Permian Regional Medical Center Employee Benefit Plan

Coverage Period: 8/1/2013 - 7/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Employee/Family | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.caprockhp.com or by calling 1-800-747-9446.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$500** family for Permian Regional Medical Center (PRMC) **$500** person / **$1,000** family for In-Network providers **$750** person / **$1,500** family for Out-of-Network provider	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, an additional Inpatient deductible In-Network Deductible **$500** Out-of-Network Deductible **$750** (waived if treatment initiated at PRMC)	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these servies.
Is there an out-of-pocket limit on my expenses?	Yes, **$1,750** person/**$3,500** family for PRMC -- **$1,750** person/**$3,500** family for In-Network providers -- **$3,750** person/**$7,500** family for Out-of-Network provider	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-certification for services, copays, deductible and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2 million	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.caprockhp.com or call 1-800-747-9446** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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- **Copayments (copay)** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance (co-ins)** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an PRMC	PPO Provider	Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	AFMC and all physicians clinics in Andrews, TX $25 copay	$25 copay	40% co-ins	——none——
	Specialist visit				
	Other practitioner office visit	10% co-ins	20% co-ins	40% co-ins	Chiropractic services are limited to $1,500 annual max.
	Preventive care/screening/immunization	No Charge up to $500, then 10% co-ins	No Charge up to $500, then 10% co-ins	No Charge up to $500, then 40% co-ins	Limited to listed items. Refer to the Summary Plan Description for details.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins	20% co-ins	40% co-ins	——none——
	Imaging (CT/PET scans, MRIs)	10% co-ins	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750.

Common Medical Event	Services You May Need	Your Cost If You Use an PRMC	PPO Provider	Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welldynerx.com.	Generic drugs	$3 copay	Retail: $5 copay Mail Order: $10 copay	Not Covered	Each copay covers up to a 90 day supply
	Preferred brand drugs	$10 Copay	$20 Copay Mail Order: $40 copay	Not Covered	
	Non-preferred brand drugs	$15 Copay	$35 Copay Mail Order: $70 copay	Not Covered	
	Specialty drugs	$15 Copay	$35 Copay Mail Order: $70 copay	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Physician/surgeon fees	10% co-ins	20% co-ins	40% co-ins	——————none——————
If you need immediate medical attention	Emergency room services	10% co-ins	20% co-ins	30% co-ins	Pre-certification is required if you are admitted into the hospital, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Emergency medical transportation	10% co-ins	20% co-ins	40% co-ins	Air Ambulance is limited to $5,000 per occurrence.
	Urgent care	10% co-ins	20% co-ins	40% co-ins	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Physician/surgeon fee	10% co-ins	20% co-ins	40% co-ins	——————none——————
If you have mental	Mental/Behavioral health outpatient services	N/A	$25 copay	40% co-ins	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an PRMC	Your Cost If You Use an PPO Provider	Your Cost If You Use an Non-PPO Provider	Limitations & Exceptions
health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	N/A	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Substance use disorder outpatient services	N/A	$25 copay	40% co-ins	——————none——————
	Substance use disorder inpatient services	N/A	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750.
If you are pregnant	Prenatal and postnatal care	10% co-ins	20% co-ins	40% co-ins	Pre-certification is required for inpatient stays longer than 48 hours for vaginal delivery or 96 hours for cesarean delivery, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Delivery and all inpatient services	10% co-ins	20% co-ins	40% co-ins	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	40% co-ins	——————none——————
	Rehabilitation services	10% co-ins	20% co-ins	40% co-ins	Pre-certification is required, call (888) 819-3775. Penalty for failure to pre-certify is $750. See your policy or plan document for specific limitations per re/habilitation service type.
	Habilitation services	10% co-ins	20% co-ins	40% co-ins	
	Skilled nursing care	10% co-ins	20% co-ins	40% co-ins	——————none——————
	Durable medical equipment	10% co-ins	20% co-ins	40% co-ins	Equipment is limited to rental up to purchase price. Pre-certification is required for rental greater than $2,000 billed per date of service, call (888) 819-3775. Penalty for failure to pre-certify is $750.
	Hospice service	No Charge	No Charge	40% co-ins	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an PRMC	PPO Provider	Non-PPO Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	No Charge	40% co-ins	none
	Glasses	Not Covered	Not Covered	Not Covered	No Coverage for Glasses
	Dental check-up	No Charge	No Charge	No Charge	Routine oral exam is limited to 2 per 12 month period

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture,
- Cosmetic surgery,
- Glasses.
- Hearing aids,
- Infertility treatment,
- Long-term care,
- Non-emergency care when traveling outside the U.S.,
- Private-duty nursing.
- Routine eye care,
- Routine foot care,
- Weight loss programs.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery,
- Chiropractic care,
- Dental care.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-747-9446. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Caprock HealthPlans, Attention Appeals, P.O. Box 54139, Lubbock, Texas 79453-4139 or by calling 1-800-747-9446.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-747-9446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-747-9446

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-747-9446

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-747-9446

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,634
- **Patient pays** $1,906

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$6
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$1,906**

Managing type 2 diabetes
(routine maintenance of a well controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,711
- **Patient pays** $689

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$610
Coinsurance	$0
Limits or exclusions	$79
Total	**$689**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.