**Memorial Hospital**

**“ MEDICAL SCHEDULE OF BENEFITS” NON-PPO PPO Mem Hosp Semi Phy**

 Payments subject to

 Maximum Allowable\*\*

DEDUCTIBLES

Individual - - - - - - - - - - - - - - - $1,000 - - - - - - - - - - - - - - -

Family - - - - - - - - - - - - - - - $3,000 - - - - - - - - - - - - - - -

Pre-Certification Treatment Penalty - - - - - - - - - - - - - - - -$250 - - - - - - - - - - - - - - --

(90-day carryover for deductible)

CO-INSURANCE / (OUT OF POCKET)

Individual - 50%\*\* 80% 90%

Out of Pocket after Deductible $4,000\*\* $2,000 $1,000

Family Out of Pocket after Deductible $12,000\*\* $6,000 $3,000

COPAYS

Doctor's Office Visits 50%\*\* subject $25 $20

then Lab,X-ray, and injections to Deductible

received in conjunction of the office visit

covered at 100%with a maximum benefit of

$200 for those services

SUPPLEMENTAL ACCIDENT BENEFITS - - - - - - - - - - - first $300 at 100% - - - - - - - - - remainder subject to ded and coinsurance

WELLNESS BENEFITS 100% 100% 100%

 $300 covered per plan yr charges above not covered

PRESCRIPTION DRUG

Prescriptions generic $10 copay, brand with no generic $50

 brand with generic available $50 plus 50% of cost of Rx

ANNUAL MAXIMUM BENEFIT - - - - - - - - - - - - -$2,000,000 - - - - - - - - - - - - -

(per person)

TRANSPORTATION - - - $2,500 maximum benefit per confinement - -

Air, Ambulance, or Rail

MATERNITY - - - - - - - - - - as any other illness - - - - - - - - - -

Employee or Spouse only

HOME HEALTH CARE

Home Health Care Visit 50%\*\* 80%\* 90%

Home Health Care Limits $100 per day Usual and customary

SUBSTANCE ABUSE/MENTAL OR NERVOUS DISORDERS

(alcohol or controlled substance)

Inpatient/Out Patient Co-Insurance 50%\*\* 80%\* 90%\*

CHIROPRACTIC CARE

Co-Insurance 50%\*\* $25 $20

Limits - - -$500 maximum benefit per calendar year - - -

SKILLED NURSING FACILITY

Co-Insurance 50%\*\* 80%\* 90%\*

HOSPICE CARE 50% 80% 90%

TEMPOROMANDIBULAR JOINT SYNDROME

Co-Insurance 50%\*\* 80%\* 90 %\*

Limits - - - - - - - - - - $1,000 lifetime benefit - - - - - - - -

DURABLE GOODS

Co-Insurance 50%\*\* 80%\* 90 %\*

 $10,000 lifetime maximum benefit

**Outpatient Dialysis Services:** The Plan does not use a preferred provider organization for dialysis services. The in-network deductible and co-insurance will apply.

Reimbursement for Outpatient Dialysis will be subject to Outpatient Dialysis Service Max Allowable.

**Limitations/Requirements:** A Covered Person must: 1) Notify Spectrum Review when diagnosed with End Stage Renal Disease (“ESRD”); and 2) Notify Spectrum Review when dialysis treatment begins;

Outpatient Dialysis Max Allowable for outpatient dialysis services is 125% of Medicare allowable fees and the Plan will adjudicate the claims using in network co-insurance.

CLAIMS FILING LIMITS

**claim must be filed and received within 12 months from date of service, or there is no coverage**

 \*All claims subject to Deductible

**\*\*If you receive treatment from a Non PPO Provider, your out of pocket may exceed the scheduled amount because the provider may be charging above Maximum Allowable (Example; Provider Charges $20,000 and the Maximum Allowable is determined to be $8,000. Payment will be at 50%, unless your out of pocket has been meet, and the difference between $20,000 billed and $8,000 Maximum Allowable is not covered.) Maximum Allowable will be 125% of Medicare Allowable charges for the service area for out of network providers.**