Kendrick Oil Company Employee Benefit Plan 2017

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*	$2,000,000
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*	 $2,000 $6,000	 $4000 $12,000
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*	 $3,000 $6,000	 $10,000 $20,000
*The out-of-pocket expense limit does not 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* • *deductible* applies	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	
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 • $30 per prescription or refill for *brand name drugs**		Limited to a 30-day supply per purchase

SCHEDULE OF MEDICAL BENEFITS (Continued)

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