**Memorial Hospital**

| **" MEDICAL SCHEDULE OF BENEFITS"** | **NON-PPO** Payments subject to Maximum Allowable** | **PPO** | **Mem Hosp** |
|---|---|---|---|
| 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% - - - - - - - - - | | |
| WELLNESS BENEFITS | 100% | 100% | 100% |
| | $300 covered per plan yr charges above not covered | | |
| PRESCRIPTION DRUG | | | |
| Prescriptions | subject to deductible and always paid at 80% for brand, 90% for generic | | |
| 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.**