PARKVIEW HOSPITAL

SCHEDULE OF MEDICAL BENEFITS 2017

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 • Family Unit • Individual with treatment at Parkview Hospital	 $1,000 $3,000 $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) Percentage Payable at Parkview	80% 90%	60%
Out-of Pocket Expense Limit • Individual • Family Unit • Parkview Hospital	 $3,000 $9,000 $1,500	 $15,000 $35,000
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 incurred at Parkview 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		

Percentage Payable For:	***Hospital Inpatient* Services**	**Limits:**
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	Subject to deductible and coinsurance	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 • Lab or X-rays • Allergy Care • Injections • Other Covered Services	$20 office copay at Parkview, $35 office copay elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	
Mental or Nervous Disorder Office Visit and Outpatient	$20 office copay, then 100% up to $500 for additional services, charges above are subject to deductible and coinsurance in Seminole $25 copay elsewhere	60% of *usual, customary and reasonable* fees • *deductible* applies	
Substance Abuse Office Visit and Outpatient	$35 office copay, then 100% up to $500 for additional services, charges above the $500 are subject to deductible and coinsurance	60% of *usual, customary and reasonable* fees • *deductible* applies	

Chiropractic Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
Chiropractic Care and Therapies	$35 copayment, then 100%	60% 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	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	

Other Covered Services			
Percentage Payable For:	***PPONetwork Providers***	**Non-*PPONetwork Providers***	**Limits**
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	
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	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
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	