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*	

Percentage Payable For:	Shamrock General Hospital	Other Facilities	Limits:
***Inpatient Room & Board* & Ancillary Charges**			
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	

Other Covered Services (Non-Facility)			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
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	