SCHEDULE OF MEDICAL BENEFITS - HIGH DEDUCTIBLE HEALTH PLAN 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** (Combined Medical and Pharmacy Benefits)

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 ........................................... $2,800
Annual Deductible per Family per Benefit Period ......................................................... $5,600

The Deductible applies unless specifically indicated as waived

Benefit Percentage in excess of the Deductible .......................................................... 100%

Out-of-Pocket Maximum per Covered Person .............................................................. $2,800*
Out-of-Pocket Maximum per Family ............................................................................. $5,600*

*Combined for Medical and Pharmacy Benefits and includes the Annual Deductible

**HOSPITAL SERVICES**

Deductible Applies, Benefit Percentage ................................................................. 100%
Hospital Room and Board Limitation ......................................................................... Average Semi-Private
Intensive Care Unit Limitation ..................................................................................... Maximum Eligible Expense

**CHIROPRACTIC CARE**

Deductible Applies, Benefit Percentage ................................................................. 100%
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 Applies, Benefit Percentage ................................................................. 100%

**NEWBORN INPATIENT NURSERY/PHYSICIAN CARE**

Deductible Applies, Benefit Percentage ................................................................. 100%

**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 .............................................. 100%
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
Deductible Applies, Benefit Percentage .............................................. 100%

ALCOHOLISM, AND/OR CHEMICAL DEPENDENCY
Deductible Applies, Benefit Percentage .............................................. 100%

SURGICAL IMPLANT AND/OR DEVICES AND RELATED SUPPLIES
Deductible Applies, Benefit Percentage .............................................. 100%
Maximum Benefit per Implant for the following:
   Orthopedic Implants ................................................................. $40,000
   Cardiac Implants (except for LVAD and RVAD) ........................... $60,000
   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