RETIREE BENEFIT SUMMARY

Effective January 1, 2018

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services, or Medicare-allowable fee limits for Medicare-eligible patients) 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 calendar year deductible unless otherwise noted. Age limitations are applied as of the last day of the month in which the eligible dependent's birthday occurs. Deductibles and out-of-pocket amounts satisfied under the Active Plan do not carry over to the Retiree Plan.

Reasonable and Customary Charge

Actual charge for the service or supply is comparable to what is usually charged for the same service or supply in the provider's geographic area.

If you are eligible for Medicare, Medicare will be your primary health plan and the benefits below will be coordinated (reduced) to supplement Medicare's benefits. You must use a provider who participates in Medicare; no benefits will be paid for services provided outside of the Medicare network.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

Operators' Health Center	
Annual physical exam, preventive care/wellness visits, immunizations, blood draws and condition management Ages two and up Not subject to deductible	100%

CVS Minute Clinics	
Non emergency, unscheduled acute illness or injuries Additional cash pay services are available at a cost to the patient Not subject to the deductible	Most services covered at 100%

Medical Out-of-Pocket Expense Maximum	
The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year, including the deductible	$2,500 per individual $6,000 per family

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Medical Benefits **(Comprehensive Medical Benefit)**		
Annual Maximum Per calendar year	$2,000,000	
Individual Deductible Per person, per calendar year All benefits are subject to the deductible unless otherwise noted Three month carryover applies	$300	
Family Deductible Per calendar year Three month carryover does not apply	$700	
PPO Network	BlueCross BlueShield (hospital and physicians, MRI and CT scans) ComPsych (MAP, mental and nervous and substance abuse - through 3/31/2018)	
	In-Network	**Out-of-Network**
Inpatient Hospital Services Room allowances based on the hospital's most common semi-private room rate Requires approval by the Case Manager	90%	80%
Skilled Nursing Facility If recommended by a physician and confinement begins within 30 days of a hospital confinement Maximum per disability: 45 days Follow Medicare guidelines for break in skilled nursing facility care Requires approval by the Case Manager	90%	80%
Home Health Care If ordered by a physician Requires approval by the Case Manager	90%	80%
Outpatient Hospital Services Including licensed surgery centers	90%	80%
Diagnostic X-rays/Lab X-rays and/or tests to diagnose a condition or to determine the progress of an illness or injury	90%	80%
MRI and CT Scans	100%	80%
Outpatient Physical and Occupational Therapy Must be performed by a licensed therapist or licensed physical therapist assistant Requires approval by the Case Manager	90%	80%
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed speech therapist Requires approval by the Case Manager	90%	80%

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children Dependent children age two through five Calendar year maximum: $2,000 Requires approval by the Case Manager	90%	80%
Outpatient Speech Therapy for Developmental Condition including Congenital Neurological Diseases for Dependent Children Dependent children age six through age 18 Calendar year maximum: $500 Requires approval by the Case Manager	90%	80%
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for Dependent Children Dependent children through age 18 only Requires approval by the Case Manager	90%	80%
Orthoptic Training Dependent children up to age 10 only Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits Requires approval by the Case Manager	50%	
Physician's Medical/Surgical Care Office visits, hospital visits, surgery, assistant surgeon, etc.	90%	80%
Preventive Care Routine physical exams Benefit for member and spouse only Calendar year maximum: $350	100%	80%
Well Baby Care Includes routine hospital visits, outpatient visits and immunizations, age limitation of zero to 24 months	100%	80%
Chiropractic Services For members and dependents over age five Medically necessary x-rays are covered Maximum of 24 spinal manipulations per calendar year up to $60 per visit	90%	80%
Durable Medical Equipment Rental paid up to purchase price of the equipment Includes necessary adjustments or repairs Replacement, if more cost effective Not subject to the deductible Electric wheelchair limited to $15,000 Required approval by the Case Manager on equipment over $1,000	80%	

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Medical Benefits (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Foot Orthotics Custom fitted foot orthotics prescribed by a physician Calendar 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%	
Transplants Available to all non-Medicare member *Medicare eligible members 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 Organ or tissue procurement maximum: $25,000 Requires approval by the Case Manager	90%	Not covered
Temporomandibular Joint Disease (TMJ) Lifetime maximum: $2,500 Not subject to the deductible Requires approval by the Case Manager	50%	
Cochlear Implants Dependent children age one through 18 Requires approval by the Case Manager	90%	Not covered
Cochlear Implants Age 19 and older Lifetime maximum: $30,000 Requires approval by the Case Manager	70%	
Cancer drugs Drugs used to treat cancer are subject to the deductible and calendar year maximum	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	90%	80%
Acupuncture Services performed by a licensed acupuncturist (physician referral required) or physician practicing within the scope of his or her license Maximum of 12 treatments per calendar year Up to $125 allowable per visit	90%	80%

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Medical Benefits (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Sleep Apnea Appliance When ordered by a physician and provider by a medical equipment supplier or dentist Appliance replacement of existing appliance covered every five years Requires approval of the Case Manager	90%	80%

Mental Illness and Substance Abuse (Subject to the medical deductible)	In-Network	Out-of-Network
Mental Health and Substance Abuse Network	BlueCross BlueShield ComPsych (through March 31, 2018)	Not applicable
Inpatient Care Subject to medical deductible	90%	80%
Outpatient Care Subject to medical deductible	90%	80%
Residential Facility Subject to medical deductible Requires approval by the Case Manager	90%	80%

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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		
	In-Network	**Out-of-Network**
	Copayment (Retail) 30-day fills	**Copayment Maintenance Choice (either CVS retail pharmacies or CVS Caremark Mail Service Pharmacy ONLY) 90-day fills**
Generic Drugs (Tier 1)	$5 copayment[1] for a 30-day supply	$15 copayment[1] for a 90-day supply
Preferred Brand Name Drugs (Tier 2)	$10 copayment[1] for a 30-day supply	$30 copayment[1] for a 90-day supply
Non-Preferred Brand Name Drugs (Tier 3)	$25 copayment[1] for a 30-day supply	$45 copayment[1] for a 90-day supply
Specialty Drug (Requires Authorization) (Tier 4) [2]	$100 copayment for a 30-day supply	Not covered
Compounded Drugs (all ingredients must be FDA approved for their intended use)	Prescriptions exceeding $300 require authorization[2]	
Maximum Annual Benefit (MAB)	$30,000 per individual per calendar year	
Maximum Hepatitis C Benefit (during initial pre-approved 12-month treatment period)	No maximum	
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.

(2) 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 copayment for generic specialty medication per 30-day supply and $10 copayment 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 copayment 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 a 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'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 a participant requests 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 proved medically necessary through the appeals process.

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Dental Benefits	In-Network	Out-of-Network
PPO Network	Delta Dental	Not applicable
Deductible	$0	
Calendar Year Maximum No maximum for children under age 19	$1,500 per adult (age 19 and older)	
Preventative	100%	
Basic and Restorative	70%	
Orthodontia Dependent children through age 18 only Lifetime maximum: $2,000	50%	

Family Supplemental Benefit	Coverage
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. Other than stated above, this benefit cannot be used to reimburse the deductible, copayment or amount over the reasonable and customary amount.	Maximum per family, per calendar year: $1,500