RETIREE BENEFIT SUMMARY

Effective January 1, 2019

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; Does not include premiums, balance-billing charges, Family Supplemental Benefits, dental benefits, prescription drugs and health care not covered by the Plan	$2,500 per individual $6,000 per family

Medical Benefits (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Annual Maximum Per calendar year	$2,000,000	

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
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)	
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	90%	80%
Hospital Emergency Room Facility charges	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%
Diagnostic MRI/CT and PET Scans	100%	80%
Outpatient Physical and Occupational Therapy Must be performed by a licensed therapist or licensed therapist assistant Requires approval by the Case Manager	100% if received at an ATI facility, not subject to the deductible; otherwise 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	100% if received at an ATI facility, not subject to the deductible; otherwise 90%	80%
Orthoptic Training Dependent children up to age 10 only Training needs to be prescribed by a covered provider Lifetime maximum: 40 visits Not subject to the deductible or out-of-pocket maximums 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, immunizations, employment physicals, hearing exams Benefit for member and spouse only Not subject to the deductible Calendar year maximum: $350	100%	
Well Baby Care Includes routine hospital visits, outpatient visits and immunizations, age limitation of zero to 24 months Not subject to the deductible	100%	
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%

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
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 or out-of-pocket maximums Electric wheelchair limited to $15,000 Required approval by the Case Manager on equipment over $1,000	80%	
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 members *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 Requires approval by the Case Manager	90%	Not covered
Temporomandibular Joint Disease (TMJ) Lifetime maximum: $2,500 Not subject to the deductible or out-of-pocket maximums 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	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%	

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Medical Benefits (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
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%
Sleep Apnea Appliance When ordered by a physician and provided 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	Not applicable
Inpatient Care Requires approval by the Case Manager	90%	80%
Outpatient Care	90%	80%
Residential Facility Requires approval by the Case Manager	90%	80%

Prescription Drug Program			
Pharmacy Benefit Manager Prescription drug benefits will be paid for prescriptions on the OptumRx Select Formulary Mail order is available through OptumRx for 90-day supplies; long-term medications (maintenance drugs) must be purchased through the OptumRx Mail Service Pharmacy No coordination of benefits applies			
	In-Network		**Out-of-Network**
	OptumRx Network Retail Pharmacy (up to two 30-day fills)	**OptumRx Mail Service Pharmacy (up to a 90-day fill)**	
Generic Drug (Tier 1)	$5 copayment[(1)] for a 30-day supply	$15 copayment[(1)] for a 90-day supply	Not covered
Brand Name Drug (Tier 2)	$10 copayment[(1)] for a 30-day supply	$30 copayment[(1)] for a 90-day supply	Not covered
Non-Preferred Brand Name Drug (Tier 3)	$25 copayment[(1)] for a 30-day supply	$45 copayment[(1)] for a 90-day supply	Not covered
Specialty Drug (Tier 4) Requires authorization	$100 copayment[(1)] for a 30-day supply	Not covered	Not covered
Compounded Drugs (all ingredients must be FDA approved for their intended use and covered under the prescription drug program)	Prescriptions exceeding $300 require authorization		Not covered
Maximum Annual Benefit (MAB)	$30,000 per individual per calendar year		Not covered
Maximum Hepatitis C Benefit (during initial pre-approved 12-month treatment period)	No maximum		Not covered
Maximum Hepatitis C Benefit (for retreatments)	Subject to Maximum Annual Benefits (MAB)		Not covered
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 retail pharmacy or the OptumRx Mail Service Pharmacy, or pay 100% of the cost of the prescription drug. Please call OptumRx at (855) MYRX150 (697-9150) or visit www.optumrx.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.

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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 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%	

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