# PRODUCTION DOWNHOLE

# 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

Any separate lifetime maximums are included in, and are not in addition to, the Lifetime Maximum for All Benefits, shown below. The following lifetime maximums apply to each covered person:

|  |
| --- |
| Lifetime Maximum Benefits for: |
| Annual Maximum for All Benefits | $2,000,000 |
|  |  |
|  |  |
|  |  |
|  |  |

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

## Plan Year Maximum Benefits

Plan year maximum benefits will accumulate toward any applicable lifetime maximum limits.

|  |
| --- |
| Plan Year Maximum Benefits per Covered Person for: |
|  |  |
| Skilled Nursing Facility Care | 25 days |
| Chiropractic Care | $500 |
| 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*** |
| --- | --- |
| *Plan 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*
 | $3,000$6,000 | $5,000$15,000 |
| 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*. **The plan has arranged direct agreements with Covenant Hospital in Lubbock, Memorial Hospital in Seminole, and Yoakum County Hospital in Denver City. We recommend using these facilities.**

| **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 25 days per *plan year* maximum |
| *Mental or Nervous DisorderInpatient* | 80% of *allowable claim limits* for semi‑private room and ancillary charges* *deductible* applies
 |  |
| *Mental or Nervous Disorder*Facility Outpatient | 60% 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 | 60% of *allowable claim limits** *deductible* applies
 |  |
| ***Hospital* Emergency Room Services** |
| *Hospital* Emergency Room - *Accident*\* or *Illness* | 80% of *allowable claim limits** *deductible* applies
 |  |
| \*Supplemental Accident Benefit | 100% of *allowable claim limits* to $300 per *accident* – thereafter subject to *deductible* and reimbursed at 80% 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 *plan 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
 |  |

## 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:** | ***PPONetwork Providers*** | **Non‑*PPONetwork 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:** | ***PPONetwork Providers*** | **Non‑*PPONetwork 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:** | ***PPONetwork Providers*** | **Non‑*PPONetwork 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 | $20 copayment, then 100%  | 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:** | ***PPONetwork Providers*** | **Non‑*PPONetwork Providers*** | **Limits** |
| All *Covered Expenses*, Including:* Office Visit
* *Surgery*
* Lab or X-rays
* Allergy Care
* Injections
* Other Covered Services
 | $20 office copay, then 100% up to $500 for additional services, charges above the $500 are subject to deductible and coinsurance | 60% of *usual, customary and reasonable* fees* *deductible* applies
 |  |
| *Mental or Nervous Disorder* Office Visit and Outpatient | $20 office copay, then 100% up to $500 for additional services, charges above the $500 are subject to deductible and coinsurance | 60% of *usual, customary and reasonable* fees* *deductible* applies
 |  |
| *Substance Abuse* Office Visit and Outpatient |  $20 office copay, then 100% up to $500 for additional services, charges above the $500 are subject to deductible and coinsurance | 60% of *usual, customary and reasonable* fees* *deductible* applies
 |  |

| **Chiropractic Services** |
| --- |
| **Percentage Payable For:** | ***PPONetwork Providers*** | **Non‑*PPONetwork Providers*** | **Limits** |
| *Chiropractic Care* and Therapies | $20 copayment, then 100%  | 60% of *usual, customary and reasonable* fees* *deductible* applies
 | Limited to $500per *plan year* maximum benefit |

| **Other Covered Services** |
| --- |
| **Percentage Payable For:** | ***PPONetwork Providers*** | **Non‑*PPONetwork 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 | 100% of *PPO* rate* *deductible* applies
 | 100% of *usual, customary and reasonable* fees* *deductible* applies
 |  |
| 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 *plan 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 *plan 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 | 100% of *PPO* rate to $300 per accident – thereafter subject to *deductible* and reimbursed at 80% of *PPO* rate | 100% of *usual, customary and reasonable* fees to $300 per accident – thereafter subject to *deductible* and reimbursed at 60% of *usual, customary and reasonable* fees |  |
| Prescription Drugs | 100% of *usual, customary and reasonable* fees, *deductible* waived, subject to copayments as follows:* $5 per prescription or refill for generic drugs, or
* $50 per prescription or refill for brand with no generic
* $100 per prescription or refill with generic available
 | Limited to 30-day supply per purchase |
| All Other *Covered Expenses* | 80% of *PPO* rate* *deductible* applies
 | 60% of *usual, customary and reasonable* fees* *deductible* applies
 |  |