SCHEDULE OF MEDICAL BENEFITS - TRADITIONAL OPTION
FOR
ELIGIBLE PARTICIPANTS AND DEPENDENTS

ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN
EXCLUSIONS AND LIMITATIONS AND MAXIMUM ELIGIBLE EXPENSE LIMITS OF THE PLAN

THE BENEFIT PERIOD IS A CALENDAR YEAR

MEDICAL BENEFIT COST SHARING
An individual Covered Person cannot receive credit toward the Family Deductible or Out-of-Pocket
Maximum for more than the individual Annual Deductible or Out-of-Pocket Maximum than is
stated below.

Annual Deductible per Covered Person per Benefit Period ........................................... $750
Annual Deductible per Family per Benefit Period ......................................................... $1,500

The Deductible applies unless specifically indicated as waived

Benefit Percentage in excess of the Deductible
before satisfaction of Out-of-Pocket Maximum ......................................................... 80%
after satisfaction of Out-of-Pocket Maximum ........................................................... 100%

Out-of-Pocket Maximum per Covered Person .............................................................. $2,050*
Out-of-Pocket Maximum per Family ......................................................................... $4,100*

*Includes the Annual Deductible

ACCIDENTAL INJURY BENEFIT
Deductible Waived, Benefit Percentage .............................................................. 100%
Maximum Benefit per Accident ................................................................................. $300

HOSPITAL SERVICES
Deductible Applies, Benefit Percentage ................................................................. 80%
Hospital Room and Board Limitation .................................................................. Average Semi-Private
Intensive Care Unit Limitation ................................................................................. Maximum Eligible Expense

CHIROPRACTIC CARE
Deductible Applies, Benefit Percentage ................................................................. 80%
Maximum Number of Treatments per Benefit Period ........................................ 35
Maximum Benefit per treatment .............................................................................. $25
Maximum Benefit for Diagnostic X-rays per Benefit Period ............................... $100

"Treatment" includes all services provided
during a calendar day, except for X-rays

OFFICE VISIT BENEFIT
Deductible Waived*, Benefit Percentage ................................................................. 80%

*The Deductible is Waived only to charges billed for the evaluation and management (the
consultation and examination in the physical presence of the provider in an office, clinic or other
inpatient setting). Additional charges for services, i.e. diagnostic lab, office surgery, diagnostic
miscellaneous testing, allergy injections are subject to the Deductible and Benefit Percentage.
NEWBORN INPATIENT NURSERY/PHYSICIAN CARE
Deductible Applies, Benefit Percentage ..................................... 80%

PREVENTIVE CARE
Deductible Waived, Benefit Percentage ..................................... 100%

Complete list of recommended preventive services can be viewed at:
https://www.healthcare.gov/coverage/preventive-care-benefits/

If any diagnostic x-rays, labs or other tests or procedures are ordered or provided in connection with any
of the Preventive Care covered services, those tests or procedures will not be covered as Preventive Care
and will be subject to the cost sharing that applies to those specific services.

ROUX-EN-Y DIVIDED GASTRIC BYPASS SURGERY BENEFIT
Deductible Applies, Benefit Percentage ..................................... 80%
Maximum Lifetime Benefit limited to one procedure ...................... $25,000
Other Limitations:
1. Limited to Covered Employees only
2. Limited to One procedure per lifetime per Covered Person
3. No coverage if any previous bariatric surgical procedure

MENTAL ILLNESS (other than office visit)
Deductible Applies, Benefit Percentage ..................................... 80%

ALCOHOLISM, AND/OR CHEMICAL DEPENDENCY (other than office visit)
Deductible Applies, Benefit Percentage ..................................... 80%

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES
Deductible Applies, Benefit Percentage ..................................... 80%
Maximum Benefit per Implant for the following:
- Orthopedic Implants ......................................................... $40,000
- Cardiac Implants (except for LVAD and RVAD) .................... $80,000
- Cochlear Implants ......................................................... $85,000
- LVAD / RVAD Implants .................................................. $200,000

Maximums apply to any implantable device and all supplies associated with that implantable
device.

Pre-treatment Review by the Plan is strongly recommended. If Pre-treatment Review is not
obtained, the charge could be denied if the service, treatment or supply is not found to be
Medically Necessary or found to be otherwise excluded by the Plan when the claim is submitted.

MAXIMUM BENEFIT PER BENEFIT PERIOD FOR ALL CAUSES ........................ None