PLATINUM PPO PLAN SCHEDULE OF BENEFITS

Effective April 1, 2020

All benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO 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 and are subject to the Plan Year deductible unless otherwise noted. Age limitations, as specified in this *Schedule of Benefits*, 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 Not subject to the 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 & Prescription Drug Benefit Combined Out-of-Pocket Expense Maximum	**In-Network**	**Out-of-Network**
The amount of money applied toward the medical and pharmacy out-of-pocket maximum; it includes medical deductible and pharmacy copayments; it does not include coinsurance for orthoptic training or temporomandibular joint disease (TMJ) treatment	$5,500 per individual $11,000 per family	$11,000 per individual $22,000 per family

Medical Benefit (Comprehensive Medical Benefit)	**In-Network**	**Out-of-Network**
Annual Maximum Per Plan Year	Unlimited	
Individual Deductible Per person, per Plan Year All benefits are subject to the deductible unless otherwise noted The three-month carryover applies In-network and out-of-network deductibles are separate and will not cross apply	$500	$1,000
Family Deductible Per Plan Year The three-month carryover does not apply In-network and out-of-network deductibles are separate and will not cross apply	$1,250	$2,500

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Out-of-Pocket Expense Limitation The most an individual could pay in a Plan Year for covered services, including the deductible. 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	$3,500 per individual $7,000 per family	$7,000 per individual $14,000 per family
PPO Network	BlueCross BlueShield (hospital and physicians, MRI and CT scans)	Not applicable
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%
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	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 Outpatient surgical procedures not performed in the doctor's office requires approval by the Case Manager	90%	80%
Hospital Emergency Room Facility charges	$100 copayment per visit; then balance covered at 90%	$100 copayment per visit; then balance covered at 90%
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 provider Requires approval by the Case Manager	100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise 90%	80%
Outpatient Restorative Speech Therapy (Children and Adults) Must be performed by a licensed provider Requires approval by the Case Manager	90%	80%
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological Diseases for individuals ages two through 18 Limited to 25 visits per Plan Year Must be performed by a licensed provider Requires approval by the Case Manager	90%	80%

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Outpatient Physical and Occupational Therapy for Congenital Neurological Diseases for individuals through age 18 only Must be performed by a licensed provider Requires approval by the Case Manager	100%, not subject to the deductible if received at an ATI Physical Therapy Facility; otherwise 90%	80%
Orthoptic Training For 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 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. Certain procedures performed in the physician's office may require approval by the Case Manager	90%	80%
Preventive Care, including Well Woman and Well Child Care Includes routine physical exams, routine hospital visits, routine outpatient visits and immunizations Refer to **www.moefunds.com** for more information and the list of current ACA-required preventive services	100% subject to ACA guidelines, deductible does not apply	Not covered
Chiropractic Services Limit of $60 per visit and 24 visits per Plan Year	90%	80%
Durable Medical Equipment Rental paid up to purchase price of the equipment, except for lifetime items that do not have a purchase price Includes necessary adjustments or repairs, or replacement, if more cost effective Electric wheelchair limited to $15,000 Not subject to the deductible Requires approval by the Case Manager on equipment over $1,000	80%	80%
Foot Orthotics Custom-fitted foot orthotics prescribed by a physician Plan Year maximum: $300 Lifetime maximum: $1,500	80%	80%
Prosthetic Devices Artificial devices to restore a normal body function Requires approval by the Case Manager	80%	80%

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
Transplants Available to all non-Medicare-eligible members and dependents *If Medicare is primary, 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	90%	Not covered
Orthodontic Treatment of Temporomandibular Joint Disease (TMJ) Not subject to the deductible or out-of-pocket maximums 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 Individuals age one through 18 Requires approval by the Case Manager	90%	Not covered
Cochlear Implants Individuals age 19 and older Lifetime limit: $30,000 Requires approval by the Case Manager	70%	Not covered
Cancer Drugs Cancer drugs billed by the PBM Drugs billed by the PBM and used to treat cancer are subject to the annual deductible	80% of the prescription charge	Not covered
Medical Transportation Includes ground and air transport from the site of the injury, medical emergency or acute illness to the nearest facility Includes ground non-emergency transfer from hospital to home hospice care if home is less than 100 miles from hospital Inter-health-care-facility transfer maximum: $5,000	90%	
Acupuncture Services performed by a licensed provider within the scope of his or her license Maximum of 12 treatments per Plan Year Up to $125 allowable per visit	90%	80%

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Medical Benefit (Comprehensive Medical Benefit)	In-Network	Out-of-Network
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	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 IOP or PHP requires approval by the Case Manager	90%	80%
Residential Facility Requires approval by the Case Manager	90%	80%
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	

Dental Benefit	In-Network	Out-of-Network
Dental PPO Network and Claims Administration	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%*	

*Coinsurance is based on Delta Dental's Allowable Fee. You pay the full cost of services above the Allowable Fee, if you use an Out-of-Network provider.

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Prescription Drug Program

Prescription drug benefits will be paid for prescriptions on the OptumRx Select Formulary when filled at a pharmacy in the Pharmacy Benefit Manager's (PBM's) network

Long-term medications (Maintenance drugs) must be filled at a CVS retail pharmacy or through the OptumRx Home Delivery Pharmacy

Medical deductible does not apply for prescription drugs, except cancer medication obtained through the PBM

No coordination of benefits applies

Specialty medications must be filled through the Optum Specialty Pharmacy; specialty medications are limited to a 30-day fill

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
	OptumRx Network Retail Pharmacy (up to two 30-day fills)	**CVS retail pharmacy or OptumRx Home Delivery (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
Preferred 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 applicable	Not covered
Pharmacy Out-of-Pocket Maximum	$2,000 per individual $4,000 per family		$4,000 per individual $8,000 per family
Compounded Drugs (A minimum of one ingredient must be covered under the prescription drug program)	Prescriptions exceeding $300 require authorization		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 Home Delivery Pharmacy, or pay 100% of the cost of the prescription drug. Please call OptumRx at (855) 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 drugs, 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 determined medically necessary through the appeals process.

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

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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

Death Benefit	
Available to members and eligible dependents	$40,000 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 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 Plan Year: $2,000