

Non-Medicare Eligible Retiree Plan Schedule of Benefits

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	\$2,500 per person; \$5,000 per family
• Additional Non-PPO Maximum	\$1,000 person; \$2,000 per family
Calendar Year Plan Maximums	
• Overall	Unlimited beginning in 2014
Mental Health Treatment	
– Inpatient Maximum	15 days per person with up to 15 Physician visits
– Outpatient Maximum	30 visits per person
• 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 ²
Special Benefit Maximums	
• Hospital Daily Room and Board	Semi-private room rate
• Hospital Intensive Care	Three times semi-private room rate
• Inpatient Substance Abuse Treatment	One 21-day course of treatment per person per lifetime
• Infertility Treatment ³	\$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%	Plan pays 70%
• Preventive Services	Plan pays 100%; no deductible	Not covered
• Chiropractic/Spinal Care ⁴	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 ⁵		
– Inpatient	Plan pays 80%	Plan pays 70% ⁷
– Outpatient ⁶	Plan pays 80% of first \$5,000 in a year; 50% thereafter	Plan pays 50%
• Mental Health Treatment ⁸		
– Inpatient	Plan pays 80%	Plan pays 50%
– Outpatient	Plan pays 50%	Plan pays 50%

¹ Excludes amounts paid for non-covered expenses.

² 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.

³ Expenses to determine Infertility are not included under the lifetime maximum.

⁴ Chiropractic/spinal care includes all services and supplies for care of the back, neck, spine and vertebrae.

⁵ Inpatient treatment is covered if it is provided by a Hospital or approved Treatment Facility and treatment is based on completion of a course of treatment and the discharge is certified by a Physician.

⁶ Amounts paid by the Plan at the 50% level for substance abuse treatment do not apply to the out-of-pocket maximum.

⁷ Inpatient treatment provided by a Non-PPO provider is subject to the \$500 per person Non-PPO deductible for each non-Emergency admission, in addition to the calendar year deductible.

⁸ Amounts paid by the Plan at the 50% level for treatment of Mental Health do not apply to the out-of-pocket maximum.

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• Ambulatory Surgical Center	Plan pays 80%	Not covered		
• Other Covered Medical Expenses	Plan pays 70%	Plan pays 70%		
Prescription Drug Benefits (Retirees and their Dependent Spouse)				
Calendar Year Deductible	\$250 per person			
Coinsurance⁹				
• 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.			
• 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
• Diabetic Testing Supplies	The Plan pays 100%			

	VSP Provider	Non VSP Provider
Complete Eyeglass Exam (One per calendar year)	20% Discount, you pay 80%	Not covered
Lenses and Frames when a complete pair of glasses are purchased, additional glasses and sunglasses	20% Discount, you pay 80%	Not covered
Contact Lens Exam (fitting and evaluation)	15% Discount, you pay 85%	Not covered

Vision Care Discount Program (Retirees and their Dependent Spouse)¹⁰

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. To receive the discount, you must purchase glasses, lenses and contacts within 12 months of your last eye exam.