SCHEDULE OF MEDICAL BENEFITS **PERMIAN PUMP AND SUPPLY**

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

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

Plan Year Maximum Benefits per Covered Person

Plan Year Maximum for All Essential Health Benefits	$2,000,000

Calendar Year Maximum Benefits

Calendar Year Maximum Benefits per *Covered Person* for:	
Skilled Nursing Facility Care	90 days
Chiropractic Care	$1,000
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
Calendar 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	$2,500	$5,000
• *Family Unit*	$5,000	$10,000
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*.

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 90 days per *calendar year* maximum
Mental or Nervous Disorder Inpatient	80% of *allowable claim limits* for semi-private room and ancillary charges • *deductible* applies	
Mental or Nervous Disorder Facility Outpatient	80% 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	80% of *allowable claim limits* • *deductible* applies	
***Hospital* Emergency Room Services**		
Hospital Emergency Room - *Accident** or *Illness*	$50 copay then 80% of *allowable claim limits,* physician and hospital	
*Supplemental Accident Benefit	100% of *allowable claim limits* to $300 per *accident* – thereafter subject to *deductible* and reimbursed at 60% 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 *calendar 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	
Dialysis Facilities Covered Services and Supplies		
All 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 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 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:	***PPO Network Providers***	**Non-*PPO Network 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:	***PPO Network Providers***	**Non-*PPO Network 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:	***PPO Network Providers***	**Non-*PPO Network 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	80% of *PPO* rate	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:	*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	100 % up to $500 after a copayment of $20 per visit, *deductible* waived *Covered expenses* thereafter are subject to the *deductible* and reimbursed at 60% of the *PPO* rate	60% of *usual, customary and reasonable* fees • *deductible* applies	
Mental or Nervous Disorder Office Visit and Outpatient	50% of *PPO* rate up to $40 maximum • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	
Substance Abuse Office Visit and Outpatient	50% of *PPO* rate up to $60 maximum • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	

Chiropractic Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Chiropractic Care and Therapies	$20 copay of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	Limited to $1,000 per *calendar year* maximum benefit

Other Covered Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network 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	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	Limited to 100 visit maximum benefit per calendar year
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 *calendar 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	

Other Covered Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
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 *calendar 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	subject to *deductible* and reimbursed at 60% of *PPO* rate	60% of *usual, customary and reasonable and reasonable* fees	
Prescription Drugs Retail Copay Mail order	100% of *usual, customary and reasonable* fees, *deductible* waived, subject to copayments as follows: • $15 generic drugs,$35 preferred brand name drugs $50 non-preferred brandname, $50 specialty drugs plus 25% of cost of drug • $37.50 generic, $ 35 preferred brand name, $125 non-preferred brandname, $125 specialty drugs plus 25% of cost of drug		Limited to 30-day supply per purchase Limited to $10,000 per *plan year* maximum benefit Limited to $30,000 lifetime maximum benefit
All Other *Covered Expenses*	80% of *PPO* rate • *deductible* applies	60% of *usual, customary and reasonable* fees • *deductible* applies	

SCHEDULE OF DENTAL AND VISION BENEFITS

DEDUCTIBLE

Per Person	$50 (waived for preventive)
Family Deductible	$150

COINSURANCE

TYPE A; Preventive, Diagnostic, Emergency Services,	100%
TYPE B; Basic Procedures	80%
TYPE C; Major Procedures	50%

LIMITS

Calendar Year Maximum per Person	$1,000