SILVER PPO PLAN BENEFIT SUMMARY

Effective April 1, 2016

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), and any special limits noted in the Plan. Charges that exceed the reasonable and customary amount or other Plan limitations will not be considered eligible in determining Plan benefits. Eligible expenses must be medically necessary and are subject to the Plan Year deductible unless otherwise noted. Age limitations, as specified in the *Benefit Summary*, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

Operators' Health Center	
Annual/School Physical Exams, Preventive Care/ Wellness Visits, Immunizations, Blood Draws, Condition Management *Ages two and up*	100%, not subject to the deductible

Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	**In-Network**	**Out-of-Network**
The amount of money applied toward the medical and pharmacy out-of-pocket maximum. Includes medical deductible and pharmacy copays. It does not include coinsurance for Orthoptic Training or Temporomandibular Joint Disease (TMJ) treatment.	$6,000 per individual $12,000 per family	$12,000 per individual $24,000 per family

Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Annual Maximum Per Plan Year	Unlimited	
Individual Deductible Per person, per Plan Year. All benefits are subject to the deductible unless otherwise noted (for Carryover information refer to page 22 of your SPD)	$2,000	$4,000
Family Deductible Per Plan Year	$5,000	$10,000
Out-of-Pocket Expense Limitation The amount of money an individual pays toward covered hospital and medical expenses during any one Plan Year, *including the deductible*	$4,000 per individual $8,000 per family	$8,000 per individual $16,000 per family
PPO Network	BlueCross BlueShield and ComPsych (MAP, Mental and Nervous and Substance Abuse)	Not applicable
Inpatient Hospital Services Room allowances based on the hospital's most common semi-private room rate	70%	50%

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Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Skilled Nursing Facility If recommended by a physician and confinement begins within 30 days of a hospital confinement Following a hospital stay of at least three days for initial stay Follow Medicare guidelines for breaks in skilled nursing facility care Maximum per disability: 45 days	70%	50%
Home Health Care If ordered by a physician Requires approval by the Case Manager	70%	50%
Outpatient Hospital Services Including Licensed Surgery Centers	70%	50%
Hospital Emergency Room	$100 copay per visit (not subject to the deductible); then balance covered at 70%	$100 copay per visit (not subject to the deductible); then balance covered at 70%
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	70%	50%
MRI and CT Scans	100%	50%
Outpatient Physical and Occupational Therapy Requires approval by the Case Manager Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	70%	50%
Outpatient Restorative Speech Therapy (Children and Adults) Requires approval by the Case Manager Must be performed by a Licensed Speech Therapist	70%	50%
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for Dependent Children Dependent children ages two through 18 Requires approval by the Case Manager Limited to 25 visits per Plan Year	70%	50%
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children Dependent children through age 18 only Requires approval by the Case Manager	70%	50%
Orthoptic Training For dependent children up to age 10 only Training needs to be prescribed by a covered provider Requires approval by the Case Manager Lifetime maximum: 40 visits Does not count toward the Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum or the Medical Benefit Out-of-Pocket Expense Limitation. If you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for Orthoptic Training services; the Plan will not pay 100% for Orthoptic Training services after you reach a benefit out-of-pocket maximum	50%	50%

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Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Physician's Medical/Surgical Care Office visits, hospital visits, surgery, assistant surgeon, etc.	70%	50%
Preventive Care, including Well Woman and Well Child Care	100% subject to ACA guidelines (refer to page 26 of your SPD and **www.moefunds.com** for more information and the list of current ACA-required preventive services)	Not covered except in certain situations (refer to page 26 of your SPD and **www.moefunds.com** for more information and the list of current ACA-required preventive services)
Chiropractic Services For employees and dependents over age five Medically necessary x-rays are covered Up to $60 per visit Maximum of 24 spinal manipulations per Plan Year	70%	50%
Durable Medical Equipment Rental paid up to purchase price of the equipment Requires approval by the Case Manager on equipment over $1,000 Not subject to the deductible	50% Electric wheelchair limited to $15,000	50% Electric wheelchair limited to $15,000
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $300 Lifetime maximum: $1,500	70%	70%
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	70%	70%
Transplants Requires approval by the Case Manager Available to all non-Medicare-eligible employees and dependents *Medicare-eligible employees and dependents must use Medicare-approved providers* Benefit begins five days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure Transportation and lodging maximum: $10,000 Private duty nursing maximum: $10,000	70%	Not covered
Temporomandibular Joint Disease (TMJ) Requires approval by the Case Manager Not subject to the deductible Does not count toward the Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum or the Medical Benefit Out-of-Pocket Expense Limitation. If you reach an out-of-pocket maximum, you will continue to pay 50% coinsurance for TMJ services; the Plan will not pay 100% for TMJ services after you reach a benefit out-of-pocket maximum Lifetime maximum: $2,500	50%	50%

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Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Cochlear Implants For dependent children age one through 18 Requires approval by the Case Manager	70%	Not covered
Cochlear Implants Age 19 and older Requires approval by the Case Manager Lifetime limit: $30,000	70%	Not covered
Cancer Drugs Drugs used to treat cancer are subject to the annual deductible	70% of the prescription charge	70% of the prescription charge
Medical Transportation Includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility Includes transport home from hospital for hospice care Inter-health-care-facility transfer maximum: $5,000	70%	50%
Acupuncture Services performed by a licensed acupuncturist (physician referral required) or physician acting within the scope of his or her license Maximum of 12 treatments per Plan Year Up to $125 allowable per visit	70%	50%
Sleep Apnea Appliance When ordered by a physician and provided by a medical equipment supplier or dentist Plan covers up to one every five years, including dental appliances or apnea machines Requires approval by the Case Manager	70%	50%

Mental Illness and Substance Abuse Subject to the medical deductible	**In-Network**	**Out-of-Network**
Mental Health and Substance Abuse Network	BlueCross BlueShield and ComPsych	Not Applicable
Inpatient Care Requires approval by the Case Manager	70%	50%
Outpatient Care	70%	50%
Residential Facility Requires approval by the Case Manager	70%	50%

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Prescription Drug Program			
Pharmacy Benefit Manager Long Term Medication (maintenance drugs) must be purchased at a CVS or Target Retail Pharmacy. Mail order is available through Caremark for 90-day supplies only. No Coordination of Benefits applies. No coverage for out-of-network pharmacies until you reach your out-of-pocket maximum as noted below; once the out-of-pocket maximum is met, prescriptions will be paid at 100%.			
	In-Network		**Out-of-Network**
	Copay (Retail)	**Copay (Mail Order)**	
Generic Drug	$5 copay(1) for a 30-day supply	$15 copay(1) for a 90-day supply	No Benefit
Brand Name Drug	$10 copay(1) for a 30-day supply	$30 copay(1) for a 90-day supply	No Benefit
Specialty Drug	Requires Authorization (2)	N/A	No Benefit
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $4,000 per family		$4,000 per individual $8,000 per family
Compounded Drugs (all ingredients must be FDA approved for their intended use)	Prescriptions exceeding $300 Requires Authorization(2)		No Benefit
Convalescent or Nursing Home	Follows the above copay levels		50% of the cost of the medication
(1) Copays listed are the Plan's basic copay schedule. If the cost of the medication is less than the copay listed, you will be responsible for paying the lower cost. (2) Specialty medications require a prior authorization through Caremark's Specialty Guideline Management (SGM) program.			
Limitations & Exceptions Up to two 30-day supplies, of the same medication, can be filled at any local in-network pharmacy before member is required to obtain a 90-day supply. Member seeking third refill must transition to CVS or Target retail Pharmacy or Caremark Mail Service Pharmacy, or pay 100% of the cost of the prescription drug. Please call Caremark's Customer Care Call Center at (855) MYRX150 (697-9150) or visit www.caremark.com for more information.			
When available, Generic Drugs will be substituted for all Brand Name Drugs or medications. If you request a Brand Name Drug, or if the prescribing physician indicates "no substitutions," when a Generic equivalent is available, you will be required to pay the Brand Name Drug Copay plus the difference in cost between the Brand Name Drug and its Generic equivalent. *For a list of no-cost preventive medications, visit* www.moefunds.com/pharmacy.			

Dental Benefits	In-Network	Out-of-Network
Dental PPO Network	Delta Dental PPO	Not applicable If you use a non-network dentist, Delta Dental will pay you directly leaving you responsible to pay the provider
Deductible	$0	$0
Plan Year Maximum	$1,000 per adult (age 19 and older) No maximum for children under age 19	$1,000 per adult (age 19 and older) No maximum for children under age 19

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Dental Benefits	In-Network	Out-of-Network
Preventive	100%	100%
Basic and Major Services Fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services	70%	70%
Orthodontia Dependent children through age 18 only Lifetime maximum: $2,000	50%	50%

Disability Benefits	
Disability Benefit Available to members only	$250 per week for up to 52 weeks Eligibility is credited with 40 hours a week for up to 17 weeks (please refer to page 49 of your SPD)

Death Benefit	
Death Benefit	$30,000 per eligible member $2,000 per eligible dependent

Accidental Dismemberment Benefit	
Accidental Dismemberment Benefit Available to members *only*	$1,000 or $5,000 based on type of loss Limited to $10,000 for any one accident

Family Supplemental Benefit	
Family Supplemental Benefit This benefit can be used for non-covered medically necessary and un-reimbursed medical, dental and pharmacy benefit expenses,including items such as hearing aids, glasses, etc. Reimbursement for Plan maximums and items covered at 50%, except for Durable Medical Equipment, are eligible Other than stated above, this benefit cannot be used to reimburse the deductible, copay or amount over the reasonable and customary amount	Maximum per family, per Plan Year: $500