Memorial Hospital 2020

SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Covered Expenses", "Claim Review and Audit Program", and "Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *claims administrator* or the *Plan Administrator* for assistance.

The *plan year* for this *Plan* is the calendar year from January 1 through December 31 each year.

Plan Year Maximum Benefits

Plan year maximum benefits will accumulate toward any applicable lifetime maximum limits.

***Plan Year* Maximum Benefits per *Covered Person* for:**	
Skilled Nursing Facility Care	25 days
Chiropractic Care	$500
Routine Foot Care – Non-surgical	$2,000
Routine Mammogram Screening	1exam
Second Surgical Opinion – Per Surgery	$100
Organ Donor Expenses – Per Transplant, for any expenses for living or cadaver procurement	$100,000

Deductible

	PPO Network Providers* and Non-*PPO Network Providers
Plan Year Deductible	
• Individual	$1,000
• *Family Unit*	$3,000

Percentage Payable and Out-of-Pocket Expense Limits

	Hospital* Facilities *Ambulatory Surgery Centers* Dialysis Facilities and *PPO Network Providers	**Non-*PPO Network Providers***
Percentage Payable (unless otherwise stated)	80%	60%
Out-of Pocket Expense Limit		
• Individual	$4,000*	$8,000
• *Family Unit*	$9,000*	$17,000

*this amount includes the deductible, certain types of expenses are not eligible to accumulate toward the *out-of-pocket expense limit*. Please refer to the section, "Your Costs", for additional information.

Section I
Applicable to the following facilities:
Hospitals/Ambulatory Surgery Centers/Dialysis Facilities

Payment Levels and Limits – Hospital, Ambulatory Surgery Centers and Dialysis Facilities
This section of the Schedule of Medical Benefits applies only to covered expenses which are rendered by *hospital* facilities, *ambulatory surgery centers* and dialysis clinics and facilities. The benefits shown apply to all such covered, licensed *providers* of service without regard to participation in a *PPO*. **The plan has arranged direct agreements with Covenant Hospital in Lubbock, Memorial Hospital in Seminole, and will use Healthsmart PPO in Midland/Odessa only. We recommend using these facilities. Please note all claims incurred at Memorial Hospital will be covered at 90%.**

Outpatient Dialysis Services; This plan does not use a preferred provider organization for dialysis services, the in-network deducible and coinsurance will apply. Outpatient Dialysis Max Allowable for outpatient services is 125% of Medicare allowable fees and the plan will adjudicate the claim using in network benefits.

Percentage Payable For:	***Hospital Inpatient* Services**	Limits:
Medical/Surgical Room & Board & Ancillary	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Skilled Nursing Facility, Convalescent Care and Extended Care Facility	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	Limited to 25 days per *plan year* maximum
Mental or Nervous Disorder Inpatient	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Mental or Nervous Disorder Facility Outpatient	80% of *allowable claim limits* • *deductible* applies	
Substance Abuse Care *Inpatient*	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Substance Abuse Care Facility Outpatient	80% of *allowable claim limits* • *deductible* applies	
***Hospital* Emergency Room Services**		
Hospital Emergency Room - *Accident** or *Illness*	80% of *allowable claim limits* • *deductible* applies	
*Supplemental Accident Benefit	100% of *allowable claim limits* to $300 per *accident* – thereafter subject to *deductible* and reimbursed at 80% of *allowable claim limits*	
Hospital* Outpatient *Diagnostic Services		
Diagnostic X-ray and Laboratory	80% of *allowable claim limits* • *deductible* applies	
Routine Mammogram – Covered Persons Over Age 35	100 % of *allowable claim limits* • *deductible* waived	Limited to one exam per *plan year* maximum
Pre-Admission Testing	100% of *allowable claim limits* • *deductible* waived	
All Other Covered *Hospital* Services and Supplies		
All Other Covered Expenses	80% of *allowable claim limits* • *deductible* applies	
***Ambulatory Surgery Centers* Covered Services and Supplies**		
All Covered Expenses	80% of *allowable claim limits* • *deductible* applies	

Section II
Applicable to all other providers of service:

Payment Levels and Limits – Physician and Other Provider Expenses
The following tables apply to all *providers* of service other than *hospital* facilities, *ambulatory surgery centers* and dialysis facilities. Benefits are available, as shown, for reimbursement of *covered expenses* based upon the *provider's* participation in the *PPO network*.

***Physician* In-Hospital Services**			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Physician Medical Hospital Visit	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Physician – Mental or Nervous Disorder Hospital Visit	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Physician – Substance Abuse Hospital Visit	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	

Second Surgical Opinion Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Office Visit For Second Surgical Opinion	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	

Surgical Services – *Inpatient* and Outpatient/Office			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Anesthesia	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Assistant Surgeon	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	Limited to 25% of surgical fee allowance
Obstetrical	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Surgeon – Office	$25 copayment in Seminole, then 100% $50 copayment elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	
Surgeon – All Other	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	

Physician's Office and Outpatient Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
All *Covered Expenses*, Including: • Office Visit • *Surgery* • Lab or X-rays • Allergy Care • Injections • Other Covered Services	$25 office copay, then 100% up to $200 for additional services, charges above are subject to deductible and coinsurance in Seminole $50 office copay elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	
Mental or Nervous Disorder Office Visit and Outpatient	$25 office copay, then 100% up to $200 for additional services, charges above are subject to deductible and coinsurance in Seminole $50 copay elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	
Substance Abuse Office Visit and Outpatient	$25 office copay, then 100% up to $200 for additional services, charges above are subject to deductible and coinsurance $50 copay elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	

Preventive Care Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Preventive Care Services- (*Must be billed with a routine diagnosis*) • This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar test.	100% Deductible waived	Not covered	$1,000 per calendar year for all preventative services, charges above are subject to deductible and coinsurance
Preventive Care Services Enhanced- *(must be billed with a routine diagnosis).* • Mammograms, once every year (age 40 or older) • Choice between sigmoidoscopy or a colonoscopy once every 5 years (age 50 or older.)	100% Deductible waived	Not covered	$1,000 per calendar year for all preventative services, charges above are subject to deductible and coinsurance
Family Planning- Permanent Procedures for Women *Includes:* • *Sterilization*	100% Deductible waived	Not covered	$1,000 per calendar year for all preventative services.

Preventive Care Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Family Planning- Temporary procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	100% Deductible waived	60%	$1,000 per calendar year for all preventative services, charges above are subject to the deductible and coinsurance
Routine Vision Exam age 5 and over- *Limited to one exam per person per Plan Year.*	100% Deductible waived	60%	$1,000 per calendar year for all preventative services, charges above a re subject to the deductible and coinsurance

Chiropractic Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Chiropractic Care and Therapies	$20 copayment, then 100%	60% of *usual, customary and reasonable* fees • *deductible* applies	

Other Covered Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Therapy • Physical • Occupational • Speech • IV and Infusion • Cardiac Rehabilitation	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Chemotherapy and Radiation Therapy	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Durable Medical Equipment	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Home Health Services	100% of *PPO* rate • *deductible* applies	100% of *usual, customary and reasonable* fees • *deductible* applies	
Hospice	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	
Routine Non-Surgical Foot Care	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	Limited to $2,000 per *plan year* maximum benefit
Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Pre-Admission Testing	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable* fees • *deductible* waived	

Other Covered Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Ambulance— Air or Ground Transportation	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	$2,500 per treatment
Blood and Administration	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Oxygen and Administration	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Prosthetic Devices	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Lenses Following Cataract Surgery	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Supplemental Accident Benefit	100% of *PPO* rate to $300 per accident – thereafter subject to *deductible* and reimbursed at 80% of *PPO* rate	100% of *usual, customary and reasonable* fees to $300 per accident – thereafter subject to *deductible* and reimbursed at 60% of *usual, customary and reasonable* fees	
Prescription Drugs	100% of *usual, customary and reasonable* fees, *deductible* waived, subject to copayments as follows: • $10 per prescription or refill for generic drugs, or • $50 per prescription or refill for brand with no generic • $100 per prescription or refill with generic available		Limited to 30-day supply per purchase
All Other *Covered Expenses*	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	

Memorial Hospital

" DENTAL SCHEDULE OF BENEFITS"

DEDUCTIBLE	
Per Person	$50
Family Deductible	$150
COINSURANCE	
TYPE A; Preventive, Diagnostic, Emergency Services,	80%
TYPE B; Restorative and Surgical Procedures, Prosthodontia Procedures, and Orthodontic Procedures	50%
LIMITS	
Calendar Year Maximum per Person	$1,000
Orthodontic Lifetime Maximum	$500

TYPE A

1. Oral Exam-Initial Exams(limited to 1 per year) Recall Exams(limited to 2 per year) Emergency treatment for relief of pain or discomfort;
2. Radiographs and radiographic interpretations, complete series of radiographs or panographic x-rays(limited to 1 every three years), sets of bitewing radiographs to diagnose a symptom or examine progress of course of treatment;
3. Prophylaxis(limited to 2 per calendar Year);
4. Periodontal Prophylaxis;
5. Sealants and Topical Fluoride Applications, under the age of 16;
6. Space Maintainers, under the age of 14, for missing teeth;

TYPE B

1. Amalgam Restorations/Fillings;
2. Silicate, Plastic, and Composite Restorations(not for posterior teeth);
3. Extraction of teeth;
4. Performed stainless steel crowns and repairs to preformed stainless steel crowns
5. Endodontics-root can therapy and root can fillings, treatment of disease of the pulp tissue;
6. Periodontics-treatment of disease of the gum and other supporting tissues of the teeth not including splints with cast restorations;
7. Surgery and related general anesthetic;
8. Emergency or palliative services;
9. Diagnostic tests and lab exams excluding x-rays, study models, or similar records prepared for orthodontic procedures;
10. Repair of bridges, dentures or crowns(only if 6 months from date of original placement);
11. Scaling and root planning(limit to 2 times per quadrant in any 12 month period);
12. Provisional splinting;
13. Periodontal appliances;
14. Pin retention(limited to 2 pins per tooth);
15. Initial inlays and onlays
16. Initial crowns other than preformed stainless steal
17. Replacement inlays, onlays, and crowns
18. Porcelain restorations, only if the tooth cannot be restored by a filing or other means
19. Prosthodontia services (after 12 months of continuous coverage)
20. Gold post and core (only for teeth that have had root canal therapy)
21. Frenectomy

COVERAGE OFFERED ONLY TO ELIGIBLE DEPENDENTS UNDER AGE 19 WHEN TREATMENT BEGAN:

22. Interceptive, interventive, or preventive orthodontic services-other than space maintainers
23. Fixed appliances (includes diagnostic procedures, formal full banded treatment, and retention)
    A. Permanent dentition
    B Mixed dentition
    C. Deciduous dentition
24. Removable appliance (includes diagnostic procedures, removable appliance therapy, and retention)
    A. Permanent dentition
    B. Mixed dentition
    C. Deciduous dentition
25. Fixed or cemented appliances (1 per person) to control harmful habits.

DENTAL BENEFIT LIMITATIONS

NO BENEFITS PAYABLE FOR:

* Charges for any dental care, treatment or supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures
* Charges for the replacement of a lost or stolen prosthetic device
* Any charges incurred prior to the date on which these dental benefits become effective with respect to the individual on whose account the charges are incurred, and charges for any appliances or supplies which are ordered for that individual prior to that date
* Dental care not included in the list of defined eligible expenses
* Dental care which is furnished while a person is confined in a hospital operated by the U.S. government or any agency thereof, or dental care for which the person would not be required to pay if there were no insurance
* Dental care arising out of or in the course of employment for pay or profit and which is covered by Workers Comp or a similar law
* Dental care resulting from any injury sustained as a result of war, declared or undeclared, or any action of war, or any resistance to armed invasion or aggression
* Charges made by a Dentist or Dental Hygienist who is a member of your immediate family
* Dental care resulting from participating in a felony
* Treatment of TMJ and Orthognathic surgery unless specified under the medical insurance
* Dental care which is experimental or does not meet standards accepted by American Dental Association
* Charges for missed appointments
* Implants or implantology

LIMITATION ON LATE ENTRANTS

For the first 24 months that a late entrant is covered under the Dental Plan, benefits will be limited as follows:

1. First 12 months; only covered by Type A benefits, and
2. Second 12 months: limited to Type A and Type B benefits