

Non-Medicare Eligible Retiree Plan Schedule of Benefits (2017 Edition)

Comprehensive Medical Benefit (Retirees and their Dependent Spouse)		
Deductibles		
• Calendar Year Deductible	\$500 per person	
• Non-PPO Hospital Deductible	\$500 per non-Medicare eligible person for each non-emergency admission to a non-PPO Hospital	
Calendar Year Out-of-Pocket Maximums for non-Medicare eligible Retirees and Dependents¹		
• PPO Maximum		
– Major Medical	\$2,500 per person; \$5,000 per family	
– Prescription Drug ²	\$4,650 per person; \$9,300 per family	
• Additional Non-PPO Maximum	\$1,000 person; \$2,000 per family	
Calendar Year Plan Maximums		
• Chiropractic/Spinal Care	12 visits per person	
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person	
• Rehabilitative Physical Therapy	20 visits per person ³	
Special Benefit Maximums		
• Hospital Daily Room and Board	Semi-private room rate	
• Non-PPO Hospital Intensive Care	Three times semi-private room rate (three times single room rate if semi-private rooms unavailable)	
• Infertility Treatment ⁴	\$10,000 per person per lifetime	
Comprehensive Medical Benefit (Retirees and their Dependent Spouse who are Not Eligible for Medicare)		
Type of Service	PPO Provider	Non-PPO Provider
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Inpatient Hospital Services	Plan pays 80%	Plan pays 70%

• Outpatient Hospital Services	Plan pays 70%	Plan pays 70%
• Surgical Benefits (Inpatient and Outpatient)	Plan pays 80% (including surgeries during office visits)	Plan pays 70%
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Chiropractic/Spinal Care ⁵	Plan pays 70% for up to 12 visits per person per calendar year	Plan pays 70% for up to 12 visits per person per calendar year
• Substance Abuse Treatment ⁶		
– Inpatient	Plan pays 80%	Plan pays 70%
– Outpatient	Plan pays 80%	Plan pays 70%
• Mental Health Treatment		
– Inpatient	Plan pays 80%	Plan pays 70%
– Outpatient	Plan pays 80%	Plan pays 70%
• Ambulatory Surgical Center	Plan pays 80%	Not covered
• Other Covered Medical Expenses	Plan pays 70%	Plan pays 70%
• Overweight or Obesity Condition-Related Expenses	Plan pays 50% ⁷	Not covered
• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered

¹ Excludes amounts paid for non-covered expenses.

² The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act (ACA).

³ Rehabilitative Physical Therapy will be approved in excess of the Calendar Year Plan Maximum if approved in advance by pre-certification, case management, and utilization review. To ensure you receive the maximum benefits available under the Plan, you should ask your Physician to contact MCM prior to receiving treatment.

⁴ Expenses to determine Infertility are not included under the lifetime maximum.

⁵ Chiropractic/spinal care includes all services and supplies for care of the back, neck, spine and vertebrae.

⁶ Inpatient treatment is covered if it is provided by a Hospital or approved Residential Treatment Facility and treatment is based on completion of a course of treatment and the discharge is certified by a Physician.

⁷ Expenses for treatment rendered in connection with overweight or obesity conditions are covered in limited circumstances. Please see the full Summary Plan Description for further information about the circumstances in which such expenses are covered under the Plan.

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Prescription Drug Benefits (Retirees and their Dependent Spouse)				
Calendar Year Out-of-Pocket Maximum for Prescription Drugs⁸	\$4,650 per person; \$9,300 per family			
Calendar Year Deductible	\$250 per person			
Coinsurance⁹				
<ul style="list-style-type: none"> Participating Retail Pharmacy (up to 30-day supply) 	You pay 25% up to \$100 per 30-day supply; however, if you fill a maintenance medication at retail more than twice, you will pay a \$5 surcharge for Generics and a \$15 surcharge for Brand Name Drugs each time you fill the prescription at retail.			
<ul style="list-style-type: none"> Mail Order Service 		1-30 Days Supply	31-60 Days Supply	61-90 Days Supply
	Generics & Brand Single Source	25% with \$100 max	25% with \$200 max	25% with \$300 max
	Brand Multi-Source	25% with \$100 max + surcharge	25% with \$200 max + surcharge	25% with \$300 max + surcharge
<ul style="list-style-type: none"> Diabetic Testing Supplies 	The Plan pays 100%			
Vision Care Discount Program (Retirees and their Dependent Spouse) ¹⁰				
	Network	Non-Network Provider		
Complete Eyeglass Exam (One per calendar year)	\$50 with purchase of prescription eyeglasses; 20% off without purchase of prescription eyeglasses	Not covered		
Lenses and Frames when a complete pair of glasses are purchased	Frames subject to 25% Discount, additional discounts for lenses available with frame purchase	Not covered		

Contact Lens Exam (fitting and evaluation)	15% Discount, you pay 85%	Not covered
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⁸ The prescription drug calendar year out-of-pocket maximum will be adjusted annually so that the combined out-of-pocket maximums for prescription drugs and major medical equal the maximum permitted under the Affordable Care Act (ACA).

⁹ Unless requested otherwise by your Physician, prescriptions will be filled with Generic Drugs. If you request a Brand Name Medication and a Generic Medication is available you may be

required to pay the difference between the cost of the Generic Medication and the Brand Name Medication.

¹⁰ The Plan does not pay vision benefits for Retirees or their Dependent spouse. The Plan offers you a discount program on vision expenses if you see a participating VSP provider.