EPO PLAN BENEFIT SUMMARY

Effective April 1, 2018

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for EPO 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, unless otherwise noted. Age limitations, as specified in this *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%

CVS Minute Clinics	
Non-Emergency, Unscheduled Acute Illness or Injuries Additional "cash pay" services are available at a cost to the patient	Most services covered at 100%

Medical & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	**In-Network *ONLY***
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment	$6,000 per individual $13,200 per family

Medical Benefit (Comprehensive Medical Benefit)	**In-Network *ONLY***
Annual Maximum Per Plan Year	Unlimited
Individual Deductible	None
Family Deductible	None
Out-of-Pocket Expense Limitation The most an individual could pay in a Plan Year for covered services. Individuals covered under Family coverage must meet their own individual out-of-pocket expense limit until the overall Family out-of-pocket expense limit has been met Does not include premiums, balance-billing charges, Family Supplemental Benefits, TMJ, orthoptic training, dental benefits, and health care not covered by the Plan	$4,000 per individual $10,000 per family
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 copayment per admission

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Effective April 1, 2018

Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Skilled Nursing Facility If recommended by a physician and confinement begins within 30 days of a hospital confinement Follow Medicare guidelines for breaks in skilled nursing facility care Maximum per disability: 45 days Requires approval by the Case Manager	$250 copayment per admission
Home Health Care If ordered by a physician Requires approval by the Case Manager	$20 copayment per visit
Outpatient Hospital Services Including licensed surgery centers	$20 copayment per visit
Hospital Emergency Room Facility charges	$100 copayment per visit Note: Out-of-network emergency room visits are covered at the same level ($100 copayment 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 and PET Scans	100%
Outpatient Physical and Occupational Therapy Must be performed by a licensed physical or occupational therapist or therapy assistant Requires approval by the Case Manager	$20 copayment per visit
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed speech therapist Requires approval by the Case Manager	$20 copayment per visit
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for Dependent Children Dependent children ages two through 18 Limited to 25 visits per Plan Year Must be performed by a licensed speech therapist Requires approval by the Case Manager	$20 copayment per visit
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children Dependent children through age 18 only Must be performed by a licensed physical or occupational therapist or therapy assistant Requires approval by the Case Manager	$20 copayment per visit

EPO PLAN BENEFIT SUMMARY

Effective April 1, 2018

Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Orthoptic Training For dependent children up to age 10 only Training needs to be prescribed by a covered provider 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 Requires approval by the Case Manager	50%
Physician's Medical/Surgical Care Office visits, hospital visits, surgery, assistant surgeon, etc.	Primary Care: $20 copayment per visit Specialist: $40 copayment per visit
Preventive Care, including Well Woman and Well Child Care Includes routine physical exams, routine hospital visits, outpatient visits and immunizations Refer to page 25 of your SPD and **www.moefunds.com** for more information and the list of current ACA-required preventive service	100% subject to ACA guidelines
Chiropractic Services For members and dependents over age five Only medically necessary x-rays and spinal manipulations are covered Limit of $60 per visit and 24 visits per Plan Year	$20 copayment per visit
Durable Medical Equipment Rental paid up to purchase price of the equipment Includes necessary adjustments or repairs, or replacement, if more cost effective Electric wheelchair limited to $15,000 Requires approval by the Case Manager on equipment over $1,000	80%
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $300 Lifetime maximum: $1,500	80%
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	80%

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Effective April 1, 2018

Medical Benefit (Comprehensive Medical Benefit)	In-Network *ONLY*
Transplants Available to all non-Medicare-eligible members and dependents *Medicare-eligible members 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 Requires approval by the Case Manager	Follows inpatient, outpatient and physician copayments
Temporomandibular Joint Disease (TMJ) 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 Requires approval by the Case Manager	50%
Cochlear Implants For dependent children age one through 18 Requires approval by the Case Manager	Follows inpatient, outpatient and physician copayments
Cochlear Implants Age 19 and older Requires approval by the Case Manager	Follows inpatient, outpatient and physician copayments
Cancer Drugs	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 Includes transport home from hospital for hospice care Inter-health-care-facility transfer maximum: $5,000	80%
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	$20 copayment per visit
Sleep Apnea Appliance When ordered by a physician and provided by a medical equipment supplier or dentist Appliance replacement once every five years if existing appliance is covered Requires approval by the Case Manager	80%

EPO PLAN BENEFIT SUMMARY

Effective April 1, 2018

Mental Illness and Substance Abuse	In-Network *ONLY*
Mental Health and Substance Abuse Network	BlueCross BlueShield
Inpatient Care	$250 copayment per admission
Outpatient Care	$20 copayment per visit
Residential Facility Requires approval by the Case Manager	$250 copayment per admission
Member Assistance Program (MAP) Administered by Employee Resource System (ERS)	Provides members and covered dependents with up to five no-cost visits per episode per Plan Year Additional counseling or treatment may require payment

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

	In-Network *ONLY*	
	Copayment (Retail) Up to two 30-day fills	**Copayment Maintenance Choice (either CVS retail pharmacies or Caremark Mail Service Pharmacy ONLY) 90-day fills**
Generic Drug (Tier 1)	$5 copayment(1) for a 30-day supply	$15 copayment(1) for a 90-day supply
Brand Name Drug (Tier 2)	$10 copayment(1) for a 30-day supply	$30 copayment(1) for a 90-day supply
Non-Preferred Brand Name Drug (Tier 3)	$25 copayment(1) for a 30-day supply	$45 copayment(1) for a 90-day supply
Specialty Drug (Tier 4) Requires authorization	$100 copayment(1) for a 30-day supply	Not applicable
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $3,200 per family	
Compounded Drugs (all ingredients must be FDA approved for their intended use and covered under the prescription drug program)	Prescriptions exceeding $300 require authorization	
Convalescent or Nursing Home	Follows the above copayment structure	50% of the cost of the medication

(1) Copayments listed are the Plan's basic copayment schedule; if the cost of the medication is less than the copayment listed, you will be responsible for paying the lower cost.

Limitations & Exceptions

Maximum of up to two 30-day supplies, of the same medication, can be filled at any local in-network pharmacy before you are required to obtain a 90-day supply. If you are seeking a third refill, you must transition to a 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 copayment plus the difference in cost between the brand name drug and its generic equivalent unless proven medically necessary through the appeals process.

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

EPO PLAN BENEFIT SUMMARY

Effective April 1, 2018

Dental Benefit	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	
Plan Year Maximum No maximum for children under age 19	$1,500 per adult (age 19 and older)	
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 Lifetime maximum: $2,000	50%	

Disability Benefit	
Available to members only	$400 per week for up to 52 weeks Eligibility is credited with 40 hours a week for up to 17 weeks (please refer to page 48 of your SPD)

Death Benefit	
Available to members and eligible dependents	$30,000 per eligible member $2,000 per eligible dependent

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	
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. It cannot be used to reimburse expenses covered under the prescription drug program Reimbursement for Plan maximums and items covered at 50% that are not subject to the out-of-pocket maximum are eligible Durable medical equipment must be pre-authorized to be eligible for reimbursement Other than stated above, this benefit cannot be used to reimburse copayments or amounts over the reasonable and customary amount	Maximum per family, per Plan Year: $500