

### **BOWLING TRANSPORTATION INC. - 55930**

### Renewal Rates Effective March 1, 2020

	Medical and Preso	cription Drug Plan	
Coverag	e Election	Current Rates	Reserve Drawdown Renewal Rates
	Employee Only	\$712.21	\$747.82
Plan C	Employee+Child(ren)	\$1,358.48	\$1,426.40
	Employee+Spouse	\$1,631.11	\$1,712.67
	Family	\$2,277.30	\$2,391.17

	Denta	l Plan	
Coverage	e Election	Current Rates	Renewal Rates
Plan D002	Employee Only	\$38.22	\$38.22
Fian D002	Family	\$95.54	\$95.54

	Visio	n Plan	
Coverage	e Election	Current Rates	Renewal Rates
Enhanced Plan	Employee Only	\$5.34	\$5.34
Ellianceu Flan	Family	\$13.37	\$13.37

	Disabil	ity Plan	
Coverage Election		<b>Current Rates</b>	Renewal Rates
Plan S800	Employee Only	\$30.36	\$30.36



# **BOWLING TRANSPORTATION INC. - 55930**

### Renewal Rates Effective March 1, 2019

		Medical and Prescription Drug Plan	ription Drug Plan		
Current Plan and Rates	n and Rates	New Plan and Rates	and Rates	Reserve Drawdown Rates	vdown Rates
Plan H003	H003	Plan C	ار ا	Plan C	1 C
Employee Only	\$678.29	Employee Only	\$898.31	Employee Only	\$712.21
Employee+Child(ren)	\$1,293.79	Employee+Child(ren)	\$1,713.45	Employee+Child(ren)	\$1,358.48
Employee+Spouse	\$1,553.44	Employee+Spouse	\$2,057.33	Employee+Spouse	\$1,631.11
Family	\$2,168.85	Family	\$2,872.37	Family	\$2,277.30

	Dental Plan	I Plan	
Coverag	Coverage Election	Current Rates	Renewal Rates
	Employee Only	\$38.22	\$38.22
Plan D002	Employee+Child(ren)	\$95.54	\$95.54
	Employee+Spouse	\$95.54	\$95.54
	Family	\$95.54	\$95.54

	Vision	Vision Plan	
Coverag	Coverage Election	Current Rates	Renewal Rates
	Employee Only	\$5.34	\$5.34
Enhanced Dlan	Employee+Child(ren)	\$13.37	\$13.37
Thinamood 1 Jan	Employee+Spouse	\$13.37	\$13.37
	Family	\$13.37	\$13.37



# BOWLING TRANSPORTATION INC. - 55930

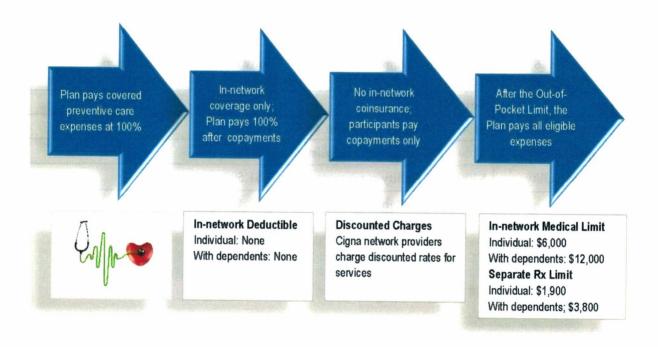
### Renewal Rates Effective March 1, 2019

	Disabil	Disability Plan	
Coverage	e Election	Current Rates	Renewal Rates
			Carrier III
Plan S600	Employee Only	\$30.60	\$30.60

### How Medical and Prescription Drug Coverage Works Under Plan C

Plan C is a medical copayment plan administered by Cigna through its Open Access Plus (OAP) network of doctors, hospitals, urgent care centers, and other medical care professionals and facilities. Prescription drugs are administered by CVS Caremark. The plan does not cover out-of-network expenses. Plan C features:

- Coverage for medical expenses from in-network providers only. Plan C does not cover expenses from out-of-network providers.
- No deductible for expenses from providers who are members of the Cigna Open Access Plus (OAP)
  network. Most covered in-network services are subject to fixed copayments. The Plan pays 100%
  after copays.
- 100% coverage for preventive care services and certain preventive medications when obtained from in-network providers, no deductible or copayments.
- No coinsurance. Participants pay their share of medical expenses through copayments only. For prescription drugs, participants pay a percentage of the cost, but the percentage is limited to a copayment maximum.
- An out-of-pocket limit. When a participant's total copays reach the out-of-pocket limit, the Plan pays 100% of that participant's eligible expenses for the remainder of the calendar year. All copayments paid by a participant count toward the out-of-pocket limit.



### **Examples**

These hypothetical examples are designed to show how Plan C and participants would share medical costs. The examples are for illustration purposes only. Actual costs will depend on an individual's actual medical expenses and plan coverage rules.

### Example 1

Mary enrolls in individual coverage and has \$4,000 of covered in-network medical expenses for the year which are subject to coinsurance rather than copayments. Her share of the cost in Plan C is summarized below.

Expense	Mary Pays	Plan Pays
\$4,000 (no deductible)	\$0	\$4,000
Total \$4,000	\$0 paid by Mary	\$4,000 paid by Plan

### Example 2

Bob enrolls in family coverage and his family has \$6,000 of covered in-network medical expenses for the year which are subject to coinsurance rather than copayments. His share of the cost in Plan C is summarized below.

Expense	Bob Pays	Plan Pays
\$6,000 (no deductible)	\$0 plus copays (see next table)	\$6,000
Total \$6,000	\$0 paid by Bob	\$6,000 paid by Plan

### Example 3

In addition to the \$6,000 in expenses in Example 2 above, Bob's family has \$3,000 in medical expenses that are subject to copayments rather than coinsurance. His total cost for copays in Plan C is summarized below.

Expense	Bob Pays	Plan Pays
\$500 - 5 doctor visits	\$150 = \$30 copay per doctor visit	\$350
\$800 - 4 specialist visits	\$200 = \$50 copay per specialist visit	\$600
\$1,700 - 1 ER facility	\$200 = ER facility copayment	\$1,500
Total \$3,000	\$550 paid by Bob	\$2,450 paid by Plan

### SIDE-BY-SIDE COMPARISON 2018 Plan C and Plan H003 What Participants Pay

	What Participants I	Pay	
	PLAN C		N H003
	In-Network Only	In-Network	Out-of-Network
FINANCIAL			
Lifetime Maximum:	Unlimited	Unlimited	Unlimited
Deductible:			\$200 September 1980 S
Individual	None	\$400	\$400
With Dependents	None	\$1,200	\$1,200
Out-of-Pocket Limit: Appli	es per calendar year - Plan C, copays only. Plan H00	3 cross accumulates in and	out of network - includes
deductible, coinsurance, and			
Individual	\$6,000	\$4,400	\$8,400
With Dependents	\$12,000	\$9,200	\$17,200
MEDICAL BENEFITS			
Allowances based on	Contract Rate	Contract Rate	UC&R
Coinsurance	0%	0% after deductible	35% after deductible
Prior Authorization	Requires prior authorization for most medical se		
PREVENTIVE CARE	requires prior authorization for most medicar se	rvices and prescription dru	igs.
Routine Examinations:	Deductible waived	Deductible waived	Deductible waived
Annual Physical Exam	Deductible waived	Deductible walved	Deductible waived
Annual Gynecology Exam			
Routine Well Child Visits		the first control to the property of	
Related Routine Lab	· 自由 · 电电子 医电子 自由 · 电子 · 电	A CONTRACTOR OF THE SECOND	272000000000
Related Routine X-rays			
Annual Pap Screening	\$0	\$0	40% coinsurance
Annual PSA Screening			
Annual Flu Shot	AND A COMPANY OF THE PARTY.		GET DESCRIPTION
Routine Immunizations			yed) a charge of
(excluding travel related)		States of Establishment and	
Routine Colonoscopy:	Deductible waived	Deductible waived	Deductible waived
Covered every 3 years from			
age 50. If doctor indicates		<b>大学工作工作工作工作</b>	And Shirt Street
high risk of colon cancer,	The state of the state of \$0 and the state of the state o	\$0	40% coinsurance
benefit is provided every 2	on the contract the state of th		
years regardless of age			And the second second
Routine Mammogram:	Deductible waived	Deductible waived	Deductible waived
1 baseline age 35-39; 1 per year from age 40	\$0	\$0	40% coinsurance
PHYSICIAN SERVICES			Transmitte news
Primary Care Office Visit		150/ 0 11 /11	400/ 0 11 111
Specialist Office Visit	\$30 copay per visit	15% after deductible	40% after deductible
Specialist Office Visit	\$50 copay per visit	15% after deductible	40% after deductible
Emanganay Baam	Facility and the last of the l	2004 2	20% after deductible
Emergency Room	Facility copay applies, includes physician cost	20% after deductible	40% after deductible if
Urgent Care	Facility copay applies, includes physician cost	200/ -0 1-1	not a true emergency
Inpatient Hospital Visit		20% after deductible	40% after deductible
	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Observation Visit	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Surgeon	Facility copay applies (office visit copay if done by physician in office)	20% after deductible	40% after deductible
Assistant Surgeon	Facility copay applies, includes physician cost	20% after deductible	40% after deductible
Anesthesiologist	Facility copay applies, includes physician cost	20% after deductible	40% after deductible

	SIDE-BY-SIDE COMP 2018 Plan C and Plan What Participants	н Н003	
	PLAN C		N H003
	In-Network Only	In-Network	Out-of-Network
FACILITY SERVICES			
Inpatient Hospital	\$500 facility copay per admission	20% after deductible	40% after deductible
Outpatient Hospital	\$200 facility copay per visit	20% after deductible	40% after deductible
		20% after deductible	20% after deductible
Emergency Room	\$200 facility copay per visit	20% after deductible	40% after deductible if not a true emergency
Urgent Care Facility	\$50 facility copay per visit	20% after deductible	40% after deductible
OTHER SERVICES			
Allergy Tests/Treatment	Physician office visit copay applies	20% after deductible	40% after deductible
Ambulance Transport	\$100 copay per event	20% after deductible	40% after deductible
Ambulatory Surgery Ctr	\$50 copay per visit	20% after deductible	40% after deductible
	Facility copay applies	20% after deductible	Not covered
Bariatric Surgery	In-network coverage only the for Bariatric Surgery a	rough CIGNA Centers of Exafter meeting clinical criteri	
Chemotherapy	\$200 copay per visit	20% after deductible	40% after deductible
Cli	\$50 copay per visit	20% after deductible	40% after deductible
Chiropractic Care	Maximum 20 days of chirop	practic treatment per calend	ar year.
Diagnostic Lab	\$20 copay per visit	20% after deductible	40% after deductible
Diagnostic X-Ray	\$50 copay per visit	20% after deductible	40% after deductible
	c Lab and X-Ray coinsurance applies to testin In a doctor's office, the applicable physician of		ory or x-ray facility.
Durable Medical	\$50 copay per item	20% after deductible	40% after deductible
Equipment (DME)	All benefit options – Maximum re (or preferred provider contract rate)		
Home Health Care	\$100 copay per visit	20% after deductible	40% after deductible
Hospice Care	\$100 copay per visit	20% after deductible	40% after deductible
Organ Transplant	Paid like any other illness.	20% after deductible	40% after deductible
	\$50 copay per visit	20% after deductible	40% after deductible
Podiatry Treatment	All benefit options have a maximum of 3 the 30 days limit does not ap		
Pre-Admission Testing	\$50 copay per visit	20% after deductible	40% after deductible
Prosthetics / Orthotics	\$50 copay per visit	20% after deductible	40% after deductible
0.4.4.4.0.1.1.111.4.4	\$30 copay per visit	20% after deductible	40% after deductible
Outpatient Rehabilitative Therapy	Maximum 50 days treatment per cal including physical therapy, speech th		
Radiation Therapy	\$200 copay per visit	20% after deductible	40% after deductible
	\$200 copay per visit	20% after deductible	40% after deductible
Skilled Nursing Facility	Maximum 100 days o	f treatment per calendar yea	ar. gebesiense lees

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	What Participan	ts Pay	
	PLAN C	PLAN	V H003
	In-Network Only	In-Network	Out-of-Network
MENTAL HEALTH CAR	E		
Inpatient	\$500 copay per admission	20% after deductible	40% after deductible
Outpatient Facility	\$200 copay per visit	20% after deductible	40% after deductible
Outpatient Visits	\$50 copay per visit	20% after deductible	40% after deductible

SIDE DV SIDE COMPADISON

### PRESCRIPTION DRUG BENEFITS

Inpatient

**Outpatient Facility** 

**Outpatient Visits** 

**Program Includes generic step therapy** which requires generic or equivalent be tried before preferred or non-preferred brand is covered (unless brand is pre-authorized). No copay or coinsurance is required for generic and single source brand **female contraceptives**. Prior authorization is required for **compound drugs** over \$300, for all **male androgens**, and for all specialty drugs. Formulary exclusions apply but excluded items may be considered with prior authorization of medical necessity.

\$50 copay per admission

\$200 copay per visit

\$50 copay per visit

20% after deductible

20% after deductible

20% after deductible

40% after deductible

40% after deductible

40% after deductible

CVS Caremark Network Pharmacies	Plan H003 – All Pharmacies
None	None
Individual: \$1,900 Family: \$3,800	Individual: \$2,000 Family: \$4,000
to covered prescription drugs at all participati	ng retail pharmacies
\$10 copay per script	\$20 copay per script
20% up to \$50 maximum	\$40 copay per script
30% up to \$100 maximum	\$50 copay per script
to maintenance drugs by mail-order or at CVS	S retail pharmacies
\$20 copay per script	\$40 copay per script
20% up to \$100 maximum	\$80 copay per script
30% up to \$200 maximum	\$100 copay per script
cialty Medications - Require prior-authorizati quantities based on type of medication and dos	on and use of specialty pharmacy – sage and handling requirements.
	Generic:\$40 copay
20% up to \$120	Preferred:\$80 copay
	Non-preferred:\$100
AGE LIMIT FOR DEPENDI	ENT CHILDREN
ered to age 26. Coverage under the Plan ends the	last day of the month in which a child reaches age 26.
	None Individual: \$1,900 Family: \$3,800  to covered prescription drugs at all participati \$10 copay per script  20% up to \$50 maximum  30% up to \$100 maximum  to maintenance drugs by mail-order or at CVS \$20 copay per script  20% up to \$100 maximum  30% up to \$200 maximum  cialty Medications - Require prior-authorization quantities based on type of medication and dos  20% up to \$120  AGE LIMIT FOR DEPENDI

The information in this document is for general informational purposes only. It does not, and is not intended to, replace or supercede the plan documents (Plan Document or Summary Plan Description [SPD]) that apply to the Plan. This information isn't an offer of coverage, solicitation of coverage, summary of coverage or guarantee of coverage. Coverage is subject to medical necessity (except preventive care) and may be subject to limitations and exclusions. Consult the applicable plan documents to determine all governing provisions, including eligibility and participation, the plan of benefits, and exclusions and limitations relating to this Plan. In the event of a conflict between the applicable plan documents and this general information, the plan documents will govern.



## Medical Benefits Effective January 1, 2018

Comparison of	Plan A an	Plan A and Plan A+	Pla	Plan B	Plan C	Plan D and	Plan D and Plan D+HSA
Benefit Options	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
FINANCIAL					NO OUT OF NETWORK		
Lifetime Maximum:	Unlir	Unlimited	ijμU	Unlimited	Unlimited	nilnU	Unlimited
Deductible: Applies per calendar year - cross accumulates in and out of network (where applicable) - includes 4th quarter deductible carry-over	endar year - cross accum	ulates in and out of netwo	rk (where applicable) - in	cludes 4th quarter deducti	ble carry-over		
- Individual - Family	\$100	\$100	None	\$3,000	None	\$2,000 (includes Rx)	\$3,000
Out-of-Pocket Limit: Applies per calendar year -		cross accumulates in and out	t of network - includes de	of network - includes deductible, coinsurance, and copayments	d copayments	(m. 100m) 000't d	
- Individual		\$3,100	\$4,000	\$13,000	86,000	\$6,000 (includes Rx)	\$13,000
- Family	\$3,200	\$6,200	\$10,000	\$39,000	\$12,000	\$12,000 (includes Rx)	\$26,000
MEDICAL BENEFITS							
Allowances based on:	Contract Rate	UC&R	Contract Rate	UC&R	Contract Rate	Contract Rate	UC&R
Coinsurance:	10% after deductible	30% after deductible	%0 	50% after deductible	%0	20% after deductible	50% after deductible
Prior Authorization:	All benefit design	All benefit designs require prior authorizat	ion for most medical serv	rices. Many prescription dr	ion for most medical services. Many prescription drugs require prior authorization under both CVS/caremark and Cigna.	tion under both CVS/care	mark and Cigna.
PREVENTIVE CARE							
Routine Examinations:	Deductible waived	Deductible waived	No deductible	Deductible applies	No deductible	Deductible waived	Deductible applies
Annual Physical Exam							
Annual Gyn Exam							
Routine Well Child Visits							
Related Routine Lab							
Related Routine X-ravs							
Annual Pap Screening	%0	30%	%0	50% after deductible	%0	%0	50% after deductible
Annual PSA Screening							
Annual Flu Shot							
Routine Immunizations							
(excluding travel related)							
Routine Colonoscopy:	Deductible waived	Deductible waived	No deductible	Deductible applies	No deductible	Deductible waived	Deductible applies
Covered every 3 years from							
age 50. If doctor indicates							
high risk of colon cancer,	%0	30%	%0	50% after deductible	%0	%0	50% after deductible
benefit is provided every 2							
years regardless of age							
Routine Mammogram:	Deductible waived	Deductible waived	No deductible	Deductible applies	No deductible	Deductible waived	Deductible applies
1 baseline age 35-39;	%0	30%	%0	50% after deductible	%0	%0	50% after deductible
PHYSICIAN SERVICES							
Primary Care Office Visit	\$5 copay per visit	30% after deductible	\$25 copay per visit	50% after deductible	\$30 copay per visit	20% after deductible	50% after deductible
Specialist Office Visit	\$10 copay per visit	30% after deductible	\$40 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
Emergency Room	10 To	Facility copay applies	i i	Facility copay applies	12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-1414	20% after deductible
Physician Visit	raciiity copay applies	30% after deductible if not a true emergency	raciiity copay appiles	50% after deductible if not a true emergency	racility copay applies	ZU% alter deductible	50% after deductible if not a true emergency
Inpatient Hospital Visit	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible



## Medical Benefits Effective January 1, 2018

Comparison of	Plan A an	and Plan A+	20	Dian B	O Hold		*31.10
Donofit Ontions			100	) :	r Iaii o	2	FIGII DTD3A
Benefit Options	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
PHYSICIAN SERVICES (continued)	continued)						
Observation Visit	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Urgent Care Physician	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Surgeon	Facility copay applies (office visit copay if done by physician in office)	30% after deductible	Facility copay applies (office visit copay if done by physician in office)	50% after deductible	Facility copay applies (office visit copay if done by physician in office)	20% after deductible	50% after deductible
Assistant Surgeon	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
Anesthesiologist	Facility copay applies	30% after deductible	Facility copay applies	50% after deductible	Facility copay applies	20% after deductible	50% after deductible
HOSPITAL / URGENT CA	CARE FACILITY SERVICES:	SES:					
Inpatient Hospital	\$75 copay per admit	30% after deductible	\$350 copay per admit	50% after deductible	\$500 copay per admit	20% after deductible	50% after deductible
Outpatient Hospital	\$50 copay per visit	30% after deductible	\$200 copay per visit	50% after deductible	\$200 copay per visit	20% after deductible	50% after deductible
Emergency Room	\$50 copay per visit	\$50 copay per visit 30% after deductible if not a true emergency	\$100 copay per visit	\$100 copay per visit 50% after deductible if not a true emergency	\$200 copay per visit	20% after deductible	20% after deductible 50% after deductible if
Urgent Care Facility	\$25 copay per visit	30% after deductible	\$50 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
OTHER SERVICES							
Allergy Tests/Treatment	Visit copay applies	30% after deductible	Visit copay applies	50% after deductible	Visit copay applies	20% after deductible	50% after deductible
Ambulance Transport	10% after deductible	30% after deductible	\$50 copay per event	50% after deductible	\$100 copay per event	20% after deductible	50% after deductible
Ambulatory Surgery Ctr	10% after deductible	30% after deductible	\$50 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
Bariatric Surgery	Facility copay applies	Not covered	Facility copay applies	Not covered	Facility copay applies	20% after deductible	Not covered
	In netw	vork only coverage throug	h CIGNA Centers of Exce	ellence for Bariatric Surge	In network only coverage through CIGNA Centers of Excellence for Bariatric Surgery when clinical criteria is met - No out of network coverage	et - No out of network cov	verage
Chemotherapy	10% after deductible	30% after deductible	\$200 copay per visit	50% after deductible	\$200 copay per visit	20% after deductible	50% after deductible
Chiropractic Care	\$10 copay per visit	30% after deductible	\$40 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
	Maximum zo days treat	Maximum zu days treatment per calendar year	Maximum 20 days treat	Maximum 20 days treatment per calendar year	Max 20 days per year	Maximum 20 days treatment per calendar year	ment per calendar year
Diagnostic Lab	10% after deductible	30% after deductible	\$10 copay per visit	50% after deductible	\$20 copay per visit	20% after deductible	50% after deductible
Diagnostic X-Ray	10% after deductible	30% after deductible	\$50 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
Diagnostic Lab and X-F	₹ay coinsurance and copa	≓ا	esting at an independent	laboratory or x-ray facility	듸	plicable physician office v	visit copay applies.
Durable Medical Equipment (DME)	10% after deductible	30% after deductible priors – Maximum rental b	\$50 copay per item	50% after deductible	deductible 30% after deductible \$50 copay per item 50% after deductible \$50 copay per item 20% after deductible 50% after deductible 50	20% after deductible	50% after deductible
Home Health Care	10% after deductible	30% after deductible	\$50 copav per visit	50% after deductible	\$100 copav per visit	20% after deductible	50% after deductible
Hospice Care	10% after deductible	30% after deductible	\$40 copay per visit	50% after deductible	\$100 copay per visit	20% after deductible	50% after deductible
Organ Transplant	Paid like any	Paid like any other illness	Paid like any other illness	other illness	Like any other illness	Paid like any other illness	other illness
Podiatry Treatment	\$10 copay per visit	\$10 copay per visit 30% after deductible \$40 copay per visit 50% after deductible	\$40 copay per visit		\$50 copay per visit	20% after deductible	50% after deductible
	All Deficil C	pulons nave a maximum o	or so days or podiatry treat		- the 30 days limit does not apply to covered surgical procedures	apply to covered surgical p	procedures
Pre-Admission Testing	10% after deductible	30% after deductible	\$40 copay per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% after deductible
Prosthetics / Orthotics	10% after deductible	30% after deductible	\$50 copay per item	50% after deductible	\$50 copay per item	20% after deductible	50% after deductible
Outpatient Rehabilitative	\$10 copay per visit	30% after deductible	\$25 copay per visit	50% after deductible	510 copay per visit 30% after deductible \$25 copay per visit 50% after deductible \$30 copay per visit 20% after deductible	20% after deductible	50% after deductible
Dediction The	Maximum 50 days tre	earment per calendar year	for all types or renabilitat	live therapy including phys	sical therapy, speech therap	by, occupational therapy, o	cardiac therapy, etc.
Nation Therapy	10% affer deductible	30% affer deductible	\$200 copay per visit	50% after deductible	\$200 copay per visit	20% after deductible	50% after deductible



## Medical Benefits Effective January 1, 2018

Comparison of	Plan A an	Plan A and Plan A+	Pla	Plan B	Plan C	Plan D and	Plan D and Plan D+HSA
Benefit Options	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	IN NETWORK	OUT OF NETWORK
OTHER SERVICES (continued)	tinued)					· · · · · · · · · · · · · · · · · · ·	
Skilled Nursing Facility	10% after deductible	30% after deductible	\$200 copay per stay	50% after deductible	\$200 copay per stay	20% after deductible	50% after deductible
	Maximum 100 days treatment per cal year	reatment per cal year	Maximum 100 days t	Maximum 100 days treatment per cal year	Max 100 days per year	Maximum 100 days to	Maximum 100 days treatment per cal year
MENTAL HEALTH CARE							
Inpatient	\$75 copay per admit	30% after deductible	\$350 copay per admit	50% after deductible	\$500 copay per admit	20% after deductible	50% offer deductible
Outpatient Facility	\$50 copay per visit	30% after deductible	\$200 copay per visit	50% after deductible	\$200 conav ner visit	20% after deductible	50% after deductible
Outpatient Visits	\$10 copay per visit	30% after deductible	\$40 copav per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% offer deductible
ALCOHOL, DRUG & CHEMICAL DEPENDENCY TREATMENT	EMICAL DEPENDENCY	Y TREATMENT			nei pad fado oo	בס יים שונפו מפממכווטופ	20 % alter deductible
Inpatient	\$75 copay per admit	30% after deductible	\$350 copay per admit	50% after deductible	\$500 copay per admit	20% after deductible	50% offer doductible
Outpatient Facility	\$50 copay per visit	30% after deductible	\$200 copay per visit	50% after deductible	\$200 conav ner visit	20% after deductible	50% after deductible
Outpatient Visits	\$10 copay per visit	30% after deductible	\$40 copav per visit	50% after deductible	\$50 copay per visit	20% after deductible	50% offer deductible
PRESCRIPTION DRUGS					Total and forder one	במיס מוכו מסממוסום	20 /8 arter deductible
Drogram Includes concinciate the state of							

Program Includes generic step therapy which requires generic or equivalent be tried before preferred or non-preferred brand is covered (unless brand is pre-authorized). No copayment or coinsurance is required for generic and single source brand female contraceptives. Prior authorization is required for compound drugs over \$300, for all male androgens, and for all specialty drugs. Formulary exclusions apply, but excluded items may be considered with prior authorization of medical necessity

charge apply, but exclud	oversions upply; but excluded items in ay be considered with prior authorization of medical necessity	of medical necessity.				
Coverage Details	CVS/caremark - All Pharmacies	CVS/caremark - C	CVS/caremark - CVS Network Only	CVS - Network Only	Cidna - Pharmacy Notwork Only	v Notwork Only
Deductible	None	No	None	None	Combined - see page 1 deductible	y Network Offing
Out-of-Pocket Limit	Individual: \$1.600	Polivibal 81 800	81 800	000 100 100 100 100 100 100 100 100 100	000	age I deductione
		aividaai.	000,1	maividual: \$1,900	Caridado	the desired and the second
(per calendar year)	Family: \$3,200	Family: \$3,600	\$3,600	Family: \$3,800	Combined - see page 1 out-or-pocket	ge i out-or-pocket
34 Day Supply - Applies to	34 Day Supply - Applies to covered prescription drugs at all participating re	retail pharmacies				
- Generic	\$10 copay per script	\$10 copay	Not covered	\$10 copav	7 20% after deductible	Not covered
- Preferred Brand	\$20 copay per script	20% up to \$30 max	Not covered	20% in to \$50 may	20% offer deductible	Not covered
- Non-Preferred Brand	\$30 copay per script	30% up to \$60 may	Not covered	30% in to \$100 max	20% after deductible	ואסו מסאפופת
90 Day Supply - Annlies to	maintenance drink have the concrete maintenance	:	noi coveled	So to the community	ZU% after deductible	Not covered
or sounded field to the control	or at CVS reta	III pharmacies				
- Generic	\$20 copay per script		Not covered	\$20 copav	Z0% after deductible T	Not covered
- Preferred Brand	\$30 copay per script	20% up to \$60 max	Not covered	20% up to \$100 max	20% after deductible	Not covered
- Non-Preferred Brand	\$40 copay per script	30% up to \$120 max	Not covered	30% in to \$200 max	October 20 State	מסו מסום מסום מסום
Specialty Medications	The section of the se	2000 ap 120 111ax	NOI COVERED	30 % up to \$200 max	20% after deductible	Not covered
Specially medications - Ref	Specially medications. Require prior authorization and use of specially pharmacy. Days supply will be based on type of medication, and dosage and handling requirements	armacy - Days supply w	ill be based on type of	medication, and dosage a	and handling requiremen	ıts
- All Specialty Meds	\$40 Copay	20% up to \$120	Not covered	20% up to \$200	20% after deductible	Not covered
OPTIONAL BENEFITS	Plan A+ (additional cost option)	Plan B (no options)	options)	Plan C (no options)	Plan D+HSA (additional cost ontion)	onal cost ontion)
Surgical Vision Correction	10% after deductible 30% after deductible					and cost obtain)
Benefits	Max \$1,000 per eye to	Not available	ailable	Not available	Not available	ilable
Hearing Aids	10% after deductible 30% after deductible	Not available	ilable	oldelieve toN	oldolious told	oldolio
Health Savings Account	Not available	oldelieve told	idalio	oldania de la compania del compania del compania de la compania del	ואסו מאמ	liable
ACE IMIT FOR PERFIN	THE CHANGE OF THE PARTY OF THE	IVOLANG	illable	Not available	Health Savings Account is optional	count is optional
AGE CIMIL FOR DEPENDENT CHILDREN:	ENI CHILDREN:				を できる という かんこう はまま かんしゅう	1000年

For all benefit options, eligible dependent children are covered to age 26 (coverage ends the last day of the month in which the child turns age 26)

Please note - The above is a summary of benefits only. Coverage is subject to medical necessity (except preventive care) and may be subject to limitations and/or exclusions. Please refer to the Summary Plan Description or contact the Fund Office for information about any limitations and/or exclusions. Updated 01/19/2018