Classic Bargained Plan Schedule of Benefits (2018 Edition)

Comprehensive Medical Benefit (Active Employees and their Dependents)	
Deductibles	
• Calendar Year Deductible	$1,000 per person; $3,000 per family[1]
• Non-PPO Hospital Deductible	$500 per person for each non-Emergency admission to a Non-PPO Hospital (in addition to the calendar year deductible)
Calendar Year Out-of-Pocket Maximums[2]	
• PPO – Major Medical – Prescription Drug[3]	 $5,000 per person; $10,000 per family $2,350 per person; $4,700 per family
• Additional Non-PPO Maximum	$2,000 per person; $11,300 per family
Calendar Year Plan Maximums	
• Chiropractic	12 visits per person
• Rehabilitative Physical Therapy	20 visits per person[4]
• Rehabilitative Speech Therapy (to restore normal speech)	30 visits per person
• Habilitative outpatient Physical and Speech Therapy	30 visits for Speech Therapy and a combined 70 visits for Speech and Physical Therapy
Special Benefit Maximums	
• Hospital Daily Room and Board	Single room rate
• Non-PPO Hospital Intensive Care	Three times semi-private room rate (three times single room rate if semi-private rooms unavailable)
• Hearing Aid Program	$600 per person every three years
• Infertility Treatment[5]	$10,000 per person per lifetime

Comprehensive Medical Benefit (Active Employees and their Dependents)		
Type of Service	**PPO Provider**	**Non-PPO Provider**
• Outpatient Pre-Admission Tests	Plan pays 100%; no deductible	Plan pays 100%; no deductible
• Hospital Inpatient and Outpatient Surgeries and Hospital Inpatient Services	Plan pays 80%	Plan pays 65%
• Emergency Room	Plan pays 80% after $400 deductible which is waived if admitted	Plan pays 80% (65% if not Emergency) after $400 deductible which is waived if admitted
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Non-Hospital Services (e.g., Office Visits, Lab Tests)	Plan pays 80%	Plan pays 65%
• Chiropractic[6]	Plan pays 80% for up to 12 visits per person per calendar year	Plan pays 65% for up to 12 visits per person per calendar year
• Substance Abuse Treatment[7] – Inpatient – Outpatient	 Plan pays 90% Plan pays 80%	 Plan pays 70% Plan pays 70%
• Mental Health Treatment – Inpatient – Outpatient	 Plan pays 90% Plan pays 80%	 Plan pays 70% Plan pays 70%
• Hearing Aid Program	Plan pays 100% up to $600 per person every three years	Plan pays 100% up to $600 per person every three years
• Ambulatory Surgical Center	Plan pays 80%	Not covered
• Other Covered Medical Expenses	Plan pays 80%	Plan pays 65%
• Overweight or Obesity Condition-Related Expenses	Plan pays 50%[8]	Not covered

[1] If you are a newly organized Active Employee, you may be able to use amounts paid toward annual deductibles under your prior health coverage toward your calendar year deductible under the Plan if your Employer previously made arrangements with the Fund and if you submit substantiation records of such expenses to the Fund Office within 90 days of the date you are first eligible for Active Employee Benefits under the Plan.

[2] Excludes amounts paid for non-covered expenses.

[3] 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).

[4] 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.

[5] Expenses to determine Infertility are not included under the lifetime maximum.

[6] Chiropractic includes all services and supplies provided by a licensed Chiropractor.

[7] 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.

[8] 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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• Telemedicine Services	Plan pays 100% for specifically contracted services with Plan's selected vendor; no deductible	Not covered
• Imaging Procedures (CT/PET scans, MRIs)	Plan pays 100% with no deductible if the Plan's designated imaging provider is used; Plan pays 80% for non-contracted providers	Plan pays 65%

Prescription Drug Benefits (Active Employees and Dependents)		
Calendar Year Out-of-Pocket Maximum for Prescription Drugs[9]	$2,350 per person; $4,700 per family	
Participating Retail Pharmacy Program	**For up to a 30-day supply, you pay:**	**For each 30-day supply fill at Retail after two, you pay:**
• Generic Medication	25% ($5 minimum/$20 maximum)	100% of network discounted drug cost
• Preferred Brand Drug	30% ($25 minimum/$100 maximum)	100% of network discounted drug cost
• Non-Preferred Brand Drug	35% ($31.25 minimum/$125 maximum)	100% of network discounted drug cost
Mail Order Service or Walgreens Retail Pharmacies (preferred after two fills)	**For up to a 90-day supply, you pay:**	
• Generic Medication	25% ($15 minimum/$60 maximum)	
• Preferred Brand Drug	30% ($75 minimum/$300 maximum)	
• Non-Preferred Brand Drug	35% ($93.75 minimum/$375 maximum)	
• Immunizations administered through the Fund's pharmacy benefits manager	Plan pays 100% (please see SMM for a list of specific covered immunizations)	
• Diabetic Testing Supplies and Syringes	Plan pays 100%	

Dental Benefits (Active Employees and Dependents)	
Calendar Year Maximum (not applicable to preventive oral care for eligible Dependent children under age 19)	$1,000 per person
Calendar Year Deductible	
• Routine Dental Services	$25 per person

Copayment Percentages	
• Routine Dental Services	Plan Pays 100% after deductible
• Basic Dental Services	Plan pays 50%
• Major Dental Services and Orthodontia	Not covered

Vision Benefits (Active Employees and Dependents)	**Network Provider**	**Non-Network Provider**
Complete Eye Exam (One per calendar year)	100%; no deductible	Plan pays up to $25 per person
Lenses and Frames or Contact Lenses (every 2 years)	Plan pays up to $100 maximum per person every 2 years	Not covered
Lasik Surgery	Plan pays up to $250 per eye for $500 total allowance after 15% discount if surgery performed at network provider	Plan pays up to $250 per eye for $500 total allowance

Death Benefit (Active Employees and Totally Disabled Former Active Employees Only)	
Amount	$20,000

Accidental Death & Dismemberment Benefit (Active Employees Only)	
• Death • Both Hands • Both Feet • One Hand and One Foot • Entire Sight of Both Eyes • One Hand and Entire Sight of One Eye • One Foot and Entire Sight of One Eye	$20,000
• One Hand • One Foot • Entire Sight of One Eye	$10,000

[9] 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).