EPO – Exclusive Provider Organization

In Network ONLY-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%
CVS MINUTE CLINICS – Non Emergency, Unscheduled Acute Illness or Injuries	Most services 100% 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	No deductible
Family Deductible - (per plan year) Three month carryover does not apply	No deductible
Out of pocket expense limitation – The amount of money an individual pays toward covered hospital and medical expenses during any one plan year.	$4,000 per individual-In Network only $10,000 per family-In Network only
PPO Network	BlueCross BlueShield PPO
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.	$250 copay per admission
Emergency Room – Facility charges	$100 co-pay per visit (Emergency Room Facility Charges are covered at the same level for Out of Network Providers)
Skilled Nursing Facility - recommended by a Physician and confinement begins within 30 days of a hospital confinement. Requires approval by the Case Manager.	$250 copay per admission Maximum per disability-45 days
Home Health Care – ordered by a physician. Requires approval by the Case Manager.	$20 copay per visit
Outpatient Hospital Services – including Licensed Surgery Centers	$20 copay per visit
Diagnostic X-rays/Lab – X-rays and /or tests to diagnose a condition or to determine the progress of an illness or injury	100%
MRI/CT Scans & PET Scans	100%
Outpatient Physical and Occupational Therapy – Requires approval by the Case Manager. Must be performed by a Licensed Therapist or Licensed Physical Therapist Assistant	$20 copay per visit
Outpatient Restorative Speech Therapy- (children and adults) Requires approval by the Case Manager. Must be performed by a Licensed Speech Therapist.	$20 copay per visit
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	$20 copay per visit 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.	$20 copay per visit
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 Out of Pocket Maximums 50% - In Network only Lifetime maximum 40 visits
Physician's Medical/Surgical Care - Office visits, hospital visits, surgery, assistant surgeon, etc.	Primary Care: $20 copay per visit Specialists: $40 copay per visit
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 $20 copay per visit

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	80% - In network only Electric wheelchair limited to $15,000
Foot Orthotics – custom fitted foot orthotics prescribed by a Physician	80% – In network only Annual maximum $300 Lifetime maximum $1,500
Prosthetic devices – artificial devices to restore a normal body function. Requires approval by the Case Manager.	80% - In network only
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.	Follows Inpatient, Outpatient and Physician copays 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 Out of Pocket Maximums 50%-In Network only Lifetime maximum $2,500
Cochlear Implants – for dependent children age 1 through 18. Requires approval by the Case Manager	Follows Inpatient, Outpatient and Physician copays
Cochlear Implants – age 19 and older. Requires approval by the Case Manager.	Follows Inpatient, Outpatient and Physician copays
Cancer drugs – drugs used to treat cancer are subject to the annual deductible	80% 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. Hospital to home for hospice care.	80% - In and out of Network for Emergencies 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 $20 copay per visit
Sleep Apnea Appliance – when ordered by a Physician and provided by a medical equipment supplier or Dentist. Requires approval by the Case Manager.	80% - In network only Appliance replacement if existing appliance covered every five years
Mental Illness and Substance Abuse – BC/BS PROVIDERS ONLY	
Inpatient Care	$250 copay per admission
Outpatient Care	$20 copay per visit
Residential Facility - Requires approval by the Case Manager	$250 copay per admission

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 Only	
	Copay (Retail)	Copay (Maintenance Choice[1])
Generic Drugs	$5 copay[2] for a 30-day supply	$15 copay[2] for a 90-day supply
Preferred Brand Name Drugs	$10 copay[2] for a 30-day supply	$30 copay[2] for a 90-day supply
Non-Preferred Brand Name Drugs	$25 copay[2] for a 30-day supply	$45 copay[2] for a 90-day supply
Specialty Drugs (Requires Authorization) [3]	$100 copay for a 30-day supply	N/A
Compounded Drugs (all ingredients must be FDA approved for their intended use)	Prescriptions exceeding $300 require prior authorization [3]	
Annual Pharmacy Out-of-Pocket Maximum	$2,000 per individual $3,200 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	$0
Plan Year Maximum	$1,000 – Adults (age 19 and older) No maximum for children under age 19
PPO Network	Delta Dental
Preventive	100%
Basic and Major Services (fillings, crowns, root canal therapy, oral surgery, dentures, bridgework, and other covered dental services)	70%
Orthodontia (dependent children through age 18 only)	50% Lifetime maximum $2,000
Disability Benefits	
Disability Benefit – Available to members only	$250 per week up to 52 weeks Eligibility is credited with 40 hours per week for the first 17 weeks
Death Benefit	
Death Benefit	$30,000 member $2,000 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 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.	$500 maximum per Family per Plan Year