PARKVIEW HOSPITAL SCHEDULE OF MEDICAL BENEFITS 2020

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	$10,000

Deductible

	PPO Network Providers* and Non-*PPO Network Providers
Plan Year Deductible	
Individual	$1,000
Family Unit	$3,000
Individual with treatment at Parkview Hospital	$250

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)	70%	50%
Percentage Payable at Parkview	90%	
Out-of Pocket Expense Limit		
Individual	$4,500	$15,000
Family Unit	$13,500	$35,000
Parkview Hospital	$1,500	
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 Baptist St. Anthony in Amarillo, Covenant Hospital in Lubbock, and Parkview Hospital. We recommend using these facilities. Please note all claims for covered services rendered at Parkview Hospital will be covered at 90%.**

Percentage Payable For:	***Hospital Inpatient* Services**	Limits:
Medical/Surgical Room & Board & Ancillary	70% of *allowable claim limits* for semi-private room and ancillary charges *deductible* applies	
Skilled Nursing Facility, Convalescent Care and Extended Care Facility	70% 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	70% of *allowable claim limits* for semi-private room and ancillary charges *deductible* applies	
Mental or Nervous Disorder Facility Outpatient	70% of *allowable claim limits* *deductible* applies	
Substance Abuse Care *Inpatient*	70% of *allowable claim limits* for semi-private room and ancillary charges *deductible* applies	
Substance Abuse Care Facility Outpatient	70% of *allowable claim limits* *deductible* applies	
***Hospital* Emergency Room Services**		
Hospital Emergency Room - *Accident** or *Illness*	70% 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 70% of *allowable claim limits*	
Hospital* Outpatient *Diagnostic Services		
Diagnostic X-ray and Laboratory	70% 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	70% of *allowable claim limits* *deductible* applies	
***Ambulatory Surgery Centers and Dialysis Facilities* Covered Services and Supplies**		
All Covered Expenses	70% of *allowable claim limits* *deductible* applies	
Dialysis Facilities		
All *Covered Expenses*	Charges limited to 125% of the Medicare allowed amount, reimbursed at 70% *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	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Physician – Mental or Nervous Disorder Hospital Visit	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Physician – Substance Abuse Hospital Visit	70% of *PPO* rate *deductible* applies	50% 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	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Assistant Surgeon	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	Limited to 25% of surgical fee allowance
Obstetrical	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Surgeon – Office	Subject to deductible and coinsurance	50% of *usual, customary and reasonable* fees *deductible* applies	
Surgeon – All Other	70% of *PPO* rate *deductible* applies	50% 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 Lab or X-rays Allergy Care Injections Other Covered Services	$20 office copay at Parkview, $50 office copay elsewhere, , then 100% up to $500 for additional services, charges above are subject to deductible and coinsurance	50% of *usual, customary and reasonable* fees *deductible* applies	

Chiropractic Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Chiropractic Care and Therapies	$40 copayment, then 100%	50% of *usual, customary and reasonable* fees *deductible* applies	Limited to $500per *plan year* maximum benefit

Other Covered Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Therapy Physical Occupational Speech IV and Infusion Cardiac Rehabilitation	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Chemotherapy and Radiation Therapy	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Durable Medical Equipment	70% of *PPO* rate *deductible* applies	50% 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	70% of *PPO* rate *deductible* applies	50% 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	70% of *PPO* rate *deductible* applies	50% 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	
Routine Mammogram – *Covered Persons* Over Age 35	100 % of *PPO* rate *deductible* waived	100% of *usual, customary and reasonable* fees *deductible* waived	Limited to one exam per *plan year* maximum
Ambulance Air or Ground Transportation	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	Limited to $3,500 per trip

SCHEDULE OF MEDICAL BENEFITS (Continued)

Blood and Administration	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Oxygen and Administration	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Prosthetic Devices	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	
Lenses Following Cataract Surgery	70% of *PPO* rate *deductible* applies	50% 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 70% of *PPO* rate	100% of *usual, customary and reasonable* fees to $300 per accident – thereafter subject to *deductible* and reimbursed at 50% 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 30% 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*	70% of *PPO* rate *deductible* applies	50% of *usual, customary and reasonable* fees *deductible* applies	

Claims Audit

After a Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges and (c) charges beyond the Usual, Customary and Reasonable guidelines as determined by the Plan.

1) Change definition:

"Usual, customary and reasonable" or "usual, customary and reasonable fees" *("UCR")* means services and supplies which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the *Plan Administrator*, taking into consideration, but not limited to:

- The fee which the *provider* most frequently accepts or charges the majority of patients for the service or supply;
- The prevailing range of fees accepted or charged in the same Area by *providers* of similar training and experience for the service or supply; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

For claim determinations made in accordance with the Claim Review and Audit Program, the *UCR* fee will be the *allowable claim limits*. Please refer to the section, "Claim Review and Audit Program" for the definition of *allowable claim limits*.

"Area" means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of *providers* rendering such services or furnishing such supplies.

Parkview Hospital

" DENTAL SCHEDULE OF BENEFITS"

DEDUCTIBLE	
Per Person	$100
Family Deductible	$300
COINSURANCE	
TYPE A; Preventive, Diagnostic, Emergency Services,	100%
TYPE B; Restorative and Surgical Procedures, Prosthodontia Procedures,	80%
TYPE C; Major Care Services – 12 month wait from effective date	50%
TYPE D; Orthodontic Care Services	50%
LIMITS	
Calendar Year Maximum per Person-first year of coverage	$500
Calendar Year Maximum per Person-second year and after	$1.500

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 14;
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 canal therapy and root canal 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. Scaling and root planning(limit to 2 times per quadrant in any 12 month period);
11. Provisional splinting;
12. Periodontal appliances;
13. Pin retention(limited to 2 pins per tooth);

TYPE C

1. Repair of bridges, dentures or crowns(only if 6 months from date of original placement);
2. Initial inlays and onlays
3. Initial crowns other than preformed stainless steal

Missing tooth clause - yes 5yrs
IMPLANTS NOT COVERED

Replacement Clause 5 yrs

4. Replacement inlays, onlays, and crowns
5. Porcelain restorations, only if the tooth cannot be restored by a filing or other means
6. Prosthodontia services (after 12 months of continuous coverage)
7. Gold post and core (only for teeth that have had root canal therapy)
8. Frenectomy
9. Removable appliance (includes diagnostic procedures, removable appliance therapy, and retention)
    A. Permanent dentition
    B. Mixed dentition
    C. Deciduous dentition
10. Fixed or cemented appliances (1 per person) to control harmful habits.

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

11. Interceptive, interventive, or preventive orthodontic services-other than space maintainers
12. Fixed appliances (includes diagnostic procedures, formal full banded treatment, and retention)
    A. Permanent dentition
    B Mixed dentition
    C. Deciduous dentition

Type D

Orthodontic Care Services- only eligible for dependent children age 18 or younger

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