# SCHEDULE OF MEDICAL BENEFITS PERMIAN PUMP AND SUPPLY

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, “Medical Covered Expenses”, “Claim Review and Audit Program”, and “Exclusions and Limitations.” You may find the “Definitions” section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as “Cost Containment Provisions,” and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *claims administrator* or the *Plan Administrator* for assistance.

**Lifetime Maximum Benefits**

Lifetime Maximum for All Essential Health Benefits Unlimited

Hospice Care $20,000

**Plan Year Maximum Benefits per Covered Person**

Plan Year Maximum for All Essential Health Benefits $2,000,000

## Calendar Year Maximum Benefits

|  |  |
| --- | --- |
| Calendar Year Maximum Benefits per Covered Person for: | |
| Skilled Nursing Facility Care | 90 days |
| Chiropractic Care | $1,000 |
| Routine Foot Care – Non-surgical | $2,000 |
| Routine Mammogram Screening | 1exam |
| Second Surgical Opinion – Per Surgery | $100 |
| Organ Donor Expenses – Per Transplant | $10,000 |

## Deductible

|  | ***PPO Network Providers* and Non-*PPO Network Providers*** |
| --- | --- |
| *Calendar Year Deductible* |  |
| * Individual | $1,000 |
| * *Family Unit* | $3,000 |

## Percentage Payable and Out-of-Pocket Expense Limits

|  |  |  |
| --- | --- | --- |
|  | ***Hospital* Facilities**  ***Ambulatory Surgery Centers***  **Dialysis Facilities and**  ***PPO Network Providers*** | **Non-*PPO Network Providers*** |
| Percentage Payable (unless otherwise stated) | 80% | 60% |
| *Out-of Pocket Expense Limit*   * Individual * *Family Unit* | $2,500  $5,000 | $5,000  $10,000 |
| Certain types of expenses are not eligible to accumulate toward the *out-of-pocket expense limit*. Please refer to the section, “Your Costs”, for additional information. | | |

## Section I

**Applicable to the following facilities:**

* ***Hospitals***
* ***Ambulatory Surgery Centers***
* **Dialysis Facilities**

## Payment Levels and Limits – Hospital, Ambulatory Surgery Centers and Dialysis Facilities

This section of the Schedule of Medical Benefits applies only to covered expenses which are rendered by *hospital* facilities, *ambulatory surgery centers* and dialysis clinics and facilities. The benefits shown apply to all such covered, licensed *providers* of service without regard to participation in a *PPO*.

| **Percentage Payable For:** | ***Hospital* *Inpatient* Services** | **Limits:** |
| --- | --- | --- |
| Medical/Surgical Room & Board & Ancillary | 80% of *allowable claim limits* for semi‑private room and ancillary charges   * *deductible* applies |  |
| *Skilled Nursing Facility*, Convalescent Care and Extended Care Facility | 80% of *allowable claim limits* for semi‑private room and ancillary charges   * *deductible* applies | Limited to 90 days per *calendar*  *year* maximum |
| *Mental or Nervous Disorder Inpatient* | 80% of *allowable claim limits* for semi‑private room and ancillary charges   * *deductible* applies |  |
| *Mental or Nervous Disorder* Facility Outpatient | 80% of *allowable claim limits*   * *deductible* applies |  |
| *Substance Abuse* Care  *Inpatient* | 80% of *allowable claim limits* for semi‑private room and ancillary charges   * *deductible* applies |  |
| *Substance Abuse* Care  Facility Outpatient | 80% of *allowable claim limits*   * *deductible* applies |  |
| ***Hospital*****Emergency Room Services** | | |
| *Hospital*Emergency Room - *Accident*\* or *Illness* | $50 copay then 80% of *allowable claim limits,* physician and hospital |  |
| \*Supplemental Accident Benefit | 100% of *allowable claim limits* to $300 per *accident* – thereafter subject to *deductible* and reimbursed at 60% of *allowable claim limits* |  |
| ***Hospital* Outpatient *Diagnostic Services*** | | |
| Diagnostic X-ray and Laboratory | 80% of *allowable claim limits*   * *deductible* applies |  |
| Routine Mammogram – Covered Persons Over Age 35 | 100 % of *allowable claim limits*   * *deductible* waived | Limited to one exam per *calendar year* maximum |
| Pre‑Admission Testing | 100% of *allowable claim limits*   * *deductible* waived |  |
| **All Other Covered *Hospital* Services and Supplies** | | |
| All Other Covered Expenses | 80% of *allowable claim limits*   * *deductible* applies |  |
| ***Ambulatory Surgery Centers* Covered Services and Supplies** | | |
| All Covered Expenses | 80% of *allowable claim limits*   * *deductible* applies |  |
| **Dialysis Facilities Covered Services and Supplies** | | |
| All Covered Expenses | 80% of *allowable claim limits*   * *deductible* applies |  |

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

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

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

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

## Section II

**Applicable to all other providers of service:**

## Payment Levels and Limits – Physician and Other Provider Expenses

The following tables apply to all *providers* of service other than *hospital* facilities, *ambulatory surgery centers* and dialysis facilities. Benefits are available, as shown, for reimbursement of *covered expenses* based upon the *provider’s* participation in the *PPO network*.

| ***Physician* In‑Hospital Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| *Physician* Medical Hospital Visit | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| *Physician – Mental or Nervous Disorder Hospital* Visit | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| *Physician – Substance Abuse Hospital* Visit | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |

| **Second Surgical Opinion Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Office Visit For Second Surgical Opinion | 100% of *PPO* rate   * *deductible* waived | 100% of *usual, customary and reasonable* fees   * *deductible* waived |  |

| **Surgical Services – *Inpatient* and Outpatient/Office** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Anesthesia | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Assistant Surgeon | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies | Limited to 25% of surgical fee allowance |
| Obstetrical | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Surgeon – Office | 80% of *PPO* rate | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Surgeon – All Other | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |

| ***Physician*’s Office and Outpatient Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| All *Covered Expenses*, Including:   * Office Visit * *Surgery* * Lab or X-rays * Allergy Care * Injections * Other Covered Services | 100 % up to $500 after a copayment of $20 per visit, *deductible* waived  *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| *Mental or Nervous Disorder* Office Visit and Outpatient | 50% of *PPO* rate up to $40 maximum   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| *Substance Abuse* Office Visit and Outpatient | 50% of *PPO* rate up to $60 maximum   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |

| **Chiropractic Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| *Chiropractic Care* and Therapies | $20 copay of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies | Limited to $1,000 per *calendar year* maximum benefit |

| **Other Covered Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Therapy   * Physical * Occupational * Speech * IV and Infusion * Cardiac Rehabilitation | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Chemotherapy and Radiation Therapy | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| *Durable Medical Equipment* | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Home Health Services | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies | Limited to 100 visit maximum benefit per calendar year |
| Hospice | 100% of *PPO* rate   * *deductible* waived | 100% of *usual, customary and reasonable* fees   * *deductible* waived |  |
| Routine Non-Surgical Foot Care | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies | Limited to $2,000 per *calendar year* maximum benefit |
| Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Pre‑Admission Testing | 100% of *PPO* rate   * *deductible* waived | 100% of *usual, customary and reasonable* fees   * *deductible* waived |  |
| Routine Mammogram – *Covered Persons* Over Age 35 | 100 % of *PPO* rate   * *deductible* waived | 100% of *usual, customary and reasonable* fees   * *deductible* waived | Limited to one exam per *calendar year* maximum |
| Ambulance ⎯ Air or Ground Transportation | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Blood and Administration | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Oxygen and Administration | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Prosthetic Devices | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Lenses Following Cataract Surgery | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |
| Supplemental Accident Benefit | subject to *deductible* and reimbursed at 60% of *PPO* rate | 60% of *usual, customary and reasonable* *and reasonable* fees |  |
| Prescription Drugs  Retail Copay  Mail order | 100% of *usual, customary and reasonable* fees, *deductible* waived, subject to copayments as follows:   * $15 generic drugs,$35 preferred brand name drugs   $50 non-preferred brandname, $50 specialty drugs plus 25% of cost of drug   * $37.50 generic, $ 35 preferred brand name, $125 non-preferred brandname, $125 specialty drugs plus 25% of cost of drug | | Limited to 30-day supply per purchase  Limited to $10,000 per *plan year* maximum benefit  Limited to $30,000 lifetime maximum benefit |
| All Other *Covered Expenses* | 80% of *PPO* rate   * *deductible* applies | 60% of *usual, customary and reasonable* fees   * *deductible* applies |  |

# SCHEDULE OF DENTAL AND VISION BENEFITS

DEDUCTIBLE

Per Person $50 (waived for preventive)

Family Deductible $150

COINSURANCE

TYPE A; Preventive, Diagnostic, Emergency Services, 100%

TYPE B; Basic Procedures 80%

TYPE C; Major Procedures 50%

LIMITS

Calendar Year Maximum per Person $1,000