Bronze - PPO

Comprehensive Medical Expense Benefits Effective April 1, 2017

OPERATORS' HEALTH CENTER -Annual/School, Physical Exams, Preventive Care/Wellness Visits, Immunizations, Blood Draws, Condition Manager (Ages two and up)	100% - Not subject to the deductible
CVS MINUTE CLINICS – Non Emergency, Unscheduled Acute Illness or Injuries	Most services 100% - Not subject to the deductible Additional cash pay services are available at a cost to the patient
Annual Maximum – per Plan year	Unlimited
Individual Deductible – (per person, per plan year. All benefits are subject to the deductible unless otherwise noted) Three month carryover applies	$5,000-In Network $10,000-Out of Network
Family Deductible - (per plan year) Three month carryover does not apply	$10,000-In Network $20,000-Out of Network
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.	$5,000 per individual-In Network $10,000 per individual-Out of Network $10,000 per family-In Network $20,000 per family-Out of Network
PPO Network	BlueCross BlueShield PPO – Hospital and Physicians, MRI and CT Scans Compsych-Mental and Nervous and Substance Abuse
Inpatient Hospital Services – Room allowances based on the hospital's most common semi-private room rate. Pre-admission testing is covered once prior to surgery. Requires approval by the Case Manager.	100% In and Out of Network after deductible
Emergency Room – Facility Charges	$100 co-pay, balance considered at 100% In and Out of Network After deductible
Skilled Nursing Facility - recommended by a Physician and confinement begins within 30 days of a hospital confinement. Requires approval by the Case Manager.	100% In and Out of Network after deductible Maximum per disability – 45 days
Home Health Care – ordered by a physician. Requires approval by the Case Manager.	100% In and Out of Network after deductible
Outpatient Hospital Services – including Licensed Surgery Centers	100% In and Out of Network after deductible
Diagnostic X-rays/Lab – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	100% In and Out of Network after deductible
MRI/CT Scans & PET Scans	100% - In and Out of Network after deductible
Outpatient Physical and Occupational Therapy – Requires approval by the Case Manager. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	100% In and Out of Network after deductible
Outpatient Restorative Speech Therapy- (children and adults) Requires approval by the Case Manager. Must be performed by a Licensed Speech Therapist.	100% In and Out of Network after deductible
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children– dependent children age two through age 18. Requires approval by the Case Manager	100% In and Out of Network after deductible Limited to 25 visits per plan year
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children – dependent children through age 18 only. Requires approval by the Case Manager.	100% In and Out of Network after deductible
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.	Not subject to Deductible or Out of Pocket Maximums 50% - In and Out of Network Lifetime maximum 40 visits
Physician's Medical/Surgical Care - Office visits, hospital visits, surgery, assistant surgeon, etc.	100% In and Out of Network after deductible
Preventive Care -routine physical exams.	100% - Subject to ACA guidelines - In Network ONLY
Well Baby Care – includes routine hospital visits, outpatient visits and immunizations,	100% - Subject to ACA guidelines - In Network ONLY
Chiropractic Services – eligible for members and dependents over age 5. Medically necessary x-rays are covered	Maximum of 24 spinal manipulations per plan year up to $60 per visit 100% In and Out of Network after deductible

Durable Medical Equipment – rental paid up to purchase price of the equipment. Includes necessary adjustments or repairs. Replacement, if more cost effective. Requires approval by the Case Manager for equipment over $1,000	100% In and Out of Network after deductible Electric wheelchair limited to $15,000
Foot Orthotics – custom fitted foot orthotics prescribed by a Physician	100% In and Out of Network after deductible Annual maximum $300 Lifetime maximum $1,500
Prosthetic devices – artificial devices to restore a normal body function. Requires approval by the Case Manager.	100% In and Out of Network after deductible
Transplants -Requires approval by the Case Manager. Available to all active and non-Medicare members. **Medicare eligible members must use Medicare approved providers**. Benefit begins 5 days (30 days for bone marrow) before the transplant date and ends 18 months after transplant procedure.	100% In Network ONLY after deductible Transportation and Lodging maximum $10,000 Private Duty Nursing maximum $10,000
Temporomandibular Joint Disease (TMJ) – Requires approval by the Case Manager	Not subject to Deductible or Out of Pocket Maximums 50%-In and Out of Network Lifetime maximum $2,500
Cochlear Implants – for dependent children age 1 through 18. Requires approval by the Case Manager	100% In Network ONLY after deductible
Cochlear Implants – age 19 and older. Requires approval by the Case Manager.	100% In and Out of Network after deductible Lifetime maximum $30,000
Cancer drugs – drugs used to treat cancer are subject to the annual deductible	100% In and Out of Network of the prescription charge after deductible
Medical Transportation – includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility. Hospital to home for hospice care.	100% In and Out of Network after deductible Inter-health-care-facility transfer maximum $5,000
Acupuncture – services performed by a licensed acupuncturist (Physician referral required) or Physician	Maximum of 12 treatments per plan year up to $125 allowable per visit 100% In and Out of Network after deductible
Sleep Apnea Appliance – when ordered by a Physician and provided by a medical equipment supplier or Dentist. Requires approval by the Case Manager.	100% In and Out of Network after deductible Appliance replacement if existing appliance covered every five years
Mental Illness and Substance Abuse - subject to medical deductible	
Inpatient Care	100% In and Out of Network after deductible
Outpatient Care	100% In and Out of Network after deductible
Residential Facility - Requires approval by the Case Manager	100% In and Out of Network after deductible

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 (Maintenance Choice[1])	
Generic Drugs	$20 copay[2] for a 30-day supply	$50 copay[2] for a 90-day supply	Not covered
Preferred Brand Name Drugs	$40 copay[2] for a 30-day supply	$100 copay[2] for a 90-day supply	Not covered
Non-Preferred Brand Name Drugs	$55 copay[2] for a 30-day supply	$115 copay[2] for a 90-day supply	Not covered
Specialty Drugs (Requires Authorization) [3]	$100 copay for a 30-day supply	N/A	Not covered
Compounded Drugs (all ingredients must be FDA approved for their intended use)	Prescriptions exceeding $300 require prior authorization [3]		Not covered
Annual Pharmacy Out-of-Pocket Maximum	$1,600 per individual $3,200 per family		$4,000 per individual $8,000 per family
Convalescent or Nursing Home	50% of the drug cost		

(1) CVS or Target retail pharmacy or Caremark Mail Service Pharmacy ONLY.

(2) Copays listed are the Plan's basic copay schedule. If the cost of the medication is less than the copay listed, the Participant will be responsible for paying the lower cost.

(3) Certain specialty medications are subject to review through Caremark's Specialty Guideline Management (SGM) program. All existing specialty medication utilizers prior to April 1, 2017 will continue to pay the $5 copay for generic specialty medication per 30-day supply and $10 copay for brand name specialty medication per 30-day supply. All new specialty prescriptions prescribed on or after April 1, 2017 for new utilizers or existing utilizers that are prescribed a different specialty medication will be responsible for paying the increased specialty copay of $100 per 30-day supply.

Limitations & Exceptions

Maximum of up to two 30-day supplies, of the same medication, can be filled at any local in-network pharmacy before the Participant is required to obtain a 90-day supply (Maintenance Choice; either a CVS or Target Pharmacy or Caremark Mail Service Pharmacy ONLY). A Participant 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 at (855) MYRX150 (697-9150) or visit www.caremark.com for more information.

When available, generic medications will be substituted for all brand name medications. If a Participant requests a brand name medication, or if the prescribing physician indicates "no substitutions", when a generic equivalent is available, the Participant will be required to pay the brand name copay plus the difference in cost between the brand name medication and its generic equivalent unless proven medically necessary through the appeals process.

For a complete list of no-cost preventive medications, visit www.moefunds.com/pharmacy.

Dental Benefits	
Deductible	No benefits
Plan Year Maximum	No benefits
PPO Network	No benefits
Preventive	No benefits
Basic and Major Services (fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services)	No benefits
Orthodontia (dependent children through age 18 only)	No benefits
Disability Benefits	
Disability Benefit – Available to members only	No benefits
Death Benefit	
Death Benefit	No benefits
Accidental Dismemberment Benefit	
Accidental Dismemberment Benefit-Available to members only	No benefits
Family Supplemental Benefit	
Family Supplemental Benefit - This benefit can be used for non-covered expenses, including items such as hearing aids, glasses, etc., and non-covered drugs, except for prescriptions, which could have been purchased under the Prescription Drug Program. 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.	$250 maximum per Family per Plan Year