Kendrick Oil Company/Hub City Convenient Employee Benefit Plan

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	Unlimited

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

Plan Year Maximum Benefits

Plan year maximums for a benefit which is payable under either Section I or Section II providers will be combined and applied to the maximums listed below. The following *plan year* maximums apply to each *covered person*:

***Plan Year* Maximum Benefits for:**	
Plan Year Maximum for All *Essential Health Benefits*	Unlimited
Home Health Care	60 visits

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

	Section I Providers and *PPO Network Providers*	**Non-*PPO Network Providers***
Plan Year Deductible • Individual • *Family Unit*	 $3,000 $9,000	 $6,000 $18,000
Note: *Covered expenses* which are applied to your individual *plan year deductible* in the last three months of the *plan year* will be allowed as credit again toward your individual *plan year deductible* in the following year. This carryover credit does not apply to the *family unit deductible*.		
Percentage Payable (unless otherwise stated)	80%	50%
Out-of Pocket Expense Limit • Individual • *Family Unit*	 $7,000 $14,000	 $15,000 $30,000
*The out-of-pocket expense limit does include the *deductible* amount and does not apply to benefits for chiropractic care.		

Section I

Applicable to facilities including, but not limited to:

- ***Hospitals***
- **Ambulatory Health Care Centers**
- **Dialysis Clinics and Other Facilities**

Payment Levels and Limits – Hospitals, Ambulatory Health Care Centers and Other Facilities
This section of the Schedule of Medical Benefits applies only to covered expenses which are rendered by *hospital* facilities, ambulatory health care centers, *ambulatory surgery centers*, dialysis clinics and other covered facilities. The benefits shown apply to all such covered, licensed providers of service without regard to participation in a *PPO*.

Percentage Payable For:	Inpatient Services	Limits:
Hospital Medical/Surgical *Inpatient Room & Board &* Ancillary	80% of *allowable claim limits* for semi-private room and ancillary charges • subject to a $1500 copayment per *hospital* confinement*	
Mental or Nervous Disorder and *Substance Abuse Treatment Inpatient Room & Board &* Ancillary	80% of *allowable claim limits* for semi-private room and ancillary charges • subject to a $500 copayment per *hospital* confinement*	
*The *Plan* has arranged for a special negotiated discount arrangement at the following facilities. **The $1500 copayment requirement is waived for all of these *hospital* providers:** • Covenant Hospital, Lubbock Texas • Baptist St. Anthony Hospital, Amarillo Texas • Friona Hospital, Friona, Texas		
Skilled Nursing Facility, Convalescent Care and Extended Care Facility	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
***Hospital* Emergency Room Services**		
Hospital Emergency Room - Accident or Illness	80% of *allowable claim limits* • *deductible* applies	
Facility Outpatient Diagnostic Services		
Diagnostic X-ray and Laboratory	80% of *allowable claim limits* • *deductible* applies	
Facility Charges for Routine Preventive Care	100% of *allowable claim limits* to $300 • *deductible* waived thereafter 80% of *allowable claim limits* • subject to *deductible*	Mammograms are limited to one per *plan year* maximum
All Other Covered Facility Services and Supplies		
Home Health Care Facility Charges	80% of *allowable claim limits* • *deductible* applies	Combined with non-facility benefits, limited to 60 visits per *plan year* maximum
Hospice Facility Charges	100% of *allowable claim limits* • *deductible* waived	Combined with non-facility benefits, limited to $5,000 per lifetime maximum benefit
Other Facility *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 Shorman Solutions when diagnosed with End Stage Renal Disease ("ESRD"); and 2) Notify Shorman Solutions when dialysis treatment begins; 800-410-0699

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 – Physicians and Other Provider Expenses
The following tables apply to all providers of service other than *hospital* facilities, ambulatory health care centers, and other covered facilities. Benefits are available, as shown, for reimbursement of covered expenses based upon the provider's participation in the *PPO* network.

Physician's Office Services			
Percentage Payable For:	***PPO* Network Providers**	**Non-*PPO* Network Providers**	**Limits**
Office Visit – Medical/Surgical	100 % of *PPO* rate after a copayment of $40 per visit • *deductible* waived	50% of *usual, customary and reasonable fees* • *deductible* applies	
Office Visit – *Mental or Nervous Disorder* and *Substance Abuse Treatment*	100 % of *PPO* rate after a copayment of $40 per visit • *deductible* waived	50% of *usual, customary and reasonable fees* • *deductible* applies	
Additional Covered Services During Office Visit Including: • Surgery • Lab or X-rays • Allergy Care • Injections • Other Covered Services	Covered expenses payable at 100% of *PPO* rate up to $200, thereafter reimbursed at 80% of the *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Second Surgical Opinion – Required under Pre-certification Program	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable fees* • *deductible* waived	
Routine Preventive Care	100% of *PPO* rate to $300 • *deductible* waived thereafter 80% of *usual, customary and reasonable fees, charges above $300 are subject to deductible and coinsurance*	50% of *usual, customary and reasonable fees* • *deductible* applies	Mammograms are limited to one per *plan year* maximum
Chiropractic Care	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	Limited to 30 visits per *plan year* maximum

***Physician* Services – *Inpatient* and Outpatient (other than office)**			
Percentage Payable For:	***PPO* Network Providers**	**Non-*PPO* Network Providers**	**Limits**
Medical/Surgical Visits	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Mental or Nervous Disorder and *Substance Abuse Treatment* Visits	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Surgeon	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Assistant Surgeon	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	Limited to 25% of surgical fee allowance

Other Covered Services			
Percentage Payable For:	***PPO* Network Providers**	**Non-*PPO* Network Providers**	**Limits**
Ambulance — Air or Ground Transportation	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Therapy • Physical • Occupational • Speech • IV and Infusion • Cardiac Rehabilitation	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Chemotherapy and Radiation Therapy	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Durable Medical Equipment	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Home Health Services	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	Combined with facility benefits, limited to 60 visits per *plan year* maximum
Hospice	100% of *PPO* rate • *deductible* waived	100% of *usual, customary and reasonable fees* • *deductible* waived	Combined with facility benefits, limited to $5,000 per lifetime maximum benefit
Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	
Prosthetic Devices and Medical Supplies	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	

Other Covered Services			
Percentage Payable For:	***PPO* Network Providers**	**Non-*PPO* Network Providers**	**Limits**
Prescription Drugs – Pharmacy Purchase	100% of *usual, customary and reasonable fees*, *deductible* waived, subject to copayments as follows: • $20 per prescription or refill for *generic drugs*, or • $50 copay plus 30% of cost per prescription or refill for *brand name drugs**		Limited to a 30-day supply per purchase
Prescription Drugs – Mail Order Purchase	100% of *usual, customary and reasonable fees*, *deductible* waived, subject to copayments as follows: • $40 per prescription or refill for *generic drugs*, or • $60 copay plus 30% of cost per prescription or refill for *brand name drugs**		Limited to a 90-day supply per purchase
*Unless a brand name drug is ordered "dispense as written" by your *physician*, you must also pay the difference in cost between a *generic drug* and its *brand name* equivalent.			
Other Non-facility *Covered Expenses*	80% of *PPO* rate • *deductible* applies	50% of *usual, customary and reasonable fees* • *deductible* applies	

Kendrick Oil Dental "Schedule of Benefits"

DEDUCTIBLE
Per Person $50 Family Deductible $150

COINSURANCE
TYPE I 100% no deductible TYPE II 80% TYPE III 50%* TYPE IV 50%*
*waiting period for TYPE III and TYPE IV is 12 months from date of coverage and are not covered until after the waiting period

LIMITS

Calendar Year Maximum per Person	$1,000
Orthodontic Lifetime Maximum	$1,000

TYPE I
Oral Exam-Initial Exams(limited to 1 per year) Recall Exams(limited to 2 per year) Emergency treatment for relief of pain or discomfort, Radiographs and radiographic interpretations, complete series of radiographs or panographic x-rays(limited to 1 every three years), sets of bitewing radiographs to diagnose a symptom or examine progress of course of treatment, Prophylaxis cleaning(limited to 1 per calendar Year), Periodontal Prophylaxis, Sealants and Topical Fluoride Applications, under the age of 16, Space Maintainers, under the age of 12, for missing teeth

TYPE II
Restoriative, basic fillings, oral surgery (extractions and impacted teeth), endodentics (root canal and pulpal therapy), periodontics (treatment of gum diseases), denture and crown repair

TYPE III
Restorative (inlays & crowns), prosthetics (bridges) -Buildups,

TYPE IV
Orthodontia (orthodontic are for proper alignment of teeth), Orthodonia is provided only to dependent children who are under the age 19 when treatment is received

DENTAL BENEFIT LIMITATIONS

NO BENEFITS PAYABLE FOR:
* Charges for any dental care, treatment or supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures
* Charges for the replacement of a lost or stolen prosthetic device
* Any charges incurred prior to the date on which these dental benefits become effective with respect to the individual on whose account the charges are incurred, and charges for any appliances or supplies which are ordered for that individual prior to that date
* Dental care not included in the list of defined eligible expenses
* Dental care which is furnished while a person is confined in a hospital operated by the U.S. government or any agency thereof, or dental care for which the person would not be required to pay if there were no insurance
* Dental care arising out of or in the course of employment for pay or profit and which is covered by Workers Comp or a similar law
* Dental care resulting from any injury sustained as a result of war, declared or undeclared, or any action of war, or any resistance to armed invasion or aggression
* Charges made by a Dentist or Dental Hygienist who is a member of your immediate family
* Dental care resulting from any injury which is self inflicted
* Dental care resulting from participating in a felony
* Treatment of TMJ and Orthognathic surgery unless specified under the medical insurance
* Dental care which is experimental or does not meet standards accepted by American Dental Association
* Charges for missed appointments
* Implants or implantology

LIMITATION ON LATE ENTRANTS
For the first 12 months that a late entrant is covered under the Dental Plan, benefits will be limited to Type I benefits only, Type II, Type III, and Type IV, would not be covered until the insured has been covered for 12 consecutive months.

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* Charges for the replacement of a lost or stolen prosthetic device
* Any charges incurred prior to the date on which these dental benefits become effective with respect to the individual on whose account the charges are incurred, and charges for any appliances or supplies which are ordered for that individual prior to that date
* Dental care not included in the list of defined eligible expenses
* Dental care which is furnished while a person is confined in a hospital operated by the U.S. government or any agency thereof, or dental care for which the person would not be required to pay if there were no insurance
* Dental care arising out of or in the course of employment for pay or profit and which is covered by Workers Comp or a similar law
* Dental care resulting from any injury sustained as a result of war, declared or undeclared, or any action of war, or any resistance to armed invasion or aggression
* Charges made by a Dentist or Dental Hygienist who is a member of your immediate family
* Dental care resulting from any injury which is self inflicted
* Dental care resulting from participating in a felony
* Treatment of TMJ and Orthognathic surgery unless specified under the medical insurance
* Dental care which is experimental or does not meet standards accepted by American Dental Association
* Charges for missed appointments
* Implants or implantology