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Summary of Benefit Changes for year 2012

Each year, Memorial reviews the benefit plans offered to team member's to ensure we are still meeting the needs of our team members and their families, to ensure we are in compliance with all legal requirements, and to ensure we are able to support the on-going costs of the plans from an organizational perspective. Listed below are the changes Memorial will be making effective January 1, 2012 to the benefit plans:

Medical Plans

SRC Affordable Choices:

- SRC Affordable Health Choices® will continue to be an option for staffing team members.
- There are two SRC plans to choose from.

Please refer to the Schedule of Benefits on page 15 for further information regarding these options.

Meritain Health

- Beginning in 2012, all maintenance medications must be filled at Memorial Team Pharmacy. A maintenance medication is considered any medication that you take on an on-going basis, and refill routinely. The first "fill" of a prescription can be purchased at any network pharmacy. Any subsequent refills would need to be filled at Team Pharmacy, or will not be covered by the Memorial plan. As always, you can choose to fill your prescriptions at either a 30 day or 90 day supply. You can also choose to pick up your prescriptions at Memorial Team Pharmacy, or have them mailed to your home (or other location of your choice). All you need to do to transfer your current prescriptions to Team Pharmacy is complete the form on page 25 of this guide. If you need assistance in transferring your current prescription(s) to Team Pharmacy, contact Team Pharmacy at 574-647-3534.



- Beginning in January 2012, all self injectable medications will now be processed through the prescription drug card, instead of through the major medical plan. These prescriptions can now be filled at Memorial Home Care, allowing participants to take advantage of

potential 340b and GPO pricing, and eliminating the need to meet the deductible before the plan will pay. The co-insurance for these medications will remain 20% (plan will pay 80%), however, there will now be a \$150.00 maximum co-pay per prescription for participants.

- Case Management services will be offered face-to-face at Memorial. For many years, the Memorial Plan has offered Case Management services to participants who are dealing with a serious medical condition such as cancer. This is a voluntary program and focuses on working with plan participants to explore, discuss, and recommend coordinated and/or alternate types of appropriate medically necessary care. Previously, these case managers have been located at Meritain and have only been available to interact with plan participants via telephone and mail. Plan participants will have the opportunity to meet directly with their case manager, and even have the case manager attend appointments and meet directly with the physicians and other providers involved in their care, if desired. The program will continue to be voluntary and free of charge to team members and their families. Plan participants who are currently participating in the case management program will be automatically transferred to the on-site case manager unless you inform Human Resources that you prefer to remain with the telephonic case manager located at Meritain.
- Meritain Health is asking for your help in getting information on other Medical insurance coverage currently in effect for you or your dependents. The required information you provide on the "Other Insurance Coverage Information" form will allow any claims for you or dependents to be expedited. If this information is not received by Meritain, it may delay processing any payment of your claims beginning January 1, 2012. Please stop by the Meritain table at one of the benefit fairs or print the form from the HR intranet site, and follow the return instructions on the form.

Prevention Plan (for plans administered by Meritain Health)

Memorial is excited to announce we will continue to participate in "The Prevention Plan", in partnership with U.S. Preventive Medicine. This program will provide each team member covered under the Memorial Health Plan with a customized "Prevention Plan", an individualized report that will summarize a person's top

health risks and recommendations towards improving health. Additionally, your report will include a "Physician Report" for you to share with your regular physician. If you do not currently have a regular physician, you are encouraged to establish a relationship with a family physician. A listing of MMG providers can be found on the Human Resources intranet page. You can also find a listing of CHA network providers at www.chanetwork.com.

PLEASE NOTE: you are required to participate in the Prevention Plan in order to be covered under any of Memorial's medical plans administered through Meritain. If your spouse is covered under a Memorial plan, he/she must also participate in the program. The Prevention Plan does NOT pertain to individuals enrolled in the SRC plans.

In order to participate in the program, you will need to undergo a fasting blood test **and** complete an online Health Risk Appraisal (HRA). The lab work will be considered your "Wellness Lab Work" for 2012, and will be paid by the plan. There will be no out of pocket cost to you. You may complete the lab test at any time between November 1, 2011 and January 31, 2012. There are several locations available for you to complete this testing. Dates, Times, and locations are listed on the Prevention Plan website.

By participating in the Prevention Plan, a Memorial Hospital patient record will be established for each participant. This allows these individuals to access the hospital's 340b and GPO pricing for prescription medications filled at Team Pharmacy (see page 26 for Rx Transfer Form).

If you do not complete the biometric testing and HRA prior to the January 31 deadline, your coverage under the Memorial Health Plan will be terminated, effective March 1, 2012. If you complete the required actions, but your spouse does not, you can maintain your coverage, but your spouse's coverage will be terminated effective March 1, 2012. Dependent children are not required to participate in this program at this time.

Memorial, as the employer, will not receive any individual specific information regarding the results of the lab testing. We will only receive aggregate reports of the entire population's results, which

will help us design programs and enhancements to help improve team members' health.

Team Members who are hired January 1, 2012 and after, are not required to complete the biometric testing until Open Enrollment 2013.

Premium: There will be a 15% increase in premiums. Please refer to the Medical Schedule of Benefits for the 2012 premium structure.

Dental Plans

Guardian Dental

Premium: There will be an 8% increase in dental premiums for 2012.

SRC Affordable Choices-Dental

You also have a dental option through the Affordable Choices Plan.

Please refer to the Affordable Choices enrollment materials for further information and premium structure.

Vision Plan

Guardian Vision

Premium: There will be no change in vision premiums for 2012.

SRC Affordable Choices Vision:

You have a vision option through the Affordable Choices Plan.

Please refer to the Affordable Choices enrollment materials for further information and premium structure.

Flexible Spending Accounts

Again, in 2012, all participants in the Medical Flexible Spending Account Plan will have a flex debit card. This debit card can be used to pay for your out-of-pocket medical expenses, including office visit co-pays, prescriptions and eye glasses at the point of sale! You will no longer have to pay for these services up front and wait for reimbursement from your flexible spending account. The reimbursement will be immediate. There are no reimbursement claims to file for medical, dental, prescription, or vision when you use your debit card.

If you participated in the Flex Plan in 2011 and you already have a flex debit card, you will NOT be issued a new card. Your 2012 election will be loaded on to your current flex debit card.

For medical flex accounts, the entire 2012 balance will be available to you on January 1, 2012. If you are new to the Flex plan in 2012, you will receive your flex debit card prior to January 1, 2012.

“Use it or lose it” deadline extended! Remaining funds from 2011 can be carried over in to 2012, and be used for eligible expenses incurred through March 15, 2012. However, any carry-over balance will not be able to be accessed through the flex debit card. You will need to file a reimbursement claim with Meritain. As of January 1, 2012, only your 2012 flex balance will be available through the debit card.

Claims incurred between January 1, 2011 and March 15, 2012 can be reimbursed from an individual’s 2011 flexible spending account. Claims can be filed through March 31, 2012 for reimbursement using these funds. Any remaining unused funds at that time will be forfeited back to the plan.

IRS regulations no longer permit over-the-counter items to be reimbursed through flexible spending accounts without a written doctor’s prescription. The flex debit card can not be used for these types of transactions. You must file a reimbursement claim for these transactions.

Please remember: If you currently have a Flexible Spending Account and wish to have an account in 2012 you need to re-enroll in the plan during open enrollment.



ANNUAL OPEN ENROLLMENT PERIOD

Memorial is pleased to offer a variety of insurance benefit options which include: medical, dental, vision, and flexible spending accounts. As a benefits-eligible team member, you will be given the option of enrolling in these programs or making changes to your current coverage during Memorial's Open Enrollment period.

The 2012 Open Enrollment Period is November 1 through November 18, 2011 for individuals wishing to enroll in the Meritain Health and/or Guardian dental/vision plans. For individuals wishing to enroll in the SRC plan, the 2012 Open Enrollment period will run from November 1 through November 30, 2011.

All changes made during Open Enrollment will be effective **January 1, 2012.**

What do you need to do for Open Enrollment?

READ this enrollment guide

DISCUSS your healthcare needs with your spouse

LOG ON to PeopleSoft

SELECT your benefits

CONFIRM your benefit elections and **SUBMIT** the elections in PeopleSoft

REVIEW your first paycheck in 2012 to insure your benefit elections are correct.

Once your insurance elections have been made, you cannot make changes to your insurance coverage throughout the 2012 calendar year unless you have a “Family Status Event” and you submit an Insurance Add/Change Form within **31 days** of this event occurring. **The only time you can change plans is during Open Enrollment.**

Please review the enclosed information carefully, to insure that you are enrolled in the plans that are right for you and your family.

After reviewing your current medical, dental, and vision plans, if you do not want to make any changes and you do not want a medical flexible spending account or dependent daycare flexible spending account in year 2012, it is not necessary for you to complete the Open Enrollment Process. However, review your dependent/beneficiary information for accuracy, and make any necessary corrections. **Please print a copy of your Benefit elections. This will serve as your confirmation statement.**

Remember... you must re-enroll online each year during Open Enrollment if you want a Medical Flexible Spending Account and/or a Dependent Daycare Flexible Spending Account for the following year.



This guide outlines general information on Memorial's insurance plans. For more information, refer to Memorial's Summary Plan Description, attend a Benefits Fair, or contact Memorial's Benefit Counselor.

FAMILY STATUS EVENTS

Memorial holds Open Enrollment in the fall of each year. Changes made during Open Enrollment The only other time you can make changes throughout the year to your Memorial insurance coverage is **within 31 days** of a “Family Status Event”. Family Status Events are defined below.

Qualified Family Status Events:

- *Marriage, Divorce/Legal Separation/Annulment.*
- *Death of a spouse or dependent.*
- *Birth or Adoption.*
- *Starting new or termination of employment of yourself or spouse.*
- *Reduction of assigned work hours on the part of the team member, spouse or dependent.*
- *Increase in assigned work hours on the part of the team member, spouse or dependent.*
- *Team member, spouse or dependent going on Leave of Absence.*
- *Team member, spouse or dependent returning from Leave of Absence.*
- *Team Member or spouse becomes Medicare eligible.*

A team member who experiences a Family Status Event throughout the year should immediately contact Memorial’s Benefit Department for insurance selection information and submit an Insurance Add/Change Form. The Insurance Add/Change Form, along with proof of the event (example: photocopy of the birth certificate or marriage license and social security card), must be returned to Benefits **within 31 days of the event occurring**. If this deadline is missed, the Benefits Team will be unable to process the insurance enrollment change.

Your choice of Coverage Categories:

If you are married or have dependents, you have the option to elect coverage for only yourself and not for your spouse or dependents. You may choose from the following coverage categories:

- *Employee - coverage for team member alone.*
- *Employee +1 - coverage for team member plus one family member.*
- *Family - coverage for team member and two or more dependent family members.*

DEPENDENT COVERAGE

Your dependent children are eligible to be covered on one of Memorial’s **Medical, Dental, and/or Vision Plans** until they reach **age 26**, provided they are **not eligible for coverage under their employer’s health plan**.

There is no age restriction for disabled children who are primarily supported by the team member. Documentation of “disabled” status must be submitted to the appropriate health or dental carrier. A dependent that is no longer eligible because he/she attains the maximum age is eligible to continue benefits under federal continuation provisions (COBRA). It is the team member’s responsibility to notify Memorial’s Benefit Services Representative when a dependent child is no longer eligible.

Medical Options

Meritain Health

If you decide to have medical coverage through Memorial under the Meritain Health Plan, you need to first choose a Medical Plan and then a Coverage Category. There are several medical plans from which you can choose. These include:

Choose Your Medical Plan

- *Plan A - \$200 deductible*
- *Plan B - \$500 deductible*
- *Plan C - \$800 deductible*
- *Plan D - \$1,000 deductible*
- *Waive (No Medical Coverage)*

Be sure to review the “Schedule of Benefits” as you make your decision.



PRE-CERTIFICATION LISTING

To help control expenses, under all Memorial medical plans, there is a listing of medical procedures and services which must be pre-certified. The patient or family member must call the Community Health Alliance (CHA) pre-certification phone number listed on the back of the Memorial insurance identification card. **This call must be made at least two weeks in advance of services being rendered or within 24 hours of an emergency. If you do not pre-certify, reimbursement under Memorial's medical plans will be reduced by 50% of all eligible charges. Please note that retroactive pre-certifications will not be granted.**

Listed below are procedures and services requiring pre-certification in year 2012:

- **All 23 hour observation stays.**
- **All In-Patient Admissions.**
- **Extend Care Facility, Skilled Nursing Facility (SNF), or Hospice Care.**
- **Outpatient Services:**
 1. Outpatient Surgery (excluding a physician's office)
 2. Blepharoplasty
 3. Blocks, Injections (no more than 3 per request)
 4. Bunionectomy
 5. Cheiloplasty
 6. Hammer Toe Repair
 7. Myringotomy with tubes
 8. Nasal and Sinus Surgery
 9. Sleep Studies
 10. Plantar Fasciitis
 11. Septoplasty
 12. CT Scan
 13. Varicose Vein Therapy
 14. Injectable Medications (call Envision Rx to pre-cert)
 15. Orthotic and Prosthetic Services
 16. Endoscopy, Esophago-Gastro-Duodenoscopy
 17. ERCP (endoscopic retrograde cholangiopancreatography)
 18. Nerve Entrapment Surgery (including Carpal Tunnel Syndrome)
 19. Tonsillectomy and Adenoidectomy
 20. Cardiac & Pulmonary Rehabilitation
 21. Devices for Pain Management
 22. DME (Durable Medical Equipment) over \$500.00
 23. HHC (Home Healthcare) *Nursing, IV Meds, Fluids, Home Health Aide, etc.
 24. Occupational Therapy—Must pre-cert at start of therapy
 25. Physical Therapy—Must pre-cert at start of therapy
 26. Speech Therapy—Must pre-cert at start of therapy
 27. Headache Clinic Referral (see policy)
 28. Bariatric Surgery (Gastric By-pass Surgery)
 29. Esophageal Manometry
 30. Radiation and Chemotherapy (Hospital setting, Clinic or Provider office)
 31. MRI
 32. Dialysis

A \$2,000 facility co-pay does apply to services rendered at locations other than Memorial.

Need More Information?

Any time you have questions, or would like more detailed information about any of the benefits available, please refer to the telephone number and Web site directory listed on the back cover of this guide. Or, simply call Memorial's Benefits Counselor at 574-647-6509.

PRESCRIPTION DRUG BENEFIT

Each of Memorial's medical plans includes prescription drug coverage. With Memorial's prescription drug formulary, your co-payments will be based on a three-tiered plan. This means that your co-payments depend on whether your physician prescribes a generic drug, brand name drug on the formulary list (also known as "preferred drugs"), or a brand name drug that is not on the formulary list (also known as "non-preferred drugs"). A \$5.00 minimum co-payment will apply to all tiers.

Tier 1 drugs are generally generic drugs.

Tier 2 drugs are those that have been evaluated and chosen for their clinical value and overall cost-effectiveness, and are on the formulary list.

Tier 3 drugs are those that have been evaluated but are not on the formulary list or are new drugs on the market that have not yet been evaluated.

Tier 4 drugs are self-injectable medications (excluding insulin, Imitrex, and Levonox).

Prescription Drug Program

	Memorial Family Pharmacy	Network Pharmacy	Mar-Main Pharmacy
	% of Coverage		
Generic	85%	75%	N/A
Preferred	70%	60%	N/A
Non-Preferred	50%	50%	50% (Compound Drugs only)
Self-Injectable	20% Max co-pay, \$150.00 per prescription		
Note: Drugs purchased at an out-of-network pharmacy are not covered.			
Note: Self-Injectable meds can only be purchased at Memorial Home Care.			

Please refer to the formulary listing on the web @ www.envisionrx.com to determine what medications are considered formulary.

Compound prescriptions purchased at Mar-Main Pharmacy will continue to be filed electronically with Envision Rx options. These Prescriptions will be reimbursed at the non-formulary co-pay (50%) of usual and customary. Additionally, Mar-Main Pharmacy will continue to offer a 15% discount to all team members on the purchase of all over-the-counter (OTC) items and consulting services.

HOW YOU CAN HELP REDUCE COSTS

The benefit options have costs for coverage, which are called premiums. In some instances, you are paying for these premiums with before-tax dollars deducted from your paycheck. Unfortunately, it is simply not possible for the organization to absorb the full impact of health care costs. As healthcare expenses continue to rise, it is important that everyone does his or her part in helping to reduce these costs. There are many things you can do to help minimize the amount you pay for healthcare. Remember, these are personal choices, but you may:

- Choose a medical plan that best fits the needs of your family.
- Take advantage of the Flexible Spending Accounts.
- Use network physicians, facilities and providers whenever possible.
- Always review your medical bills for billing errors.
- Use the emergency room only in emergency situations.
- Use generic prescriptions when possible.
- Follow your physician's orders to avoid set backs.
- Make it a practice to exercise, eat healthy and get plenty of rest on a regular basis.
- Never change prescription medications to over-the-counter medications without first speaking to your physician.
- Don't take double doses of prescription medication thinking you will be better quicker...more is not better in this case.
- If you are diabetic, check your blood sugar on a regular basis.
- Have a physical every year (including PAP's and breast exams for females).
- Have regular dental check-ups and cleanings to catch potential problems before they become major dental procedures like caps and crowns.

How You Pay

The amount you pay for insurance coverage is called premiums. All your premiums are taken equally, typically on a before tax basis, from each of your Memorial paychecks. See each Schedule of Benefits for specific premium information.



**Medical Schedule of Benefits
Plans A, B and C**

	NETWORK			OUT-OF-NETWORK		
	PLAN A	PLAN B	PLAN C	PLAN A	PLAN B	PLAN C
Deductible						
• Single	\$200	\$ 500	\$ 800	\$200	\$ 500	\$ 800
• Single + 1	\$600	\$1,000	\$1,600	\$600	\$1,000	\$1,600
• Family	\$600	\$1,000	\$1,600	\$600	\$1,000	\$1,600
Co-Insurance	80% Covered			60% Covered		
Out-of-Pocket Maximum						
• Single	\$1,200	\$1,500	\$1,800	\$2,200	\$2,500	\$2,800
• Single + 1	\$2,600	\$3,000	\$3,600	\$4,600	\$5,000	\$5,600
• Family	\$2,600	\$3,000	\$3,600	\$4,600	\$5,000	\$5,600
PRE-CERTIFICATION & PRE-APPROVAL REQUIRED	See Pre-certification list for all procedures requiring pre-certification under this plan.					
COVERED SERVICES	NETWORK			OUT-OF-NETWORK		
Inpatient & Outpatient Care at Memorial Hospital of South Bend (requires pre-certification)				<i>Not Applicable</i>		
• Semi-Private Room/ICU/CCU	90% Covered - After deductible					
• Delivery or Operating Room	90% Covered - After deductible					
• Equipment & Supplies	90% Covered - After deductible					
Inpatient & Outpatient Care at hospitals other than Memorial (requires pre-certification)	\$2,000 co-pay/80% after deductible			\$2,000 co-pay/60% after deductible		
All Hospitals/Surgery Centers except Memorial Hospital, South Bend						
Outpatient Diagnostic Procedures-Laboratory, X-rays, Mammograms						
• South Bend Medical Foundations Sites/Rad. Inc.	90% Covered – After deductible			60% after deductible		
• Memorial Hospital and MMG Locations	90% Covered – After deductible			60% after deductible		
• Other Hospitals or Physician Charges	80% after deductible			60% after deductible		
Emergency Care				<i>Not Applicable</i>		
• Memorial Hospital of South Bend Trauma Center (Co-pay waived if ER visit results in In-patient Admittance or 23 hr. observation)	\$200 Co-pay – Per Visit (Please note: If an ER visit is for a non-emergency diagnosis, charges for any labs and/or x-rays will be subject to deductible and co-insurance)					
• Med Point Facilities (Excludes Med Point Express)	\$50.00 Co-pay – Per Visit			60% after deductible		
• Other Hospitals	\$2,000 Co-pay / 80% after deductible			\$2,000 Co-pay / 60% after deductible		
Physicians In-Patient Care	80% after deductible			60% after deductible		
Physician Surgical Services	80% after deductible			60% after deductible		
Physician Office Visits (Including Mental Health office visits)	\$15.00 Co-pay - Med Point Express \$20.00 Co-pay - MMG Providers \$30.00 Co-pay - all other network providers			60% after deductible		
Physician Office Visits (Adult Wellness)	\$0 Co-pay – MMG Providers (Covered at 100%) 1 st \$100 paid at 100%, remaining balance covered 80% after deductible - all other network providers			NO Coverage		
Prosthetics/Orthotics	80% after deductible			60% after deductible		
Mastectomy Bras	80% after deductible			60% after deductible		
• Limit of 6 per lifetime						
Organ Transplants	80% after deductible			60% after deductible		
• Excludes experimental/investigational						
• \$250,000 maximum per transplant						
Pregnancy	80% after deductible			60% after deductible		
• Excludes dependent pregnancy						
Ambulance Service/Transport	90% after deductible–Memorial Air Ambulance 80% after deductible–all other network providers			80% after deductible		
Diagnostic Laboratory	90% after deductible–Memorial Hospital, MMG sites, SBMF) 80% after deductible–all other network providers			60% after deductible		
Diagnostic X-Ray	90% after deductible–MHO, MMG sites, MRI Cntr., Radiology Inc, Jefferson Medical Arts Radiology, Memorial Lighthouse Img., LaPorte Radiology Inc.) 80% after deductible–all other network providers			60% after deductible		
Acupuncture	80% after deductible			60% after deductible		
• 12 visits per calendar year						
Durable Medical Equipment	80% after deductible			60% after deductible		
• Requires Pre-certification above \$500						
Home Health Care	80% after deductible			60% after deductible		
• Must use Memorial Home Care when service is available (Subject to Pre-Cert. and Utilization Review)						
Hospice Care	80% after deductible			60% after deductible		
• Subject to Pre-certification/Utilization Review						
Bariatric Surgery	90% after deductible at Memorial Hospital only			Not Covered		
• Pre-certification required						
Routine Newborn Care (Infant must be added within 31 days of birth) (First four days of facility charges covered under Mother, if exceeds four days remainder covered under child)	80% after deductible			60% after deductible		
Oral Maxillofacial Surgery	80% after deductible			60% after deductible		
• Covered if medically necessary						
Skilled Nursing Facility	80% after deductible			60% after deductible		
• Limited to Semi-Private room rate- within 7 days of 5 day admittance; 100 days/calendar year limit						

Continued on next page

	NETWORK		OUT-OF-NETWORK
Spinal Manipulation/Chiropractic • 24 visits per calendar year • \$70 max. allowable charge per visit (all services)	80% after deductible		60% after deductible
Therapy • Occupational, Physical or Speech	90% at Memorial or MMG Provider after deductible 80% after deductible		60% after deductible
Compound Drugs	50% Co-pay when purchased at Mar-Main Pharmacy		Not Covered
Prescription Drug Program • Generic Drugs • Preferred (Formulary) Drugs • Non-Preferred (Non-Formulary) Drugs Minimum co-pay of \$5.00 per prescription. All Maintenance medications are required to be filled at Team Pharmacy. Over the counter medications, with the exception of Prilosec OTC, Claritin OTC, Zyrtec OTC, and OTC Smoking Cessation Medications are not covered by the plan. (Smoking cessation meds are subject to plan limitations) A listing of formulary drugs is available from HR/Ben. and is subject to periodic updates. Refer to your formulary website for detailed information on this program.	Memorial Team Pharmacy 15% Co-pay 30% Co-Pay 50% Co-pay	Other Network Pharmacies 25% Co-pay 40% Co-pay 50% Co-pay	Non-network Pharmacies Not Covered
Self Injectable Medications Co-pays for self-injectable medications will apply to deductible and out-of-pocket maximums	Memorial Home Care 20% Maximum Co-pay \$150.00 per prescription	Not Covered	Not Covered

Wellness Benefits Program

Preventative Service	Plan Guidelines	In-Network Benefit Under Memorial's Plan
Routine Wellness Exams & Immunizations		
Birth to Age 1	6 Exams	Covered at 100%
Age 1 to 2	2 Exams per year	Covered at 100%
Age 2 to 6	1 Exam per year	Covered at 100%
Age 6 to 18	1 Exam per year	Covered at 100%
Age 18 & Over	1 Exam per year	Covered at 100% - MMG Providers 1st \$100 paid at 100%; remaining balance covered at 80% all other Network Providers.
Gynecological PAP & related lab fees	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine Mammography	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine PSA	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Colonoscopies	1 every 10 years	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine Wellness/Preventative Services provided by an Out-of-Network Provider are not covered.		

PLAN A, B AND C MONTHLY PREMIUMS FOR YEAR 2012; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31, 2012

To calculate your per pay period deduction multiply the monthly premium by 12 months; then divide by the number of pay periods you are paid in a year.

	PLAN A	PLAN B	PLAN C
• Single	\$ 612.67/month	\$ 449.35/month	\$ 354.45/month
• Single +1	\$ 1115.83/month	\$ 813.71/month	\$ 638.20/month
• Family	\$ 1604.02/month	\$ 1229.76/month	\$ 906.88/month

**Medical Schedule of Benefits
Plan D**

	NETWORK	OUT-OF-NETWORK
Deductible		
• Single	\$1,000	\$1,000
• Single + 1	\$2,500	\$2,500
• Family	\$2,500	\$2,500
Co-Insurance	80% Covered	60% Covered
Out-of-Pocket Maximum		
• Single	\$3,500	\$4,500
• Single + 1	\$3,500	\$4,500
• Family	\$3,500	\$4,500
PRE-CERTIFICATION & PRE-APPROVAL REQUIRED	See Pre-certification list for all procedures requiring pre-certification under this plan.	
COVERED SERVICES	NETWORK	OUT-OF-NETWORK
Inpatient & Outpatient Care at Memorial Hospital of South Bend (pre-certification required)		
• Semi-Private Room/ICU/CCU	80% Covered - After deductible	<i>Not Applicable</i>
• Delivery or Operating Room	80% Covered - After deductible	
• Equipment & Supplies	80% Covered - After deductible	
Inpatient & Outpatient Care at hospitals other than Memorial (pre-certification required)	\$2,000 Co-pay/80% after deductible	\$2,000 Co-pay/60% after deductible
All Hospitals/Surgery Centers except Memorial Hospital, South Bend		
Outpatient Diagnostic Procedures-Laboratory, X-rays, Mammograms		
• South Bend Medical Foundations Sites/Rad. Inc.	90% Covered – After deductible	60% after deductible
• Memorial Hospital and MMG Locations	90% Covered – After deductible	60% after deductible
• Other Hospitals or Physician Charges	80% after deductible	60% after deductible
Emergency Care		
• Memorial Hospital of South Bend Trauma Center (Co-pay waived if ER visit results in In-patient Admittance or 23 hr. observation)	\$200 Co-pay – Per Visit (Please note: If an ER visit is for a non-emergency diagnosis, charges for any labs and/or x-rays will be subject to deductible and co-insurance)	<i>Not Applicable</i>
• Med Point Facilities (Excludes Med Point Express)	\$50.00 Co-pay – Per Visit	60% after deductible
• Other Hospitals	\$2,000 Co-pay / 80% after deductible	\$2,000 Co-pay / 60% after deductible
Physicians In-Patient Care	80% after deductible	60% after deductible
Physician Surgical Services	80% after deductible	60% after deductible
Physician Office Visits (including Mental Health office visits)	\$15.00 Co-pay - Med Point Express \$20.00 Co-pay - MMG Providers \$30.00 Co-pay - all other network providers	60% after deductible
Physician Office Visits (Adult Wellness)	\$0 Co-pay – MMG Providers (<i>Covered at 100%</i>) 1 st \$100 paid at 100%, remaining balance covered 80% after deductible - all other network providers	NO Coverage
Prosthetics/Orthotics	80% after deductible	60% after deductible
Mastectomy Bras		
• Limit of 6 per lifetime	80% after deductible	60% after deductible
Organ Transplants		
• Excludes experimental/investigational	80% after deductible	60% after deductible
• \$250,000 maximum per transplant		
Pregnancy		
• Excludes dependent pregnancy	80% after deductible	60% after deductible
Ambulance Service/Transport	90% after deductible–Memorial Air Ambulance 80% after deductible–all other network providers	80% after deductible
Diagnostic Laboratory	90% after deductible-Memorial Hospital, MMG sites, SBMF) 80% after deductible-all other network providers	60% after deductible
Diagnostic X-Ray	90% after deductible-MHO, MMG sites, MRI Cntr., Radiology Inc, Jefferson Medical Arts Radiology, Memorial Lighthouse Img., LaPorte Radiology Inc.) 80% after deductible-all other network providers	60% after deductible
Durable Medical Equipment		
• Requires Pre-certification above \$500	80% after deductible	60% after deductible
Home Health Care		
• Must use Memorial Home Care when service is available (Subject to Pre-Cert. and Utilization Review)	80% after deductible	60% after deductible
Hospice Care		
• Subject to Pre-certification/Utilization Review	80% after deductible	60% after deductible
Bariatric Surgery		
• Pre-certification required	90% after deductible at Memorial Hospital only	Not Covered
Routine Newborn Care (Infant must be added within 31 days of birth) (First four days of facility charges covered under Mother, if exceeds four days remainder covered under child)	80% after deductible	60% after deductible
Oral Maxillofacial Surgery		
• Covered if medically necessary	80% after deductible	60% after deductible
Skilled Nursing Facility		
• Limited to Semi-Private room rate- within 7 days of 5 day admittance; 100 days/calendar year limit	80% after deductible	60% after deductible
Spinal Manipulation/Chiropractic		
• 24 visits per calendar year	80% after deductible	60% after deductible
• \$70 max. allowable charge per visit (all services)		

Continued on next page

	NETWORK		OUT-OF-NETWORK
Therapy • Occupational, Physical or Speech	90% at Memorial or MMG Provider after deductible 80% after deductible		60% after deductible
Compound Drugs	50% Co-pay when purchased at Mar-Main Pharmacy		Not Covered
Prescription Drug Program • Generic Drugs • Preferred (Formulary) Drugs • Non-Preferred (Non-Formulary) Drugs Minimum co-pay of \$5.00 per prescription. All Maintenance medications are required to be filled at Team Pharmacy. Over the counter medications, with the exception of Prilosec OTC, Claritin OTC, Zyrtec OTC, and OTC Smoking Cessation Medications are not covered by the plan. (Smoking cessation meds are subject to plan limitations) A listing of formulary drugs is available from HR/Ben. and is subject to periodic updates. Refer to your formulary website for detailed information on this program.	<i>Memorial Team Pharmacy</i> 15% Co-pay 30% Co-Pay 50% Co-pay	<i>All Other Network Pharmacies</i> 25% Co-pay 40% Co-pay 50% Co-pay	Non-network Pharmacies Not Covered
Self Injectable Medications Co-pays for self-injectable medications will apply to deductible and out-of-pocket maximums	Memorial Home Care 20% Maximum Co-pay \$150.00 per prescription	Not Covered	Not Covered

Wellness Benefits Program

Preventative Service	Plan Guidelines	In-Network Benefit Under Memorial's Plan
Routine Wellness Exams & Immunizations		
Birth to Age 1	6 Exams	Covered at 100%
Age 1 to 2	2 Exams per year	Covered at 100%
Age 2 to 6	1 Exam per year	Covered at 100%
Age 6 to 18	1 Exam per year	Covered at 100%
Age 18 & Over	1 Exam per year	Covered at 100% - MMG Providers 1st \$100 paid at 100%; remaining balance covered at 80% -all other Network Providers.
Gynological PAP & related lab fees		
Age 18 & Over	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine Mammography		
Age 40 & Over	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine PSA		
Age 40 & Over	1 per year	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Colonoscopies		
Age 50 & Over	1 every 10 years	Covered at 90% if services are rendered by designated Memorial providers Covered at 80% if services are rendered by any other network provider
Routine Wellness/Preventative Services provided by an Out-of-Network Provider are not covered.		

PLAN D MONTHLY PREMIUMS FOR YEAR 2012; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31, 2012

To calculate your per pay period deduction multiply the monthly premium by 12 months; then divide by the number of pay periods you are paid in a year.

	PLAN D
• Single	\$ 296.08/month
• Single +1	\$ 530.16/month
• Family	\$ 749.21/month

HEALTH MANAGEMENT

Memorial is dedicated to improving the quality of life for the people of our community. We believe that the path to achieving this starts with our team members and their families. As such, Memorial is pleased to offer **The Prevention Plan**, a total program to help team members learn about both their current health risks, as well as the potential health risks they may face in the future. The Prevention Plan will also provide support and assistance to address those risks.

The Prevent Plan provides a WinWin opportunity for everyone. You will learn important information about your health and have resources available to you, including 24/7 on-line support, to assist you in making decisions about your well-being and taking health action. Most importantly, Memorial cares about our team members' health and quality of life, and we believe the Prevention Plan will contribute positively to this. Additionally, healthy team members also contribute to the productivity and success of our health system. This allows us to keep our costs down, not only with our health plan, but also the costs associated with absenteeism, short-term and long-term disability, and worker's compensation.

There are three steps to enrolling in the Prevention Plan.

1. Complete the On-line Registration at www.ThePreventionPlan.com.
2. Complete the On-line Health Risk Appraisal (HRA)
3. Complete a free comprehensive blood test

The results of your blood test, along with your responses to the HRA will be reviewed by a physician. You will receive a customized on-line report that reviews your information, identifies any concerns or potential health risks, and provides recommendations for you and your regular physician to review and consider. As part of your customized Prevention Plan report, you will receive a physician's report for you to share with your regular family physician. If you do not currently have a family physician, you are strongly encouraged to establish a regular relationship with a primary care physician. You can find a list of Memorial Medical Group (MMG) providers on the Human Resources intranet

page, or visit the CHA website (www.chanetwork.com) for a listing of all other network providers.

All of the information you share with the Prevention Plan, including your HRA and lab results will remain completely confidential and will NOT be shared with Memorial, as your employer, or Meritain Health. Memorial will only be aware that you and your spouse have enrolled in the Prevention Plan, so that your medical coverage will remain in force. Memorial will periodically receive aggregate reports reflecting the entire population's results, which will help us design future programs and enhancements to improve team members' health and manage the health plan's costs. American Health will receive individual information in order to make available disease management health coaching and counseling.

There is NO COST to you or your spouse to participate in the Prevention Plan. Recognizing the value this program brings to your overall health, Memorial has chosen to pay 100% of the cost of the program. The comprehensive lab work will serve as your wellness labs for the plan year.

Participation in the Prevention Plan is required in order to be covered under any of Memorial's medical plans. If your spouse is also covered under the Memorial plan, he/she must also participate in the Prevention Plan to be covered under the Memorial plan. You must complete all three steps to enroll in by January 31, 2012. If you do not complete the enrollment process by the January 31 deadline, your coverage will be terminated effective March 1, 2012. Covered dependent children are not required to participate in the program.

All individuals who participate in The Prevention Plan will have a patient record with Memorial Hospital. As a patient of Memorial, these individuals will have access to 340b and GPO pricing for prescription medications. Individuals can take advantage of this by filling their prescriptions at Memorial Team Pharmacy.

Additionally, you will have a chance to earn cash and other rewards from Memorial as well as from the Prevention Plan, by

taking action such as completing your preventive care visits, online action programs, and other challenges and community events.

Team members who are hired and/or become eligible for the Memorial Health Plan after January 1, 2012 will not have to participate in the Prevention Plan until Open Enrollment 2013.

TLC

Team Lead Care (TLC) is a comprehensive Disease Management Program powered by American Health, available as part of the Medical Plan. This program is an employee-based program that provides you with medication therapy and tools to better self manage your overall health. This voluntary service is powered by American Health Care and is provided to you at no cost if you are enrolled in one of the Memorial medical plans. The program focuses on all chronic conditions, including:

- Diabetes
- High cholesterol
- High blood pressure
- Asthma

Benefits of the TLC Program include:

- Reduced co-payments on qualifying prescription medications.
- Reduced co-payments on qualifying physician office visits.
- Frequent newsletters and brochures.
- Convenient face-to-face appointments with a personal “certified team care managers” to assist with the effective management of prescription and non-prescription-related issues.
- Coordination between your physician team to maximize health benefits.
- Educational information targeted to your individual needs that will help you remain in control of your disease-state and improve your overall health and well-being.

For example, if an individual with diabetes enrolls in the program and follows recommendations then they are eligible for an additional 10% discount off prescription co-pays at Team Pharmacy and a \$10 discount off physician office co-pays.

URGENT CARE OR EMERGENCY CARE?

One of the more difficult healthcare choices you may be faced with is where to go when you need medical attention for a sudden injury or illness. Many times, our first thought is to go to the Emergency Room when we need urgent care. Some people assume that the ER is the only option for after-hours medical care. While the Emergency Room is one option, Med-Point Urgent Care centers and Med-Point Express could be appropriate options as well. Your specific illness or injury should determine which level of care is appropriate.

Emergency care is necessary for medical emergencies that require immediate care to avoid disability or death (suspected heart attacks or strokes, and major trauma such as a head injury, severe pain, and uncontrolled bleeding). Urgent care is care that can safely be postponed for the time it takes to contact a physician for instructions on obtaining treatment (such as earaches, sprains, minor fractures, lacerations, rashes, fever, back pain, and colds).

Choosing the right level of care can lower your out of pocket expenses, and will help keep Memorial’s medical plan expenses under control. A visit to the emergency room for non-emergency care can cost 3-4 times more than a visit to an Urgent Care Center, such as Med-point, for the same ailment. In 2011, the average cost of an Emergency Room visit paid by the Memorial medical plan was over \$1200. Many of these visits were for a non-emergent diagnosis. On the other hand, the average cost of an office visit paid by the Memorial medical plan in 2011 was \$86. The average cost of out-patient x-rays were \$75, while the average cost of out-patient labs were \$68. Please keep in mind that your monthly premiums are determined by the amount of the claims cost the plan pays. The higher the cost of the claims that are paid, the higher your premiums will be.

Of course, you should ALWAYS seek immediate emergency care for true medical emergencies! For urgent care situations, consider the following options. These options will help you receive appropriate treatment in a timely manner.

Your Regular Physician:

During normal business hours, call your physician to determine the best course of action. Your doctor may be able to provide immediate treatment, or he/she may refer you to a specialist, Urgent Care center, or clinic. Many doctors also provide an after-hours number that you can call to determine whether or not your situation requires immediate care.

Urgent Care Centers (Med-Point):

During and after normal business hours, Urgent Care centers are open to provide medical treatment. They are staffed with physicians and nurses that are experienced in handling illnesses and injuries. They can run diagnostics such as x-rays and labs, and, if necessary, refer you to a specialist. **Don't forget – the Main Street Med-Point location is now open 24 hours a day seven days a week!**

Med-Point Hours & Locations:

1815 E. Ireland Rd - 8:00am – 8:00pm

6913 N. Main St – **Open 24 hrs!**

Both locations are open (7) days a week.

MEDPOINT express:

Those who have a minor illness can now stop at MEDPOINT express. Patients can see a nurse practitioner for minor health conditions such as strep throat, earache, flu, pink eye and allergies.

Med-Point Express Hours & Locations:

South Bend – 926 Erskine Plaza (Inside Martin's)

Monday – Friday 10:00am to 6:00pm

Saturday 9:00am – 4:00pm

Sunday 11:00am to 4:00pm

Valparaiso – 2400 Morthland Dr. (Inside Wal-Mart)

Monday – Friday 8:00am to 8:00pm

Saturday 9:00am – 4:00pm

Sunday 11:00am to 4:00pm

Elkhart – 3900 East Bristol (Inside Martin's)

Monday, Wednesday, Friday 8:00am to 8:00pm

Saturday 9:00am – 4:00pm

Sunday 11:00am to 4:00pm

They can also prescribe most medications, administer vaccinations and perform health screenings. No appointments are necessary and visits usually take about 15 minutes. It provides quick, affordable, quality health care in a fast, convenient setting.

We want you to receive the best and most timely care for any sudden injuries or illnesses. These guidelines are provided to help you do just that.

CASE MANAGEMENT

When a serious condition, such as cancer, occurs, a person may require long-term, perhaps lifetime care.

Case Management is a program whereby a case manager monitors these patients and explores, discusses, and recommends coordinated and/or alternate types of appropriate medically necessary care. The case manager consults with the patient, the family, and the attending physician in order to develop a plan of care. The case manager will coordinate and implement the Case Management Program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The treatment plan must be agreed upon by all parties involved.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Non-Participation Penalty:

Case Management is a voluntary service. Individuals identified as candidates for case management are not required to participate in the program. However, if an individual declines to participate in the case management program, the annual out of pocket maximum will increase \$1,000 for that individual.

For example, Mary is covered under Memorial's Plan A. Her annual out of pocket maximum for the year is \$1,200. Mary is diagnosed with a serious illness, and is invited to participate in the case management program. Mary declines to participate in the program. Mary's out of pocket maximum is then increased to \$2,200 for the year.

Strategic Resource Company (SRC) Health

If you decide to have medical coverage through Strategic Resource Company –SRC (an Aetna Company) you will have two plans to choose from.

See below for Medical Plan Options 1 and 2 for more information and premium structure.

Medical Option 1

Deductible		
Individual	\$250	\$250
Family	\$500	\$500
Co-insurance	20%	40%
Coveraged Services	In-network	Out of Network
Office Visits	100%	20%
Max per year	5 visits	5 visits
Co-pay/Deductible	\$10 copay	\$10 deductible
Emergency Room	100%	100%
Max per visit	\$150	\$150
Max per year	3 visits	3 visits
Deductible	\$50	\$50
Diagnostic / Surgical Procedures		
Max per year	\$400 or 5 services	\$400 or 5 services
Copay/Deductible	\$15 copay	20%
In Patient Charges		
Max per year	\$2,000	\$2,000
Prescription Drugs	100% (up to max)	100% (up to max)
Max per year	\$200	\$200
Deductible	\$10 per prescription	\$10 per prescription
Medical Option 1 Weekly Premiums for Year 2012; Effective January 1 through December 31, 2012.		
<ul style="list-style-type: none"> • Single • Single +1 • Family 	<ul style="list-style-type: none"> \$ 20.56 \$ 51.27 \$ 72.54 	

Need to contact SRC Health?

Anytime you have a question about your health benefits through SRC Health you can contact SRC directly by calling 1-888-772-9682. You can also visit the website at www.aetna.com to track claims for you and your dependents.

Medical Option 2

Deductible		
Individual	\$250	\$250
Family	\$500	\$500
Co-insurance	20%	40%
Coveraged Services	In-network	Out of Network
Office Visits	100%	20%
Max per year	5 visits	5 visits
Co-pay/Deductible	\$10 copay	\$10 deductible
Emergency Room	100%	100%
Max per year	\$1000	\$1000
Deductible	\$100	\$100
Diagnostic / Surgical Procedures		
Max per year	\$400 or 5 services	\$400 or 5 services
Copay/Deductible	\$15 copay	20%
In Patient Charges		
Max per year	\$10,000	\$10,000
Other Hospital Svcs	\$1,000 limit	\$1,000 limit
Prescription Drugs	100% (up to max)	100% (up to max)
Max per year	\$500	\$200
Deductible	\$10	\$10
Medical Option 2 Weekly Premiums for Year 2012; Effective January 1 through December 31, 2012.		
<ul style="list-style-type: none"> • Single • Single +1 • Family 	<ul style="list-style-type: none"> \$ 33.73 \$ 84.10 \$ 118.79 	

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE DESCRIBED IN THIS BENEFITS SUMMARY.

Guardian Dental

Memorial's dental plans are fully insured options administered by Guardian Dental.

The **Basic Plan** focuses on **preventative and basic services only**. There is no coverage for major dental services.

The **Standard Plan** offers coverage for preventative, basic, and major services, including orthodontia coverage for eligible dependents. To receive the maximum benefit under this plan, you **must** utilize a dental provider who participates in the Guardian network. You may utilize a provider who does not participate in Guardian's network, however your benefits will be significantly reduced.

This plan has an annual maximum benefit of \$1000. If you have used \$300 or less of this annual maximum at the end of the plan year, a portion of the unused balance may be carried over to future plan years and added to your annual limit for that plan year. In order to take advantage of this feature, you must incur at least one dental claim during the plan year. Up to \$200 may be carried over for use in future plan years increasing your annual maximum to \$1200 the following year.

The **Premium Plan** offers coverage for preventative, basic, and major services, including orthodontia coverage for eligible dependents.

This plan allows you to utilize any dental provider with no penalty. However, if you choose to see a Guardian Network Dental Provider, you may benefit from additional network savings. This plan has a \$1250 individual annual maximum. If you have used \$600 or less of your annual maximum at the end of a plan year, up to \$450 of your unused balance may be carried over into future plan years increasing your annual maximum to \$1700 the following year.

In order to take advantage of this rollover feature, you must have at least one dental claim during the plan year.

To locate a listing of Guardian Dental Providers visit Guardian's website at www.guardianlife.com

Need to contact Guardian?

Anytime you have a question about your dental benefits through Guardian Dental you can contact Guardian directly by calling (888)600-1600. You can also visit the website at www.guardianlife.com to track claims for you and your dependents.

**See next page for Schedule of Benefits for
Guardian Dental Plans**

Dental Schedule of Benefits

	Basic Plan		Standard Plan		Premium Plan	
Calendar Year Deductible	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
• Single	\$ 50	\$ 50	\$ 0	\$ 200	\$ 50	\$ 50
• Single + 1	\$ 50	\$ 50	\$ 0	\$ 200	\$ 50	\$ 50
• Family (3 per family)	\$ 50	\$ 50	\$ 0	\$ 200	\$ 50	\$ 50
Deductible Waived for PREVENTATIVE Services	Yes	Yes	Yes	No	Yes	Yes
Annual Maximum Benefit	\$1000	\$1000	\$1000	\$ 750	\$1250	\$1250
Maximum Rollover Allowed	No		Yes		Yes	
• Maximum annual claims to be eligible for rollover			\$ 300		\$ 600	
• Annual rollover amount allowed (out-of-network)			\$ 150		\$ 300	
• Annual rollover amount allowed (in-network)			\$ 200		\$ 450	
• Maximum rollover account balance			\$ 500		\$1250	
COVERED SERVICES						
Preventative Care	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
Deductible waived for preventative services on all plans except Standard Plan out-of-network.	100%	100%	100%	50 %	100%	100%
• Cleanings (one every 6 months)	100%	100%	100%	50 %	100%	100%
• Fluoride Treatments (under age 19)	100%	100%	100%	50 %	100%	100%
• Oral Exams	100%	100%	100%	50 %	100%	100%
• Sealants (per tooth)						
• X-rays						
Basic Care	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
• Fillings (one surface)	80 %	80 %	75 %	30 %	80 %	80 %
• Periodontal maintenance (every 3 months)	80 %	80 %	75 %	30 %	80 %	80 %
• Crown, Bridge, Denture Repair & Maintenance	80 %	80 %	75 %	30 %	80 %	80 %
• Simple Extractions	80 %	80 %	75 %	30 %	80 %	80 %
Major Care	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
• Anesthesia	0 %	0 %	50 %	25 %	60 %	60 %
• Bridges and Dentures	0 %	0 %	50 %	25 %	60 %	60 %
• Dental Implants	Not Covered	Not Covered	Not Covered	Not Covered	60 %	60 %
• Inlays, Onlays, Veneers**	0 %	0 %	50 %	25 %	60 %	60 %
• Perio Surgery	0 %	0 %	50 %	25 %	60 %	60 %
• Root Canal	0 %	0 %	50 %	25 %	60 %	60 %
• Scaling & Root Planing (per quadrant)	0 %	0 %	50 %	25 %	60 %	60 %
• Single Crowns	0 %	0 %	50 %	25 %	60 %	60 %
• Surgical Extractions	0 %	0 %	50 %	25 %	80 %	60 %
Orthodontia* <i>(placed prior to age 19)</i>	Network	Out-of-Network	Network	Out-of-Network	Network	Out-of-Network
	Not Covered	Not Covered	50 %	25 %	50 %	50 %
Lifetime Orthodontia Maximum	N/A		\$1000	\$ 750	\$1200	
For complete coverage listing, refer to the Summary Plan or contact Guardian Dental prior to services.						
*Children only, orthodontic appliance must be placed prior to age 19.						
**Covered only when needed because of decay or injury and only when the tooth cannot be restored with amalgam or composite filling material.						

MONTHLY PREMIUMS FOR YEAR 2012; EFFECTIVE JANUARY 1 THROUGH DECEMBER 31, 2012

To calculate your per pay period deduction multiply the monthly premium by 12 months; then divide by the number of pay periods you are paid in a year.

	Basic Plan	Standard Plan	Premium Plan
• Single	\$ 17.81/month	\$ 18.85/month	\$ 45.78/month
• Single +1	\$ 37.96/month	\$ 35.08/month	\$ 72.93/month
• Family	\$ 65.75/month	\$ 61.40/month	\$ 101.97/month

Strategic Resource Company (SRC) Health

You also have the option of electing **dental** coverage through SRC Health. For information regarding the dental coverage available through **Strategic Resource Company (SRC)**, please refer to your enrollment information.

Vision Options

Vision Service Plan (VSP)

Vision coverage helps you pay vision expenses for you and your family. Coverage is provided by Vision Service Plan (VSP). To receive the maximum benefit under the plan you should use a VSP In-Network Provider. To check if a provider is "in-network" visit the Guardian website at www.guardianlife.com.

Vision Schedule of Benefits		
Co-pay		
Exams		\$10
Materials (waived for elective contact lens)		\$25
You Pay (after copy if applicable)		
Services	Network Provider	Out-of-Network Provider
Eye Exams (per calendar year)	0%	Amount over \$39
Lenses (per calendar year)		
• Single vision	0%	Amount over \$23
• Bifocal	0%	Amount over \$37
• Trifocal	0%	Amount over \$49
• Lenticular	0%	Amount over \$64
Frames (every 2 years)	80% of amount over \$130	Amount over \$46
Contact lenses		
• Elective	Amount over \$130	Amount over \$100
• Medically necessary	\$0	Amount over \$210
• Evaluation and fitting	15% off UCR	No Discounts
Cosmetic Extras	Avg. 20-25% off retail price	No Discounts
Glasses (additional pair of frames and lenses)	20% off retail price**	No Discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No Discounts
Service		
All Eligible Team Members	Monthly Premiums	
Employee	\$ 5.81	
Employee +1	\$ 11.66	
Family	\$ 18.77	
To calculate your per pay period deduction multiply the monthly premium by 12, then divide by the number of pay periods you are paid in a year.		
**for discount to apply your purchase must be made within 12 months of eye exam.		

Strategic Resource Company (SRC) Health:

You also have the option of electing **vision** coverage through SRC Health. For information regarding the vision coverage available through Strategic Resource Company (SRC), please refer to your enrollment information.

Flexible Spending Account Options

A key part of Memorial's Benefit Program is the Flexible Spending Accounts. By using these accounts, you can reduce the money you pay out of your pocket for federal and state income and Social Security taxes. In fact, money contributed to these accounts is never taxed.

You need to carefully and conservatively decide if you want to contribute to these accounts because the Internal Revenue Service (IRS) has designed the rules that govern these plans. To help you see the benefit of participating, use Flexible Spending Account Worksheet, page 20. This worksheet helps you to determine any predictable eligible expenses you may have in the upcoming year. The minimum amount you can deduct per paycheck is \$5.00 (\$130.00 annually).

Use it or Lose It

IRS rules state that if you contribute money and don't use it by a certain date, you lose it.

Under the IRS regulations, you now have until March 15th of the following year to use your flexible spending account contributions. For example, in 2011 you contributed \$1000 to your flexible spending account. Eligible expenses incurred from January 1, 2011 through March 15, 2012 can be reimbursement under the flex spending plan. Any remaining funds after March 15 will be forfeited.

If you have a remaining flex account balance from 2011 that carries over to 2012, and you also elect to have a flex account in 2012, your remaining 2011 balance will be used first in 2012. When your carry-over balance has been exhausted, your new 2012 balance will be used.

A second key IRS rule states that you cannot increase, decrease or stop the amount being deducted from each of your paychecks for either healthcare or dependent daycare flex deductions unless you have a change in “Family Status Event” and you submit an Add/Change Form to the Human Resources/Benefits Department within 31 days of the event.

Keep in mind that your dependents for this plan are those who qualify as your dependents for income tax purposes during the calendar year you participate in the plan. Participation in either Flexible Spending Accounts does not require you or dependents to be enrolled in Memorial’s medical plans. Therefore, if you or any of your eligible dependents incur out-of-pocket medical expenses, you may use this plan to reimburse yourself for them.

If you currently have a flexible spending account and you wish to continue this, you must re-enroll in the benefit each year during the Open Enrollment period.

If you participated in the Flex Plan in 2011 and you already have a flex debit card, you will NOT be issued a new card. Your 2012 election will be loaded on to your current flex debit card. For medical flex accounts, the entire 2012 balance will be available to you on January 1, 2012. **If you are new to the Flex plan in 2012, you will receive your flex debit card prior to January 1, 2012.**

Remaining funds from 2011 can be carried over in to 2012, and be used for eligible expenses incurred through March 15, 2012. However, **any carry-over balance will not be able to be accessed through the flex debit card.** You will need to file a reimbursement claim with Meritain. **As of January 1, 2012, only your 2012 flex balance will be available through the debit card.**

Claims incurred between January 1, 2011 and March 15, 2012 can be reimbursed from an individual’s 2011 flexible spending account. Claims



can be filed through March 31, 2012 for reimbursement using these funds. Any remaining unused funds at that time will be forfeited back to the plan.

Participants will receive a flex debit card to use to pay for eligible flexible spending expenses at the point of sale. Use of debit card eliminates the need to file reimbursement claims for your eligible expenses. However, you will still need to **keep your receipts and other documentation for your records in the event you are audited.** If you prefer, you will still have the option of filing paper claims for reimbursement rather than using the debit card.

Please remember: If you currently have a Flexible Spending Account and wish to have an account in 2012 you need to re-enroll in the plan during open enrollment.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT

Eligible healthcare expenses are charges you, your spouse, or eligible dependents incur during a calendar year* in which you are contributing to the spending account. These expenses cannot be reimbursed by another plan and may not have been incurred before or after the plan year in which you contributed to the spending account. HealthCare expenses that qualify as allowable deductions for federal income tax purposes are eligible. The purchase of certain over-the-counter medications can be reimbursed through the flexible spending account. However, you must have a written prescription for these items. You must submit a reimbursement claim for these items; you will not be able to use your flex debit card to purchase these items.

A good way to budget for the coming year is to record what you spent during the current year. To help you do that, a worksheet has been created (page 20). Write down the expenses you paid so far this year (**cannot exceed \$4,500**). After eliminating any one-time expenses, such as a major operation, estimate conservatively what you are going to spend on these expenses next year and add them together for your annual total.

When enrolling in the Flexible Spending Plan in PeopleSoft, you can calculate your per-pay-period contribution by clicking on the worksheet link and entering your annual contribution. This amount

will change if you miss being paid by Memorial or if this deduction goes into arrears.



Your entire flexible spending account balance is available for use beginning on January 1, 2012. The debit card will only be accepted for qualified flexible spending account purchases. Once you have exhausted your flex account elections for the year, your debit card will no longer function for the remainder of the year.

Only your 2012 flex account balance will be available on your debit card on January 1, 2012. If you have a remaining 2011 flex account balance you will need to file a reimbursement claim prior to March 31, 2012 to use this balance.

IRS Guidelines

IRS guidelines allow reimbursement for expenses incurred through March 15 of the following year.

DEPENDENT DAYCARE SPENDING ACCOUNT

Generally, any dependent daycare expenses you incur, so that you and your spouse can work outside the home, are eligible for the Dependent Daycare Account. These expenses typically qualify for the dependent daycare tax credit on your federal income tax return.

For expenses incurred out of your home, expenses must be for a qualifying dependent under age 13 or for a dependent that regularly spends at least eight hours a day in your home (an elderly parent, for instance).

Using the space below, list the amounts you paid this year and expect to pay next year:

	This Year	Next Year
Weekly Expenses		
# of weeks	x	x
TOTAL	=	=

The resulting figure is your annual contribution amount (**cannot exceed \$5,000**). The annual amount will be divided by the number of pay periods in the year to determine the amount to be deducted from each of your Memorial paychecks (minimum \$5.00 per paycheck). This amount will change if you miss being paid by Memorial or if this deduction goes into arrears.



Has your name changed?

If you have had a name change, submit a change form to the HR Department. Name Change forms are found on the Human Resources Intranet site. Send a copy of your new Social Security Card with the form.

FLEX SPENDING WORKSHEET

	THIS YEAR	NEXT YEAR
MEDICAL EXPENSES (not covered by the medical insurance plan)		
Medical deductible	_____	_____
Medical co-insurance (including amounts over the usual customary)	_____	_____
Prescription drugs	_____	_____
Routine physical examinations	_____	_____
Vaccinations and immunizations	_____	_____
Laboratory fees	_____	_____
Well-baby care	_____	_____
Hospital private room charges	_____	_____
X-ray fees	_____	_____
Experimental surgery (so long as it is a legal operation)	_____	_____
DENTAL EXPENSES (not covered by the dental plan)		
Routine expenses	_____	_____
Orthodontia expenses	_____	_____
Artificial teeth	_____	_____
VISION EXPENSES (not covered by the vision plan)		
Eye examinations	_____	_____
Eyeglasses	_____	_____
Frames	_____	_____
Lenses	_____	_____
Contact Lenses	_____	_____
Contact lens solution	_____	_____
HEARING EXPENSES		
Ear examinations	_____	_____
Special telephone (for a deaf dependent)	_____	_____
Hearing aids	_____	_____
OTHER EXPENSES		
Therapy (speech, physical, occupational)	_____	_____
Syringes, needles and injections	_____	_____
Physician-directed weight loss	_____	_____
Guide dog	_____	_____
Halfway house (care for helping an individual adjust from life in a mental hospital to community living)	_____	_____
Alcohol or drug dependency payments to treatment centers	_____	_____
Hypnosis	_____	_____
Analysis fees (psychotherapy by a licensed practitioner)	_____	_____
Chiropractic charges (within the scope of license)	_____	_____
Acupuncture (performed by licensed practitioner)	_____	_____
Learning disability tutoring by licensed school or therapist for a dependent with severe learning disability	_____	_____
Nursing home confinement for treatment of illness or injury (regular nursing home care is not eligible)	_____	_____
Wheelchairs or crutches	_____	_____
TOTAL (may not exceed \$4,500 annually)	_____	_____

Now, divide your total by 26 to get your bi-weekly; 52 to get your weekly; and 12 to get your monthly contribution amounts.

e-Benefits Enrollment

The Benefits Enrollment link in PeopleSoft (ORACLE) allows you to review options and enroll in your benefits. After your initial enrollment, the only time you may change your benefit elections is during Memorial's annual open enrollment period or a qualified status change.

1. From your Peoplesoft Home page, click on Employee Self Service.
2. Under Employee Self Service, click on Benefits link.
3. From your Benefits Home page, click on Benefits Enrollment.
4. To begin your enrollment as well as make any changes, click the **Select** button.
5. Instructions are included on the page with a deadline of when the information needs to be completed by. Every team member needs to complete enrollment information on the computer.
6. Before submitting your work, it is important to print a copy of your information in case of an error. **This will serve as your confirmation statement. Please keep this statement for your records.** Compare your confirmation statement with the benefit information listed on your first paycheck in 2012. If you notice any discrepancies, please contact Memorial's Benefit Counselor immediately. A link is provided on the page to print your elections.
7. An Enrollment Summary is listed on the page. It is here that you can Edit any information for which you qualify. To begin this process, click the Edit button.

If you do not wish to return to the Enrollment Summary to correct any choices, click Continue and Submit your benefit choices. You will receive a Submit Confirmation screen, click OK.

Exiting PeopleSoft

1. To exit PeopleSoft, click on the Sign Out link located on the top right side of the PeopleSoft window.

PeopleSoft Tips to Remember

- Do not use your Back button on your Tool bar. Your data will not be saved when you use the Back button. If you need to go back to a previous page, use the Previous button or use the links located on the bottom of your page.
- When PeopleSoft is saving your information, you will see flashing in the right side of your screen.
- Fields that have an * next to them are required.

Do we have your correct address?

Anytime you have a change of address please remember to submit this change through the PeopleSoft system under Employee Self Service.



Frequently Asked Questions and Answers

Q: How do SRC benefit limits work?

A: Limits put a cap or ceiling on what the plan will pay. Some benefits have a limit on the dollar amounts and others on the number of services, or both. The plan will not pay for a service, or both. The plan will not pay for a service or supply once you have reached a limit on either the dollar amounts or the number of services or visits, you may not be covered for some services or visits even though you have not reached your overall maximum.

Q: Will the SRC plan always pay up to the maximum benefits per coverage year??

A: No. How much the plan pays depends on the type and amount of the health care you receive. Some types of charges may have limits that are reached before the overall maximum they are a part of is reached. This means that the plan may no longer pay for

certain types of charges you continue to have, even though the overall max benefit has not been reached.

Q: How does the SRC limited benefits insurance plan differ from a traditional major medical health plan?

A: There are important differences in what the plan will pay and what the premium costs. Both types of plans cover many types of services and supplies. However, this limited benefits insurance plan has a lower maximum benefit and places limits on how much it will pay for categories of services or supplies. Once you have used up the overall maximums or limits on specific benefits, the plan will not pay any more. And unlike most major medical plans, this limited benefits insurance plan does not have catastrophic coverage or a limit on your out-of-pocket expenses. This means that you may have large out-of-pocket cost if you have a serious or chronic medical condition.

Q: What will I pay up front when I go to a healthcare provider under the SRC plan?

A: A preferred provider, hospital or other healthcare provider may require you to pay charges for which you are responsible in advance. This could include your co-pay, deductible, percentage of charges the plan does not pay (coinsurance), charges for services excluded under the plan, and charges in excess of your coverage limits. A non-preferred provider may require that you pay all charges in advance, and it would be up to you to submit a claim for reimbursement for any charge the plan may pay.

Q: Do I have to participate in the Prevention Plan?

A: If you are covered under one of Memorial's Medical Plans you must participate in the Prevention Plan. If your spouse is covered under a Memorial Plan, he/she must also participate in the Prevention Plan to be eligible for coverage.

Q: When do I have to complete the blood test for the Prevention Plan?

A: You must complete all three steps of the Prevention Plan (registration, online HRA, and blood test) by January 31, 2012 in order to be covered under the Memorial plan. If you do not complete these requirements, your coverage will be terminated as of March 1, 2012

Q: Do dependent children over age 18 have to participate in the Prevention Plan or complete the HRA as in past years?

A: No, only team member's and their spouses have to participate in the prevention plan. There is no requirement for dependent children to participate.

Q: What is an annual deductible?

A: The annual deductible is the amount of covered charges which must be paid by the participant in a calendar year before benefits can be paid by the plan. Each year, a person covered by the plan must "meet" (or pay) the covered charges up to the amount of their annual deductible listed in the schedule of benefits. Once the deductible has been paid by the participant, the plan will begin to pay benefits as described in the schedule of benefits. Each person only pays the deductible once per calendar year. Office-visit co-pays and prescription drug co-pays do not count towards the annual deductible amount.

Q: What does the annual out of pocket maximum mean?

A: Out of pocket expenses are also referred to as "co-insurance"; and refer to the amount (after the deductible) of the covered charges that the participant must pay. Each calendar year, covered charges are paid by the plan at the percentage shown in the schedule of benefits. The participant is responsible for paying the remaining balance of these covered charges. (This amount would be the participant's co-insurance amount.) Once the participant has paid co-insurance up to the out of pocket maximum listed in the schedule of benefits the plan will pay the covered charges at 100% for the remainder of the calendar year, and the participant will no longer be responsible for a co-insurance amount. Office-visit co-pays and prescription drug co-pays do not count towards the annual out of pocket maximum. The out of pocket amount paid by a participant starts over again at \$0.00 each January 1.

Q: How are benefits handled for a pre-existing condition?

A: A pre-existing condition is an injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days immediately preceding the effective date of coverage under Memorial's plan. Limited benefits will be paid for pre-existing conditions during the first 12 months of coverage. The 12 month period will be reduced for new enrollees by the number of documented days of credited healthcare coverage that an individual had under another plan prior to their enrollment. To receive this credit, you must send a copy of the "Certificate of Creditable Coverage" to Meritain Health. Pre-existing conditions do not apply to dependent children under 19 years of age.

Q: How does Coordination of Benefits (C.O.B.) work?

A: Coordination of Benefits establishes rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person’s Spouse is covered by this Plan and by another plan or; the couple’s Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. When this Plan is secondary, the Plan will pay up to its normal Plan benefits. The total reimbursement will never be more than the maximum payable by the Plan. The plan will deduct any benefits payable by the primary carrier and pay the balance of charges up to what the Plan would normally pay. The balance due, if any, is the responsibility of the Covered Person.

An example would be: Barb is the spouse of a Memorial team member. She is covered under Memorial’s Plan as secondary and under her employer’s Plan as primary. The allowable charge is \$100.00 and Barb used an in-network provider. Assuming Barb has met her deductible for the year, her employer’s Plan would pay \$80.00 and Memorial’s Plan would pay the remaining \$20.00

Q: Can you apply for medical, dental, vision insurance at any time during the year?

A: No. Only within 31 days of first becoming eligible for benefits, during open-enrollment, or in some instances within 31 days of a change in family status (i.e., marriage/divorce, gain/loss of coverage, etc.). Refer to Memorial’s Summary Plan Description for details concerning a change in family status. Contact your Benefit Counselor immediately when a change in family status occurs.

Q: Are prescription drugs covered under the plan?

A: Yes, when you enroll in a medical plan option. Team members can go to Memorial Team Pharmacy or any participating pharmacy to get their prescriptions filled. With Memorial’s prescription plan, your co-payments will be based on a three-tiered plan. Refer to the Medical Options in this Enrollment Guide for more information.

Q: What is meant by “reasonable and customary”?

A: A medical fee is considered “reasonable and customary” (RTC) when it is in the normal range of amounts charged for that type of treatment or service in your part of the country. For example, if the normal amount

charged by doctors in your area is \$50 but your doctor charges \$60, the plan will consider only \$50 for payment and you will be responsible for the balance of \$10 (RTC charges are waived as long as you use an in-network provider).

Q: What does PPO mean?

A: PPO means Preferred Provider Organization. A PPO provider is one who has agreed to charge you a discounted price. Memorial’s plans are all PPO Plans, which use the Community Health Alliance (CHA) network of providers for the Medical Plans, and Guardian providers for the Dental Plans.

Q: What does “Non-Network” provider or the term “Out-of-Network” refer to?

A: Non-Network or Out-of-Network means any services by providers who do not participate in the Network of Providers. Typically allowable Out-of-Network services are paid at 60% (after deductible) instead of 80% (after deductible) for allowable services provided by In-Network providers.

Q: How are out-of-network services defined?

A: Out-of-Network applies to all physicians, facilities and providers who are not part of the Provider Networks. Remember, Memorial’s plans allow you to choose each time you need care whether that care is received from an in-network provider or not. The difference is that the cost to you is lower, and the coverage levels are higher if you use a network provider.

Q: Which providers are “In-Network”?

A: To determine if your provider is in-network or to inquire about other in-network providers, you should visit the CHA website at www.chanetwork.com for a Medical provider, the Guardian website at www.guardianlife.com for a dental or vision provider. You decide each time you need services whether to use an In-Network provider.

Q: Why is it beneficial to use an In-Network Provider?

A: The benefits of using a network provider are: 1) Your cost will be lower because the carriers have negotiated rates that are significantly lower than regularly billed charges; 2) The Network Provider will file your claims for you; 3) The Network Provider will only bill your deductibles and co-insurance, not the full amount of the charges or any amount above “reasonable and customary” 4) Your coverage under the plan is higher if you use a Network Provider [Generally 80% co-insurance (after

deductible) compared to 60% co-insurance (after deductible) if you do not use an in-network provider].

Q: How do I file a claim?

A: If you use an In-Network provider, the provider will file the claim for you. If you choose to use an Out-of-network provider you must ask your provider to send your claim to the carrier at the address on back of your I.D. card for payment consideration. The carrier will consider all allowable claims for payment according to Memorial's Plan. In either case, a monthly claims summary statement will be sent to your home that explains how the bill was paid. If you have questions once you receive your summary statement, contact the carrier directly.

Q: How do I file a claim under the HealthCare Spending Account?

A: Meritain Health pays claims for Memorial's flexible spending accounts. There are two ways to file your HealthCare Flexible Spending Account claims:

You may use your flex debit card to pay for flex spending account eligible expenses at the point of sale (please remember to save your receipts from these purchases for your records).

If you do not want to use your flex debit card you will need to submit a "Flexible Spending Reimbursement" Form to Meritain Health for each reimbursement you are requesting. Reimbursement Forms are available from your Benefit Services Counselor or under the "Forms" section of the Human Resources Intranet Web site.

Q: How do I file a claim under the Dependent Daycare Spending Account?

A: If your Daycare Provider accepts credit card payments, you may use your flex debit card to pay for these services. If you do not use your debit card you need to complete the "Flexible Spending Reimbursement Request" form, attach your itemized paid receipt(s) and return all materials directly to Meritain Health for processing. The "Flexible Spending Reimbursement" form can be obtained under the "Forms" section of the Human Resources Intranet Web site.

NOTE: Remember that, under this account, you can only receive payments for claims up to the balance in this account at the time the request is made.

Q: If both my spouse and I work for Memorial, can we carry insurance on one another?

A: No. You cannot be simultaneously covered under medical, dental and/or vision both as a team member and as a dependent.

Q: Do I have to participate in the Team Lead Care program?

A: No, the TLC program is entirely voluntary, but individuals who participate in the program will receive additional benefits, such as reduced co-pays for prescriptions and physician office visits.

Q: I am currently working with a case manager that I really like. Do I have to switch to the new local case manager?

A: No, you have the option to continue working with your current case manager if you would like.

Q: Now that self injectable medications are to be filled at Team Pharmacy, do I still need to pre-certify these medications through CHA?

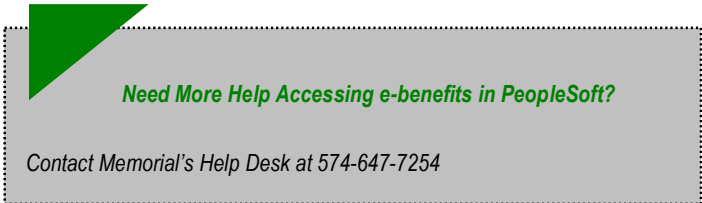
A: These medications will now be pre-certified by Envision, rather than CHA. To pre-certify these medications, call (800)361-4542, or fax (330)405-8081.

Q: I take daily blood pressure medication. Is this considered a "maintenance medication"?

A: Yes, any medication that you take on a regular basis is considered a maintenance medication, and needs to be filled at Team Pharmacy to be covered under the plan.

Q: I don't work at the hospital, and can't always get to Team Pharmacy to pick up my prescriptions. Do I still need to fill my prescriptions there?

A: You are still required to fill maintenance medications at Team Pharmacy. For your convenience, you do have the option of having your medications mailed to you.



Need More Help Accessing e-benefits in PeopleSoft?

Contact Memorial's Help Desk at 574-647-7254

Memorial Team Pharmacy

615 N. Michigan Street, South Bend, IN 46601

Phone: 574-647-3534, Fax: 574-647-6767

Team Member Information

Team Member Name:	
Date of Birth:	
Home Address:	
Home Telephone Number:	
Work Telephone Number:	
Allergies:	
<input type="checkbox"/> Check box if you want mail order to the above address. <input type="checkbox"/> 30 Day Supply OR <input type="checkbox"/> 90 Day Supply	

Insurance Information

Insurance Carrier:	
ID Number:	
Group Number:	

Dependent Information

Spouse's Name:	
Date of Birth:	
Allergies:	
Child's Name:	
Date of Birth:	
Allergies:	
Child's Name:	
Date of Birth:	
Allergies:	
Child's Name :	
Date of Birth:	
Allergies:	

Transferring Pharmacy and Drug Information

Name of Pharmacy:	
Telephone Number:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	
Name on Prescription:	
Name and Rx# of Drug:	
Fill Date Needed:	

Please allow 2 business days for transfer to Team Pharmacy

Important Numbers You Should Know

Health and Dental Insurance

For questions regarding **SCR** Medical, Dental and Vision insurance plans for Memorial Staffing Employees call (888)772-9682 or visit their website www.aetna.com.

Health Insurance

For questions regarding Memorial's Medical insurance plans with **Meritain Health** call (866)841-0852 or visit their website www.meritain.com.

Dental

For questions regarding Memorial's Dental insurance plans call **Guardian** directly at (888)600-1600 or visit their website at www.guardianlife.com.

Vision

To inquire about vision benefits or to find a vision care provider, simply call **Guardian** at the toll free number (888)600-1600 or visit their website at www.guardianlife.com.

Network Providers

To inquire about an In-Network Medical Provider in IN or MI you can call (574)284-1820 or visit the **Community Health Alliance (CHA)** website at www.chanetwork.com. If you just have general questions please call (574)647-1820.

Medical Pre-Certification

To pre-certify your medical procedure you will need to call **Community Health Alliance (CHA)** directly at (574)647-1824 or toll free (800)301-1824 if enrolled through Meritain Health.

Prescription

To inquiry about pharmacy benefits through Meritain Health call **Envision** directly at (800)361-4542, or to find the Tier level of your medication visit their website www.envisionrx.com.

Dental Network Providers

To inquire about an In-Network Dental Provider in IN or MI you can call (888)600-1600 or visit the **Guardian** website at www.guardianlife.com.

Memorial Team Pharmacy

To fill or transfer a prescription with Team Pharmacy call (574)647-3534, or fax (574)647-6767.

MMG Providers

To inquire about an MMG Provider, visit Memorial's Intranet site under Employee tab click Human Resources, then click MMG Providers.

Flexible Spending Accounts

For questions regarding either of Memorials Medical or Dependent Flexible Spending Accounts call **Meritain Health** directly at (866)841-0852 or visit their website www.meritain.com.

Memorial Perks

To access a complete discount listing offered by local and national vendors, register your perks card at www.memorialperks.com.

Memorial's Benefit Options

Other benefit related questions can be directed to **Memorial's Benefit's Counselor** at (574)647-6509 or e-mailed to dgillispie@memorialsb.org.

Team Lead Care (TLC)

To inquire about Memorial's Team Lead Care program, contact the Team Lead Care Manager at (574)647-5003.

Rewards for Savings

Have questions on your different investment options call **Diversified Investment Advisors** at their toll free customer service phone line (800)755-5801 or visit their website www.divinvest.com.

To talk one-on-one with a representative who is located in the hospital call (574)647-1026; or to talk with an HR Representative regarding your plans for retirement call (574)647-6509 or e-mail dgillispie@memorialsb.org.

U.S. Preventive Medicine

To complete your HRA or register for lab services visit the U.S. Preventive Medicine website at www.uspreventivemedicine.com.

New Avenues

For help in dealing with problems such as stress, problems at work, problems with children and school, substance abuse, marriage problems and other life issues, call (574)232-2131, (800)731-6501, or visit www.newavenuesonline.com, for additional help and resources.

