# Shamrock General Hospital

# SCHEDULE OF MEDICAL BENEFITS

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

The following lifetime maximums apply to each covered person:

|  |  |
| --- | --- |
| Lifetime Maximum Benefits for: | |
| Lifetime Maximum for All Essential Health Benefits | Unlimited |
| Hospice Care | $20,000 |

**The *plan year* for this *Plan* is the calendar year from January 1 through December 31 each year.**

## Plan Year Maximum Benefits

The following plan year maximums apply to each covered person:

|  |  |
| --- | --- |
| Plan Year Maximum Benefits per Covered Person for: | |
| Plan Year Maximum for All Essential Health Benefits | $2,000,000 |
| Mammography Screening | One screening |
| Routine Vision Exam (Preventive Care) | One exam |
| Donor-related Transplant Expenses | $10,000 per transplant |

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

The following *deductibles*, percentage payable and *out*-*of*-*pocket* *expense* limits apply per *plan* *year*:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Shamrock General Hospital** | **Other**  **Facilities**  **and**  ***PPO Network Providers*** | **Non-*PPO Network Providers*** |
| *Plan Year Deductible*   * Individual * *Family Unit* | $1,750  $3,500 | $1,750  $3,500 | $5,250  $10,500 |
| Percentage Payable (unless otherwise stated) | 90% | 80% | 50% |
| *Out-of Pocket Expense Limit*   * Individual * *Family Unit* | $2,500  $5,000 | $2,500  $5,000 | $10,000  $20,000 |
| 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. | | | |

*Covered* *expenses* *incurred* during the last three months of a *plan* *year* that were applied toward an individual *deductible* will be allowed as credit toward satisfaction of the individual’s *deductible* in the following *plan* *year*.

### Note: Any references to dependents in this summary plan description that are related to covered expenses, benefits payable, rights, responsibilities, exclusions, limitations and all terms and conditions of this Plan are intended to apply to those dependents that are being covered on and after January 1, 2014.

## 

## SECTION I

**Applicable to the following facilities:**

* ***Hospitals***
* **Ambulatory Health Care Facilities and Dialysis Facilities**
* **Other Covered Facilities**

## Payment Levels and Limits – Section I Facility Providers

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

| **Percentage Payable For:** | **Shamrock General Hospital** | **Other Facilities** | **Limits:** |
| --- | --- | --- | --- |
| ***Inpatient* *Room & Board* & Ancillary Charges** | | | |
| *Hospital* Medical/Surgical *Inpatient* | 90% of *allowable claim limits*   * *deductible* waived | 80% of *allowable claim limits*   * *deductible* applies subject to a $500 copay per treatment\* | Transplant donor-related benefits limited to $10,000 maximum per transplant |
| *Mental or Nervous Disorder* and *Substance Abuse* Care *Inpatient* | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies subject to a $500 copay per treatment\* |  |
| \*The Plan has arranged for a special negotiated discount arrangement at the following facilities. **The $500 copayment requirement is waived for all of these hospital providers:**   * Covenant Hospital, Lubbock, Texas * Baptist St. Anthony Hospital, Amarillo Texas * Shamrock General Hospital | | | |
| *Skilled Nursing Facility* | Not Applicable | 80% of *allowable claim limits*   * *deductible* applies |  |
| Hospice Care *Inpatient* | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies | Combined with non-facility charges, limited to $10,000 per lifetime maximum benefit |
| ***Hospital*****Emergency Room Services** | | | |
| *Hospital*Emergency Room - *Accident* or *Illness* | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies subject to a $500 copay per treatment\* |  |
| **Outpatient Facility *Diagnostic Services*** | | | |
| Diagnostic X-ray and Laboratory | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies subject to a $500 copay per treatment\* |  |
| Preventive Care Services | 100% of *allowable claim limits* to $200, *deductible* waived  90%, subject to *deductible* thereafter | 100% of *allowable claim limits* to $200, *deductible* waived  80%, subject to *deductible* thereafter | Benefit combined with non-facility per *plan* *year* - refer to “Medical Covered Expenses” section for covered services |
| Mammogram Screening | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies | Limited to one screening per *plan* *year* maximum |
| **All Other Covered *Hospital* Services and Supplies** | | | |
| All Other *Covered* *Expenses* | 90% of *allowable claim limits*   * *deductible* applies | 80% of *allowable claim limits*   * *deductible* applies |  |
| **Ambulatory Health Care and Other Facilities’ Covered Services and Supplies** | | | |
| All *Covered* *Expenses* | 90% of *allowable claim limits*   * *deductible* applies | 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 health care centers, and other 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 network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| *Physician – Mental or Nervous Disorder Hospital* Visit | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| *Physician – Substance Abuse Hospital* Visit | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |

| **Second Surgical Opinion Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Office Visit For Second Surgical Opinion | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |

| **Surgical Services – *Inpatient* and Outpatient/Office** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Anesthesia | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Assistant Surgeon | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies | Limited to 25% of the *usual*, *customary* and *reasonable* charge for the surgical procedure |
| Obstetrical | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Surgeon | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |

| **Chiropractic Services** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| *Chiropractic Care* and Therapies | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *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 | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| *Mental or Nervous Disorder* Office Visit and Outpatient | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| *Substance Abuse* Office Visit and Outpatient | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |

| **Other Covered Services (Non-Facility)** | | | |
| --- | --- | --- | --- |
| **Percentage Payable For:** | ***PPO* *Network Providers*** | **Non‑*PPO* *Network Providers*** | **Limits** |
| Therapy   * Physical * Occupational * Speech * IV and Infusion * Cardiac Rehabilitation | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Chemotherapy and Radiation Therapy | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| *Durable Medical Equipment* | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Home Health Services | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Hospice | 80% of *PPO* rate   * *deductible* waived | 50% of *usual, customary and reasonable* fees   * *deductible* waived | Combined with facility charges, limited to $10,000 per lifetime maximum benefit |
| Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Preventive Care | Combined with facility charges, 100% of *PPO rate* to $200 per *plan* *year*, *deductible* waived  90%, subject to *deductible* thereafter | Not Covered | Refer to “Medical Covered Expenses” section for covered services |
| Preventive Care Routine Vision Exam | 100% of *PPO* rate   * *deductible* waived | Not Covered | Limited to one per *plan* *year* maximum |
| Mammography Screening | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies | Limited to one screening per *plan* *year* maximum |
| Ambulance ⎯ Air or Ground Transportation | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Blood and Administration | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Oxygen and Administration | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Prosthetic Devices | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |
| Transplant-related Donor Charges | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies | Combined with facility charges, limited to $10,000 per transplant maximum benefit |
| Prescription Drugs | *deductible* applies to *usual, customary and reasonable* fees, payable thereafter as follows:   * 90% per prescription or refill for *generic drugs*, or * 70% per prescription or refill for *brand name drugs* | |  |
| All Other *Covered Expenses* | 80% of *PPO network provider rate*   * *deductible* applies | 50% of *usual, customary and reasonable fee*   * *deductible* applies |  |