	$0/$0
Percentage Payable	75%
Professional Services	Services must be provided by Providers within the Healthsmart Network
Physician office visits	$10 co-pay then 100% of negotiated fee
Specialist office visit	$40 co-pay then 100% of negotiated fee
Lab & X-ray in office	75%
Lab & X-Ray Outpatient Complex Imaging – CAT, MRI, MRA/MRI & PET SCANS	75%
Preventative Services - Child & Adult	100%
Outpatient Services	
Facility	Not Covered
Physician	Not Covered
Emergency Services	
Emergency Room – Facility and Physician	Not Covered
Ambulance	Not Covered
Hospital Benefits	
Facility	Not Covered
Physician	Not Covered
Mental Health	Not Covered
Substance Abuse	Not Covered
Additional Services	
Chemotherapy/Radiation Therapy	Not Covered
Skilled Nursing	Not Covered
Chiropractic/Acupuncture	Not Covered
Physical/Occupational/Speech	Not Covered
Mental Outpatient	Not Covered
Durable Medical Equipment	Not Covered
Sleep Disorder – Medically Necessary	Not covered
Substance Abuse Outpatient	Not Covered
Pediatric Dental & Vision	ACA Required Benefits
Prescriptions	
Generic	$5 co-pay
Brand Formulary	$20 co-pay
Brand Non-Formulary	Not Covered
Mail Order (90 Days)	
Generic	Not Covered
Preferred	Not Covered
Non-Preferred	Not Covered
Specialty Medication	Not Covered

Transwestern
Insurance Administrators, Inc.

	Mexicare PPO
	Mexicali, B.C., México San Luis, R.C., Sonora México Tijuana, B.C., México
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 Therapy – Medical Necessary	Plan pays 80%
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

Transwestern
Insurance Administrators, Inc.

MEXICO DENTAL PANEL BENEFITS

Deductible Amount	Mexico
Individual/Family	$10/$30
Preventative	100%
Basic	80%
Major	60%
Annual Maximum	$2,500 per Family Member
Percentage Payable	Refers to the percentage of "Reasonable & Customary" as noted below

***Services provided by panel dentist will be paid in full according to the schedule of benefits. Panel providers are those dental providers contracted with Transwestern Insurance Administrators. The employee will be responsible for charges when treatment is rendered by a non-panel provider.**

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

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.

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 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 any applicable exclusions and/or limitations in your Transwestern Insurance Summary Benefits Description and member eligibility at the time services are rendered.