Classic Option

Medical Plan Document

2008

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Classic Option Medical Plan Document
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I. Welcome to BHP

This Medical Plan Document describes the medical benefits provided by the Butler Health Plan ("the Plan") Classic Option. It explains who can be covered, how payments are made, how to file a claim, and other important information about how the Plan works. Check the BHP web site **http://www.butlerhealthplan.org** for the most up to date issue of the Medical Plan Document.

For your convenience, two addendums are attached at the end of this Plan Document. The first (the Index) will enable you to find specific terms and provisions by page number at a more detailed level than is provided in the Table of Contents. The second (the Summary Schedule) provides a quick review of the Plan's coverages. However, this Summary Schedule is not meant to provide complete detail and the provisions of the full document will always take precedence over any such summary information provided. Please read this entire Plan Document to be sure you understand all the provisions.

If you have questions about the meaning of language or terms, or if you have a question that is not covered in this Plan Document, please call the Claim Administrator. BHP has hired a Claim Administrator to process your claims and answer your questions regarding the Plan.

The Claim Administrator is accessible 24 hours a day, seven days a week through an automated phone system or the web site. Customer service representatives are available during business hours to take your calls. Have the Employee Participant's ID Number and the claim information available when you call regarding a specific claim.

The Claim Administrator information is:

Allied Benefit Systems, Inc.
P.O. Box 909786-60690,Chicago, IL 60690
Chicago, IL 60690
1-312-906-8080
1-800-288-2078 (Outside Illinois)
www.alliedbenefit.com

(This information is also on your ID card)

As a condition of enrollment, each Employee has consented and authorized any dentist, physician, supplier, hospital, pharmacy, insurance company, employer or organization to disclose any medical information concerning him or herself, or any Dependents, to the Butler Health Plan or its agents or contractors for the purpose of administering, supervising and monitoring the health Plan(s). As a further condition of enrollment, each Employee has consented to the subsequent disclosure of medical information concerning him or herself, or any Dependents, by Butler Health Plan or its agents or contractors to contractors who provide wellness, disease management, case management or other health and health care related services to Butler Health Plan and/or its participants. This consent shall be valid until revoked in writing by the Employee.

If you have questions concerning your Prescription Drug Benefit, please contact BHP's Pharmacy Benefit Administrator:

(Please see your ID card for all appropriate contact information)

Any Participant who disagrees with a decision made by the Plan regarding the Participant's eligibility or benefits may appeal that decision by following the procedures described in the "How Claims Are Administered" section of this Plan Document. This includes, but is not limited to, decisions regarding:

1. Eligibility, enrollment and termination of coverage.
2. COBRA eligibility, election, and termination.
3. The amount of benefits payable under the Plan.
4. Precertification of services and supplies when required by the Plan.
5. Case management.
6. Coordination of benefits.

Appeals that do not follow the procedures described in "How Claims Are Administered," will not be considered

II. Standard Schedule of Benefits – Classic Option Plan

The following schedule describes Deductible, Co-Insurance rates and Out-of-Pocket Maximum levels that apply under the Classic Option. These provisions are subject to certain limitations and special provisions, which are more fully described under "What Is Covered" and "What Is Not Covered".

Deductibles

Each Participant is responsible for paying the following:

- $25 per calendar year individual Deductible for prescription drugs. This Deductible does not count toward the Annual Out-of-Pocket Maximum for prescription drugs.
- $100 per visit individual Deductible for emergency room treatment. Deductible is waived if patient is admitted, treated for an accident or a medical emergency.
- $500 per individual/$1,500 per family Deductible per calendar year for Out of Network expenses.

Co-Insurance

Each Participant (or family, if applicable) is then responsible for paying the following:

- 20% of the first $7,500 ($1,500) per Participant, or 20% of the first $22,500 ($4,500) per family of covered charges for In-Network Medical, Surgical, Mental Illness, Alcoholism and Substance Abuse Services.
- 20% of the first $3,750 ($750) per Participant, or 20% of the first $11,250 ($2,250) per family of covered generic and/or formulary prescription drug charges.
- 40% of the first $5,000 ($2,000) per participant, or 40% of the first $15,000 ($6,000) per family of the Usual and Customary charges (U&C) for Out-of-Network Medical, Surgical, Mental Illness, Alcoholism and Substance Abuse Services.
- 40% of covered non-formulary prescription drug charges (this expense does not count toward the annual Out-of-Pocket Maximum for prescription drugs.
- 100% of the difference between the cost of a covered generic prescription drug and its brand name equivalent (this expense does not count toward the annual Out-of-Pocket Maximum for prescription drugs.
- 100% of Out-of-Network covered charges determined to be above U&C (this expense does not count toward the annual Out-of-Pocket Maximum).

BHP is responsible for paying the following:

- 80% of the first $7,500 ($6,000) per Participant, or 80% of the first $22,500 ($18,000) per family of covered charges for In-Network Medical, Surgical, Mental Illness, Alcoholism and Substance Abuse Services, then 100% of covered charges.
- 80% of the first $3,750 ($3,000) per participant, or 80% of the first $11,250 ($9,000) per family of covered prescription drug charges after the prescription drug Deductible(s) are met, then 100% of covered charges.
- 60% of the first $5,000 ($3,000) per participant, or 60% of the first $15,000 ($9,000) per family of the U&C amount of covered charges for Out-of-Network Medical, Surgical, Mental Illness, Alcoholism and Substance Abuse Services after the Out-of Network Deductible(s) are met, then 100% of U&C.
- 60% of covered non-formulary prescription drug charges after the prescription drug Deductible(s) are met.

Out-of-Pocket Maximum

Each Participant is responsible for paying a Co-Insurance percentage of each covered claim until the Out-of-Pocket Maximum has been reached. The Participant's Out-of-Pocket expenses are calculated based on a calendar year's claims and are reset to zero on January 1 of each year.

For Participant Only Coverage, the Out of Pocket Maximum is:

- $1,500 In-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.
- $750 Prescription Drugs (Generic and Preferred Formulary Brand).
- $2,000 Out-of-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.[*]

For Employee +1 Coverage, the Out of Pocket Maximum is:

- $3,000 In-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.
- $1,500 Prescription Drugs (Generic and Preferred Formulary Brand).
- $4,000 Out-of-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.[*]

For Family Coverage, the Out of Pocket Maximum is:

- $4,500 In-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.
- $2,250 Prescription Drugs (Generic and Preferred Formulary Brand).
- $6,000 Out-of-Network Medical, Surgical, Mental Health, and Alcoholism and Substance Abuse Services.[*]

[*] NOTE: All Out-of-Network payments are based on Usual and Customary charges (U&C) for the care, service or treatment provided. If your actual charges are more than U&C you will be responsible for paying the difference between your charges and U&C. Extra amounts you have to pay will not count toward your annual Co-Payment maximum limits.

Co-Payments

Co-Payments are fixed amounts that you will pay for certain In-Network services. Co-Payment amounts do not accumulate toward your annual Out-of-Pocket Maximums.

$25 Co-Payment for all Medically Necessary Doctor's office visits, which applies to office visit only.

Lifetime Maximum Benefit

Each Beneficiary's Lifetime Maximum Benefit is $5 million. This Lifetime Maximum Benefit level applies during the entire time you are covered by the Plan as an Employee or Dependent, regardless of which Plan Option you are enrolled.

III. What Is Covered

The Plan helps pay for many different types of care, service, and treatment, and these are described in this Plan Document. This section describes the major categories of covered services and important general points about all benefits. The section entitled "What Is Not Covered" contains important information about exceptions to these general rules—charges that are not covered by the Plan, even if they fall within one of the major categories listed below.

Provider Network

The Participant is free to choose any Provider for primary and specialty care, but Co-Insurance rates are lower when an In-Network Provider is selected. This results in lower out-of-pocket expenses to the Participant. To verify that your Provider is In-Network, view the website at **http://www.butlerhealthplan.org** or call the Provider network phone number on your ID card. Note that a printed listing of network providers will be furnished automatically, without charge, as a separate document by the Plan Administrator.

Medically Necessary Services

The Plan will only pay charges for care, service, or treatment that is Medically Necessary in diagnosing or treating a covered Illness or Injury. There are limited exceptions to this general rule. (See - "What Is Not Covered"). An item of care, service, or treatment your Provider has recommended or prescribed is Medically Necessary if it is necessary according to accepted medical standards for your condition. The Claim Administrator determines whether or not a particular type of care, service, or treatment is Medically Necessary. The Claim Administrator will consider, among other things, whether the care, service, or treatment:

1. Is consistent with the symptoms of your condition or your Provider's diagnosis of your condition according to current national norms;
2. Is in keeping with current medical standards;
3. Is for legitimate medical purposes, rather than being solely for your or your Provider's convenience.

When services are provided Out-of-Network, the Plan will only pay charges that are Usual and Customary.

Except in those cases where this Plan Document specifies a different payment level:

1. The Plan pays at 80% of In-Network and 60% of Usual and Customary Out-of-Network charges until you have reached your Out-of-Pocket Maximum assigned to the In-Network or Out-of-Network benefit.
2. After you have reached your In-Network Out-of-Pocket Maximum, the Plan will pay 100% of In-Network charges. After you have reached your Out-of-Network Out-of-Pocket Maximum, the Plan will pay 100% of Usual and Customary Out-of-Network charges. **These Out of Pocket Maximums are separately tracked – expenses applied toward one do not apply to the other.**

Doctor Services

The Plan will pay for the following listed services rendered by the Providers indicated:

Your Doctors and Attending Physicians

The Plan will cover:

1. Medical Services, including office visits, house calls, and other outpatient services, diagnostic X-rays, and laboratory work.
2. Surgical services. Charges for preoperative and postoperative care are considered part of the fee for the surgery itself.
3. Visits to your bedside while you are a Hospital inpatient. If you are in the Hospital for treatment of more than one condition, each of which requires the care of a specialist, the Plan will pay charges for more than one Doctor to visit you while you are an inpatient.
4. Chiropractic Services, to the extent that such services are Medically Necessary for the active treatment of an Illness or Injury, but payment is limited to a maximum of $1,000 in a calendar year. The Co-Insurance amounts for chiropractic treatments will not count toward your Out-of-Pocket Maximum and the Plan will not pay 100 percent even if your Out-of-Pocket Maximum has been reached.

Consulting Physicians

Examination and consultation by Doctors other than your attending Physician, either on an inpatient or outpatient basis, to help with the diagnosis and treatment of your condition.

Hospital-Based Physicians

Services rendered by Physicians other than your attending Physician, such as emergency physicians, radiologists, anesthesiologists (and registered nurse anesthetists working under Physician supervision), and pathologists who provide care primarily to patients of a particular Hospital. As long as the Hospital is In-Network, your Co-Payment percentage of a Hospital-based Physician's charge will be paid at the In-Network rate up to the Usual and Customary charge, even if the Hospital-based Physician is not a network participant.

Assistant Surgeons

Services of an assistant surgeon to help your surgeon if one is Medically Necessary because of the complexity of the surgery or the nature of your condition. Payments for an assistant surgeon will be limited to a percentage of the primary surgeon's rate. The Plan does not cover charges for surgical assistance provided by a Hospital intern, resident, or employee, or by a medical student or a Physician's employee.

Hospital Services

The Plan will pay for:

1. Inpatient Hospital services, if applicable certification notification requirements have been met.

2. Outpatient surgery services provided on the day of surgery in the outpatient department of a Hospital, an Ambulatory Surgical Center, or an Intermediate Care Facility.

The following Hospital services and charges are covered only to the extent indicated:

1. Room and board charges for:
    a. Semi-private room;
    b. Private room, but only if Medically Necessary because of your condition;
    c. Intensive care, coronary care, and other specialty care units which are Medically Necessary to treat your condition;
    d. Operating, recovery, labor, delivery, and other types of treatment rooms;
    e. Newborn nursery.
2. Miscellaneous services and supplies, such as:
    a. Facility charges;
    b. Medical services and supplies;
    c. General nursing services;
    d. Meals and special diets;
    e. Drugs and medicines;
    f. Oxygen and Respiratory Therapy;
    g. Laboratory and Pathology tissue examinations;
    h. X-ray examinations and scanning procedures;
    i. Blood transfusions and blood typing, including charges for blood products if unavailable without charge from blood banks, voluntary donors or other sources;
    j. Electrocardiograms (EKGs), Electroencephalograms (EEGs), and Electromyograms (EMGs);
    k. Physical, Speech and Occupational Therapy;
    l. Radiation, radioactive materials and substances;
    m. Kidney Dialysis;
    n. Splints, casts, dressings and solutions.

<u>Emergency Care</u>

If you receive emergency care from a Doctor for an accidental Injury or acute Illness in the emergency or outpatient department of a Hospital or Ambulatory Surgical Center, the Plan will pay benefits at In-Network rates, up to the Usual and Customary charge. If you receive treatment for an Illness that is not a medical emergency in the emergency department of any Hospital, you will have to pay the first $100 of covered charges which will not be applied to the Out-of-Pocket Maximum, unless:

1. Your Doctor gave you a written referral to the Hospital, or
2. You are admitted to the Hospital directly from the emergency department, or
3. You are more than 50 miles from your residence.

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A medical emergency means any treatment or service that the Claims Administrator determines to be due to the sudden onset of severe medical symptoms that:

1. Could not have been reasonably anticipated; and
2. Require immediate medical care.

Urgent Care

If you receive care from a Doctor for an urgent condition in the emergency or outpatient department of a Hospital, an Ambulatory Surgical Center, an immediate care center, or an urgent care facility, and the condition resulted from an accidental Injury, the Plan will pay benefits at In-Network rates up to the Usual and Customary charge.

If the condition resulted from an Illness, the Plan will pay:

1. 80% of In-Network charges.
2. 60% of Usual and Customary Out-of-Network charges if the facility is located within a 50-mile radius of your home.
3. 80% of Usual and Customary Out-of-Network charges if the facility is located beyond a 50-mile radius from your home.

Pharmacy Benefits

These Pharmacy Benefits only apply to those drugs and pharmaceutical products purchased from a retail pharmacy or through the Mail Order option. The benefits for drugs and pharmaceutical products administered while receiving Hospital or Physician services are described under Hospital Services and Doctor Services, respectively.

Prescription Drugs and Pharmaceutical Products

Covered Prescription Drugs: Except for excluded items, the Plan covers drugs that, by law, may be dispensed only by prescription and that fall within one of the following categories:

1. Federal (United States) Legend Drugs (including oral and injectable contraceptives);
2. State restricted drugs; or
3. Compound drugs that contain at least one Prescription Legend Drug.

Covered Pharmaceutical Products: The Plan also covers insulin, diabetic testing devices, test strips, syringes, and needles.

Maintenance Drugs: A 90-day supply of a maintenance drug must be purchased by mail order after the third 30-day fill at a retail pharmacy.

Drugs and Pharmaceuticals Not Covered: The Plan does not pay for any of the following medications or pharmaceutical products:

1. Any covered drug in excess of the quantity specified by the Physician, or any refill dispensed after 1 year from the Physician’s order.
2. Any device or appliance (e.g., orthotics and other non-medical substances).
3. Diagnostic medications.
4. Experimental drugs.
5. Fluoride Preparations.
6. Gold Compounds – prepared with raw chemical ingredients, or legend drugs prepared in a non-FDA approved dosage form.
7. Irrigation Solutions.

8. Medications furnished on an in-patient basis covered under any other carrier providing group coverage for prescription legend drugs or insulin through Coordination of Benefits provision (e.g. major medical, home health care benefits, outpatient benefits).
9. Medical Supplies (e.g. Ostomy Supplies).
10. More than a 30-day supply of a covered Drug.
11. More than a 90-day supply of a covered Maintenance Drug.
12. Over-the Counter products.
13. Pharmaceutical Products used for Cosmetic purposes.
14. Prescription vitamins, except pre-natal.
15. Serums, Toxoids, and Vaccines.
16. Smoking Cessation Products (See “What Is Covered” —“Smoking/ Tobacco Cessation”).
17. Therapeutic Devices or Appliances.
18. Yohimebine.

Prescription Drug Benefit Levels

There is an individual $25 calendar year Deductible applied to prescription drugs before the Plan pays benefits. The level at which the Plan pays benefits will vary depending upon whether the prescription drug is generic, formulary, or non-formulary.

Generic Drugs: Generic drugs are regulated by the U.S. Food and Drug Administration (FDA) according to the same standards of safety, effectiveness and quality as their brand name equivalents. FDA approved generic drugs provide the same therapeutic benefits as their brand-name counterparts – at a substantial savings to you. The Plan pays 80% of the cost of a generic drug. The Plan will pay 100% the cost of a generic once your annual prescription Out-of-Pocket Maximum is reached.

If a brand drug is purchased when a generic is available (even if the prescription includes words such as “dispense as written” or “DAW”), the Plan will pay 80% of the cost of the generic. You pay 20% of the cost of the generic (which counts toward the annual prescription drug Out-of-Pocket Maximum) plus the difference between the cost of the brand and generic (which does not count toward the annual Out-of-Pocket Maximum for prescription drugs). The Plan will pay 100% the cost of a generic once your annual Out-of-Pocket Maximum for prescription drugs is reached. You will pay 100% of the difference between the cost of the brand and generic.

Formulary Drugs: The drug formulary is a list of preferred medications for the care of Plan Participants. The preferred medications are selected to provide the best therapeutic care to you at a low cost. Copies of the formulary are distributed to all participating Physicians and pharmacies by our pharmacy benefit manager.

The Plan pays 80% of the cost of drugs listed on the formulary. You pay 20%, which counts toward your annual prescription Out-of-Pocket Maximum.

Non-Formulary Drugs: A Non-Formulary Drug is any drug, brand name or generic, that is not on the current formulary drug list of our pharmacy benefit manager. The Plan pays 60% of the cost of a non-formulary drug. You pay 40%, which does not count toward your annual prescription Out-of-Pocket Maximum.

Filling Your Prescription

Retail Pharmacy: New prescriptions and non-maintenance drugs are limited to a 30-day supply. When you receive your prescription drug card, a list of participating pharmacies will be provided to you. These pharmacies have agreed to charge a discounted amount for prescriptions. By using a participating pharmacy, you will only pay the Co-Insurance amount at the time of purchase. If you use a non-participating pharmacy, you must pay the total non-discounted cost of the prescription, and then submit a claim for reimbursement to the Pharmacy Benefit Manager as shown on your ID card.

When you are prescribed a new maintenance drug, you are limited to a 30-day supply if the prescription is filled at a retail pharmacy. You may have your prescription for a maintenance drug filled at a retail pharmacy only three times, for a total of 90 days. After you have had your maintenance drug prescription for a 30-day supply filled three times, you must fill your maintenance drug prescription through the mail order pharmacy. See your member ID card for the mail order facility phone number.

Mail Order for Maintenance Drugs: A 90-day supply of a maintenance drug must be purchased by mail order after the third 30-day fill at a retail pharmacy. Submit the original prescription and complete the form supplied by the mail order facility for a 90-day supply. You may call the mail order facility to request authorization to pay your Co-Insurance by check or credit card.

Controlled Substance Dispensing: The mail order facility dispenses medications in accordance with federal pharmacy law and the laws of the state where it is located. Under federal pharmacy law, controlled substances level three, four, and five (*e.g.,* cough syrups with codeine, anti-anxiety drugs) are refillable for a maximum of five refills or six months. Level two controlled substances (*e.g.* narcotics) are not refillable. Level two controlled substances (*e.g.*, Ritalin) can only be distributed in a 30-day supply.

Specialty Pharmacy: Specialty pharmacy is available to members with specialized prescription drug needs for diseases such as: Hepatitis, Cancer, Infertility, Growth Deficiency, Rheumatoid Arthritis, Crohn's Disease, Multiple Sclerosis, RSV, Hemophilia, Organ Transplant, and HIV/AIDS. This program covers:

1. Free home delivery of up to a 30-day supply of your medication (Retail Co-Insurance applies);
2. Ready access to a staff of pharmacists, nurses, and care coordinators who are trained specialists on the medications provided and the conditions being treated;
3. Educational material, support or home instruction;
4. Ancillary supplies such as syringes and needles; and
5. A higher level of coordination of care with your Physician.

Drugs Limited or Requiring Prior Approval

When it is Medically Necessary for a patient to obtain the non-formulary brand over the formulary brand, or brand over generic, your Physician is required to request in writing a prior authorization from the Pharmacy Benefit Manager. The Physician must document the adverse reaction or ineffectiveness of the formulary or generic medication on the prior authorization request form. The outcome of the approval process is provided to the patient via telephone or mail.

Certain drugs require prior approval before prescriptions are filled and coverage is provided. Generally, these are drugs that are limited by the FDA in therapy, are very expensive, or may cause harm if not

used correctly. Contact the Pharmacy Benefit Manager if you have a question regarding the following drugs classes:

1. ADD/ ADHD medications;
2. Anticoagulants;
3. Anti-Rheumatics;
4. Cosmetic Agents (*e.g.* Accutane, Retin A);
5. Drugs to treat Crohn's Disease;
6. Fertility Drugs (note that these drugs are limited to a maximum Lifetime payment of $7,500 per participant);
7. Growth hormones;
8. Drugs to treat Impotence;
9. Drugs to treat Irritable Bowel Syndrome;
10. Drugs to treat Narcolepsy;
11. Drugs to treat Osteoarthritis;
12. Steroids; or
13. Drugs to treat Weight Loss.

It is important to note that every drug in the classes listed above may not require a prior authorization. In some cases only one or two medications within the drug class may require a prior authorization.

Other Covered Services

Ambulance Services

The Plan covers charges for:

1. Medically Necessary ambulance service.
2. Air ambulance service beginning and ending within the continental United States if your Doctor certifies that it is Medically Necessary.

Blood Products

The Plan covers charges for blood products not replaced and the costs of administering blood products.

Chiropractic Care

The Plan covers charges for chiropractic services limited to a maximum of $1,000 in a calendar year.

Contraceptive Management

The Plan covers charges for contraceptive devices that can only be obtained from a Physician. Examples include: IUD, diaphragm, or contraceptive implant. Birth control pills may be obtained through the prescription drug plan. The Plan does not cover devices that can be purchased over-the-counter or that do not require a Physician's prescription.

Cosmetic Surgery

The Plan covers surgical charges for reconstructive surgery following mastectomy (See ”What Is Covered”—“Mastectomy”) or Cosmetic Surgery to treat an accidental Injury or birth defect. Charges for Cosmetic Surgery are not otherwise covered.

Dental Treatment

The Plan covers charges for dental services in connection with treatment of an accidental Injury to sound natural teeth or jaw, as long as treatment begins within six months after the date of the accident. Injuries from chewing or biting are not considered accidental Injuries that qualify for payment.

Diagnostic X-rays and Laboratory Services

The Plan covers charges for ancillary services (e.g., diagnostic X-rays and laboratory services) including those performed when there are no symptoms but are due to a documented “family history” of disease, with “family” meaning parents, grandparents, and siblings.

Diagnostic Imaging Outpatient Services

The Plan covers diagnostic imagining services such a CT Scans, PET Scans, MRI, Nuclear Medicine procedures, and Ultrasound procedures received on an outpatient basis at a Hospital or alternate facility.

Durable Medical Equipment

The Plan covers the cost of durable medical equipment used for therapeutic purposes, such as wheelchairs, Hospital beds, and breathing equipment. It does not cover items of common use or convenience, such as air conditioners, saunas, or exercise equipment.

Durable medical equipment eligible for coverage is equipment that:

1. Can be used over and over;
2. Is usually and mainly used for a medical purpose;
3. Is not useful to you if you don’t have an Illness or Injury; and
4. Can be used at home.

The Plan pays rental charges up to a maximum of the purchase price of the equipment. The Plan may pay charges for buying durable medical equipment when it is less costly and more practical to buy than to rent. The decision whether to rent or buy this equipment is made by the Claim Administrator.

Repair or replacement of purchased durable medical equipment will be considered a covered expense when necessary due to normal use or growth of a child.

Foreign Travel

If you receive care or treatment or require medication while traveling out the United States, the Plan will pay for charges covered by the Plan. However, you should be prepared to pay cash or use a credit card for medical care if a Provider outside the United States will not file a claim for you.

If you elect to go out of the United States for medical care, you must contact the Claim Administrator at least four weeks before your travel date for pre-approval. Procedures that are considered Experimental in the United States and drugs that are not FDA approved in the United States will not be covered if received outside of the United States without prior approval of the Claim Administrator.

You may submit a claim to the Claim Administrator for medical care you have received outside the United States, but the claim must provide sufficient detail and it must be written in English. Charges for covered urgent and emergency medical care will be paid at 80% of the Usual and Customary charge in the United States. Elective medical care will be paid at the Out-of-Network level of Usual and Customary charge in the United States.

Genetic Testing shall only be covered under the following circumstances:

- **For prenatal testing only when** a) the pregnancy is categorized as high risk, including cases where the mother is 35 years of age or older, or b) the mother or father has a family history that establishes him/her as at risk for having a hereditary generic disorder. Procedures include amniocentesis or chorionic villius sampling (CVS).

- **For diagnostic testing** only where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder; or when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease.

- **For carrier testing or predictive testing.** Such procedures involve genetic testing of apparently healthy individuals who show no symptoms of any Illness, although it is possible such individuals may be carriers for a disease that may be passed on to their children, or that they may be at risk for developing a genetic disorder themselves at some point in the future. Such testing is not within the scope of diagnosing or treating an actual Illness and is only payable under the wellness care benefit subject to the maximum benefit amount payable under that benefit.

Hearing Aids

The Plan covers charges for hearing aids with a Maximum Benefit of $500 within a 3-year replacement cycle.

Home Health Care

If you are homebound and unable to obtain medical services on an outpatient basis, the Plan may pay for home health care services. Home health care is intended to shorten the length of your Hospital (or Intermediate Care Facility) stay, or to avoid an inpatient admission altogether, if you can be safely treated at home with professional help.

In order to be covered by the Plan, the home health care services must:

1. Be provided under a written treatment plan prepared by your Doctor and approved by the Claim Administrator;
2. Be provided by a licensed home health care agency; and
3. Meet the following requirements if provided following your discharge from a Hospital:

   a. The services must be provided by a home health care agency that has an agreement to accept referrals from the Hospital;
   b. The provision of home health care services must permit an earlier discharge from the Hospital than would otherwise be possible; and
   c. The services must be connected to the Illness or the Injury for which you were hospitalized.

Covered services are:

1. Skilled nursing care by a registered nurse, or by a licensed practical nurse working under the supervision of a registered nurse;
2. Occupational therapy;
3. Physical therapy;
4. Speech therapy; and
5. Services of a home health aide; if all of the following conditions are met
   a. You or a member of your family cannot perform these services;
   b. You are also receiving covered nursing and therapy services;
   c. The aide is an employee of the home health care agency or working under the agency's supervision;
   d. The aide is trained in the care of the sick; and
   e. The aide is working under the supervision of a home health care professional.

One home health care visit is considered to be: A visit by a member of the home health care team; or four hours of home health aide service.

Hospice Care

If you are terminally ill (that is, if you have a life expectancy of six months or less as certified by your Doctor), the Plan will pay charges for covered hospice services that are required because of the terminal condition.

Eligible hospice services are those that are:

1. Designed to provide relief from pain and other symptoms of a terminal Illness and to help patient and family cope with the Illness; and
2. Provided by a team of professional caregivers and volunteers.

Covered Hospice services are:

1. Skilled nursing services and services of home health aides and social workers;
2. Services of trained volunteers that are part of the hospice care program;
3. Inpatient or outpatient charges for a licensed hospice facility, which facility may be free-standing and independent or part of a Hospital;
4. Services of a Physician or Physician consultant;
5. Pastoral services and family counseling provided by a licensed or certified psychologist or counselor;
6. Drugs, supplies, lab charges, oxygen, physical, occupational, and respiratory therapy, and durable medical equipment;
7. Bereavement services within six months following a patient's death; and

8. Nutrition services, including nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

The Plan will pay 80% of the Usual and Customary charges for covered services. After you have reached your Out-of-Pocket Maximum, the Plan will pay 100% of Usual and Customary charges for the rest of the calendar year.

Infertility Treatment

The Plan will pay charges in connection with the diagnosis and treatment of infertility problems, up to a Lifetime maximum payment of $15,000 per Participant split equally between infertility drugs ($7,500) and medical services ($7,500). The Co-Insurance you make for treatment of infertility problems will not count toward your Out-of-Pocket Maximum and the Plan will not pay 100 percent even if your Out-of-Pocket Maximum has been reached. Covered charges include in-vitro fertilization, artificial insemination, GIFT or ZIFT, and prescription drugs related to treatment of infertility.

Intermediate Care Facility

The Plan will pay charges you incur in an Intermediate Care Facility to the same extent as it would have paid the same charges had the services been provided in a Hospital. However, the Plan will not pay charges for:

1. Custodial care;
2. Treatment of a mental deficiency or mental retardation; or
3. Treatment of Mental Illness unless you are transferred from a Hospital and there is a good chance of recovery.

Jaw Joint Treatment

The Plan will pay charges for treatment of jaw joint problems up to a maximum payment of $1,000 in a calendar year without pre-determination of medical necessity. The Co-Insurance for Jaw Joint Treatment will not accumulate toward your annual Out-of-Pocket Maximum and the Plan will not pay 100 percent even if your Out-of-Pocket Maximum has been reached. The $1,000 maximum payment and Co-Insurance limitations may be waived if your benefits are pre-determined by the Claim Administrator and the treatment of this condition is found to be Medically Necessary. The Plan will pay charges for one jaw joint appliance, but will not cover orthodontic-related expenses due to jaw joint problems even if Medically Necessary.

Mastectomy

The Plan, as required by the Women's Health and Cancer Rights Act of 1998, will pay charges for Medically Necessary mastectomy, and will also pay for the following related items:

1. Care and treatment for complications from a mastectomy, including lymphedemas;
2. Reconstructive breast surgery necessary because of a mastectomy;
3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast; and
4. An external breast prosthesis and the first permanent internal breast prosthesis necessary because of a mastectomy.

Please contact the Plan Administrator for more information about benefits related to mastectomy.

Maternity Services

The Plan pays covered charges in connection with pregnancy, complications of pregnancy, and miscarriages in the same manner it covers Illness or Injury. The Plan covers charges for prenatal, delivery, and postpartum services received in a Hospital, Physician's office, or Birthing Center.

The Plan covers services of a midwife, provided the midwife is a registered nurse, is formally trained and licensed in the practice of midwifery, and works under the supervision of a licensed Physician.

The Plan may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Illness, Alcoholism and Substance Abuse

Inpatient Treatment: The Plan will pay covered inpatient Hospital and medical charges (See "What is Covered"—"Doctor Services" and "Hospital Services") for treatment of Mental Illness, Alcoholism and Substance Abuse, to the same extent as it does for other Illnesses or Injuries.

Outpatient Treatment: The Plan will pay charges for outpatient treatment of Mental Illness, Alcoholism and Substance Abuse. Covered charges include those for:

1. Day treatment programs;
2. Doctors' fees;
3. Clinical psychologist (Ph.D.); provided that the Provider is licensed by the state in which he or she is practicing or, if licensure is not available in that state, is certified by an appropriate professional body as being qualified to practice as a clinical psychologist;
4. Clinical licensed social worker who is licensed by the state in which he or she is practicing;
5. Partial hospitalization;
6. Services provided by a clinical psychologist, licensed professional clinical counselor, clinical licensed alcoholism and substance abuse counselor or certified chemical dependency counselor (C.C.D.C), provided the above named practitioners are working under the direct supervision of an M.D., D.O. or Ph.D. in psychology;
7. Psychological testing;
8. Laboratory testing; and
9. X-rays.

Morbid Obesity Treatment

General Statement. Surgical treatment of Morbid Obesity, as defined by the National Institutes of Health (NIH), may be covered in the limited circumstances outlined below. Only the following bariatric surgery procedures are eligible for coverage:

1. Gastric bypass surgery (Roux-en-Y gastroenterostomy);

2. Adjustable gastric banding (Lap-Band Procedure);
3. Laparoscopic silicone gastric banding; and
4. Biliopancreatic bypass with duodenal switch.

Requirements for Coverage. Morbid Obesity will be covered only if ALL of the following requirements are met:

1. Acceptable documentation provided by a physician who does not perform bariatric surgery (such as the patient's internist, pediatrician, or family physician) demonstrates that the patient:
    a. Has a current diagnosis of Morbid Obesity.
    b. Has had a medical history of Morbid Obesity for at least the last five years.
    c. Has a medical history of participating, without success, in a conventional weight reduction program that:
        i. was supervised and monitored by a physician;
        ii. continued for at least 24 months, ending no more than one year before the proposed surgery; and
        iii. included, at a minimum:
            1. conservative medical treatment;
            2. an exercise program; and
            3. dietary treatment with dietician visits.
2. Acceptable documentation demonstrates that the patient:
    a. Is eighteen years of age or older.
    b. Is an acceptable operative risk.
    c. Has been evaluated and cleared for the proposed surgery by a licensed mental health provider who confirms the patient's willingness to comply with treatment plans.
    d. Has been provided, and has agreed to, a strategy regarding follow-up medical care for at least two years.

Orthopedic Equipment and Appliances

The Plan covers items such as braces and crutches, but does not cover charges for corrective shoes.

Prosthetic Appliances

Covered items include:

1. Artificial limbs and eyes;
2. Wigs to replace natural hair lost due to chemotherapy or radiation therapy, up to a maximum payment of $200 in a calendar year;
3. Two prosthetic bras in a calendar year to help restore natural appearance following mastectomy;
4. Eye examination and the first set of lenses and frames following cataract surgery;

A replacement appliance is covered only when replacement has been approved by the Claim Administrator as being necessary because of physiological changes or because the existing appliance has become non-functional through continued use.

Second Surgical Opinion

If your Doctor suggests that you need to have surgery, it is always a good idea to get a second surgical opinion so you can be sure surgery is the best way to treat your condition. The Plan covers the cost of a

second surgical opinion, but there is no penalty if you do not obtain one. Covered charges include the Doctor's charges for an examination and written report, and any laboratory tests or X-rays that are needed to help the Doctor make his recommendation. If you need assistance in determining the kind of specialist needed to offer a second opinion, or you have any other questions, you may contact the Claim Administrator.

Smoking/Tobacco Cessation

Covered treatment is limited to hypnosis and smoking/tobacco cessation sessions conducted by the American Lung Association, American Heart Association, American Cancer Society, or a Hospital, Physician, or certified group leader. Nicotine patch costs will be covered for a maximum of six weeks per plan year per Participant. Prescription smoking/tobacco cessation drugs are covered to the limits of the benefit. Treatment not covered includes smoking/tobacco cessation gum, books, tapes, videos and mail order programs.

Benefits will be paid at 50%, with Deductible waived, of the Usual and Customary costs, up to a lifetime maximum payment of $300 for each Participant. Receipts for smoking /tobacco cessation treatments and prescription drugs must be sent to the claim administrator to receive reimbursement. This benefit does not apply toward the Out-of -Pocket Maximum.

Sterilization

The Plan covers charges in connection with voluntary sterilization (vasectomy or tubal ligation). The Plan does not cover charges for reversal of sterilization procedures.

Therapy Services

The Plan covers:

1. Biofeedback therapy if related to covered physical therapy or chiropractic care, or to the covered treatment of Mental Illness, Alcoholism, or Substance Abuse. After 26 visits, continued benefits will be paid only if a review by the attending Physician confirms that continued improvement in patient condition can be achieved with additional treatments.
2. Dialysis therapy or treatment.
3. Inversion therapy if related to covered physical therapy or chiropractic care. After 26 visits, continued benefits will be paid only if a review by the attending Physician confirms that continued improvement in patient condition can be achieved with additional treatments.
4. Physical and occupational therapy for Medically Necessary conditions but only with a Physician's prescription and only if services can be expected to result in significant improvement in your condition within a reasonably and generally predictable period of time. After 26 visits per therapy, continued benefits will be paid only if a review by the attending Physician confirms that continued improvement in patient condition can be achieved with additional treatment.
5. Radiation therapy and chemotherapy.
6. Respiratory therapy.
7. Speech therapy administered by a qualified therapist in connection with treatment of an Illness or accidental Injury or in connection with a surgical procedure, but only if the services can be expected to result in significant improvement in your condition within a reasonably and generally predictable period of time. After 26 visits, continued benefits will be paid only if a review by the attending Physician confirms that continued improvement in patient condition can be achieved with additional treatment.

Transplant Services

The Plan will pay charges in connection with a human-to-human organ, tissue or bone marrow transplant, other than an Experimental or Investigational Procedure or one performed under a study, grant, or research program:

1. When you are the transplant recipient, whether or not your donor is also covered by the Plan.
2. When you require grafting of an organ or tissue from one part of your body to another (such as a skin or bone graft). In this case, the Plan covers charges for the transplant procedure itself, complications that may develop, and related medical care costs.
3. When you are a transplant recipient, the Plan will cover acquisition costs to the extent they would have been allowed by Medicare. Donor costs will be paid by the Plan, up to a maximum of $5,000, when they are not covered by the donor's own health plan. If the donor's plan will cover these costs, the Plan will coordinate its benefits as secondary payor up to a maximum of $5,000. The donor cost limitation of $5,000 may be waived if the Plan Administrator participates in pre-transplant contract negotiation with the Provider.
4. The following human-to-human organ or bone marrow transplant procedures will be considered covered charges, subject to all limitations and Maximum Benefits:
    a. Heart
    b. Heart/Lung (simultaneous)
    c. Lung
    d. Liver
    e. Kidney
    f. Pancreas
    g. Small bowel
    h. Bone Marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Coverage is for one transplant or infusion only within a 12-month period, unless a tandem transplant or infusion meets the Plans' definition of Medically Necessary Care and is not for an Experimental or Investigational measure.
5. Cornea and skin transplants are not covered as Transplant Services. Instead, cornea and skin transplants are covered under the normal provisions of the Plan and are not subject to any special provisions set forth in this Transplant Services section.

Benefits paid for Transplant Services will be applied to your Medical Lifetime Maximum Limit.

Wellness Services

The Plan pays for certain types of routine preventive health care. Covered services are:

1. Routine tests and examinations given to children up to age two (i.e., well-baby care), including the first inpatient pediatric exam following your baby's birth if the exam is performed by a Doctor other than the one who delivered your baby or administered anesthesia. However the Plan will not pay these charges for an examination of your Dependent Child's new baby unless the baby otherwise qualifies as your Dependent.
2. Routine tests and examinations for Participants over age two, up to a maximum of $150 per Participant in a calendar year.
3. The following routine services, provided in keeping with current medical recommendations or the standards of the American Cancer Society, are paid in addition to the $150 maximum for an annual physical exam:
    a. Immunization for infants and children.

b. Immunizations for adults, including flu shots. Hepatitis B immunizations (3 shots) will be paid after the final shot of the series is administered.
c. Mammograms and associated exam (one baseline mammogram from age 35-39; one per Calendar Year thereafter)
d. Pap smears. and associated exam (one per Calendar Year for females age 18 and over)
e. PSA Tests (one per Calendar Year for males age 50 and over)
f. Colorectal screenings (including annual digital rectal exam and occult blood test for Participants over age 30; additional sigmoidoscopy once every five years **or** routine colonoscopy once every ten years for Participants over age 50).
g. Health screenings and flu shots provided at school site wellness events for covered employees and spouses will be paid at 100% in addition to the $150 maximum for routine tests and examinations.

IV. What Is Not Covered

Although the Plan covers charges for most Illnesses and Injuries, it does not cover charges for or in connection with:

Cosmetic Surgery

The Plan does not pay for Cosmetic Surgery unless provided:

1. For reconstructive purposes following mastectomy,
2. In connection with an accidental Injury, or
3. To treat a birth defect.

Dental Services

The Plan does not pay for dental treatment unless provided in connection with accidental Injuries to sound natural teeth and begun within six months after the accident.

Eye Care

The Plan does not pay for eye examinations, visual training, surgical treatment of visual refractive problems (such as radial keratotomy), or prescription or fitting of eyeglasses or contact lenses (except for eye examination and the first set of lenses and frames following cataract surgery).

Foot Care

The Plan does not pay for routine foot care such as:

1. Treatment of corns, fallen arches, flat feet, chronic foot strain or other symptomatic complaints of the feet, or purchase of related items such as corrective shoes, wedges, splints or pads.
2. Treatment of calluses or cutting of toenails. However, treatment will be covered for ingrown toenails, and where Medically Necessary because of diabetes or other medical conditions.
3. Treatment of bunions, except by capsular or bone surgery.

Government Service and Illegal Acts

The Plan does not pay for treatment of a condition or Injury resulting from or caused or prolonged by:

1. Involvement in an illegal occupation.
2. War (whether declared or undeclared), civil war, invasion, hostilities, riot, or resistance to armed aggression.
3. Duty as a member of the armed forces of any country or state.
4. Public service, where the U.S. Government or any state or local government provides the treatment.
5. Services or supplies that are in violation of any law.
6. Performance or attempted performance of an assault or felony.
7. An altercation in which you were the aggressor.

Hearing Exams

The plan does not pay for hearing examinations or examinations for prescribing and fitting hearing aids except as stated (See "What Is Covered" —"Hearing Aids")

Incidental and Personal Convenience Items

The Plan does not pay for incidental and personal convenience items such as:

1. Telephone, television, haircuts, and newspapers while you are a Hospital inpatient.
2. Completion of claim forms.
3. Missed appointments.
4. Travel mileage or lodging.

Non-Medical and Experimental Procedures

The Plan does not pay for:

1. Physical examinations, tests and reports performed for non-medical reasons, such as those for insurance, school, camp, employment, sports, governmental or legal reasons, or travel.
2. Experimental or investigational drugs or procedures, or care, service or treatment provided under a study, grant or research program, or for research purposes.

Pre-Existing Conditions

If you have a Pre-Existing Condition when you enroll in the Plan, Plan payment of charges for treatment of that condition will be limited to 50% of In-Network charges, up to a maximum payment of $5,000 during your first 12 consecutive months of Plan coverage. You will be responsible for paying the other 50% of these charges, as well as all charges over the Plan's $5,000 payment. Amounts you pay for treatment of a Pre-Existing Condition will not count toward your Out-of-Pocket Maximum.

A Pre-Existing Condition is any Illness, Injury or related condition for which you received treatment during the three months immediately before you became covered by the Plan. For the purposes of this section, treatment includes advice, a physical examination, diagnosis, prescription for medication, or administration of medication.

Covered charges for an Illness or Injury you develop after your effective date of coverage will be paid as described in this Plan Document beginning on your effective date of coverage. After 12 consecutive months of Plan coverage, your Pre-Existing Condition will be covered just like any other Illness or Injury covered by the Plan.

Some or all of the Pre-Existing Condition waiting period may be waived:

1. If you provide satisfactory proof of acceptable Creditable Coverage (See Definitions—"Creditable Coverage.") that you had prior to your coverage under this Plan, and you have not experienced a break in coverage greater than 63 days.
2. If you were previously enrolled in your Spouse's health plan and you enrolled in this Plan within 31 days after your Spouse's coverage ended.

3. If you have been a regular Employee of a Participating Employer for a period of at least 12 consecutive months and then choose to enroll in this Plan during an Open Enrollment.
4. In the case of a newborn Dependent Child who began coverage at birth or was covered under Creditable Coverage within 60 days of birth.
5. In the case of a Dependent Child adopted or placed for adoption prior to attaining 18 years of age who began coverage or was covered under Creditable Coverage within 60 days of the adoption or placement.
6. In the case of maternity claims.

Services or Supplies

The Plan does not pay for services and supplies:

1. That are self-administered;
2. That are provided by a member of your immediate family or by a person who normally lives with you;
3. That are provided in a medical department or clinic maintained by your Employer; or
4. For which you would not be required to pay if you didn't have Plan coverage.

Work-Related Injury/Illness

The Plan does not cover treatment of any Illness or Injury received or developed in the course of any work for wage or profit:

1. Unless and until the claim has been submitted to, and a final decision made by, the State Bureau of Workers' Compensation, and thereafter the Plan will cover such charges only to the extent they are not allowed by Workers' Compensation, and subject to all other Plan limitations and requirements.
2. If the Bureau of Workers' Compensation denies the claim because it was not submitted to the Bureau within applicable time limits.
3. By a self-employed Plan Participant who did not obtain Workers' Compensation coverage.

Other Exclusions

The Plan does not pay for the following, even if recommended or prescribed by a Doctor:

1. Acupuncture.
2. Aromatherapy.
3. Biofeedback except as specified. (See "What is Covered"—"Smoking/ Tobacco Cessation")
4. Care, service, treatment, or items that:
    a. Were provided before your effective date of Plan coverage or after your coverage ended;
    b. Are not Medically Necessary as initially determined by the Claim Administrator and as may be confirmed through the appeals process;
    c. Are routine services except as specified. (See— "What is Covered");
    d. Are provided by any Out-of Network Provider, to the extent the charges are more than the Usual and Customary charges as determined by the Claim Administrator; or
5. Custodial care, maintenance therapy or supportive care, including services provided primarily for pain relief.
6. Developmental speech therapy.
7. Donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.

8. Educational services or classes.
9. Elective abortion, except for care in connection with a spontaneous abortion or complications resulting from an abortion.
10. Enrollment in a health, athletic, or similar club.
11. Homeopathic Treatment.
12. Hospitalization for change of environment.
13. Hypnotism (See "What Is Covered"—"Smoking/Tobacco Cessation.")
14. Maintenance contracts for purchased durable medical equipment.
15. Marital counseling.
16. Massages or other personal services.
17. Medical evacuation to return home when traveling outside of the continental United States.
18. Nutritional supplements.
19. Organ donation. The Plan does not pay for donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.
20. Postmortem expenses.
21. Private duty professional services while confined as an inpatient.
22. Purchase or rental of:
    a. Items of common or personal use such as thermometers, bandages, first aid ointments and supplies, non-allergy pillows and mattresses, air purifiers, air conditioners, water purifiers, exercise equipment, saunas, steam baths, swimming pools, and waterbeds.
    b. Motorized transportation equipment, chair lifts, escalators, or elevators, except for Medically Necessary equipment such as wheelchairs.
    c. Spare or duplicate prosthetics, orthotics, appliances, or supplies.
23. Recreational, educational, self-help, or self-care training, except for Medically Necessary, Hospital-based, nutritional counseling related to the treatment of newly-diagnosed diabetes.
24. Rest cures.
25. Reversal of sterilization procedures.
26. Seeing-eye dogs or other domestic animals providing therapy or assistance with daily living.
27. Sex change procedures.
28. Testing, treatment, or training related to learning disabilities.
29. Treatment of non-morbid obesity or enrollment in a weight loss or similar program.
30. Vitamins or minerals, unless administered by a Physician in an injectable form.

V. Who Can Be Covered

Coverage for an Employee

You, as an Employee of a Participating Employer, and your Dependents are eligible for coverage under the Butler Health Plan (the Plan) if you meet applicable requirements. In this section, "you" and "your" refer to the covered Employee only. (See Definitions—"You.") In order to obtain coverage for yourself or any Dependent, you must take certain steps such as completing enrollment forms. You are eligible to enroll in the Plan if you work for a Participating Employer and you are a member of a group of Employees designated by your Participating Employer as eligible to participate, or if you are a full-time Employee of the Butler Health Plan. Consult with your Participating Employer to find out how to obtain coverage or if you have any questions about whether you or your Dependents are eligible for Plan coverage.

Non-Discrimination

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

Coverage for Dependents

Your Dependents are also eligible to enroll in this Plan for as long as you remain covered. Individuals who are otherwise eligible for coverage under the Plan are not disqualified by virtue of being eligible for, or covered under, the federal Medicare program. The following may qualify as your Dependents:

Spouse

Your Spouse may qualify as your Dependent, provided he/she has complied with the Plan's requirements related to enrolling in an available medical plan through his/her employer.

In order to be eligible for coverage under the Plan, any Spouse of an eligible Employee who has coverage available through an employer sponsored group health plan **must join** that plan on at least a single enrollment basis. A Spouse is considered to have coverage available if:

1. The Spouse has access to continuous (non-seasonal) group coverage through employment (other than employment with a BHP Participating Employer), or would have such access but for a provision of the Spouse's employer's plan which determines eligibility with reference to the Spouse's eligibility to participate in this Plan; and
2. The Spouse works more than 20 hours in an average work week, and
3. The Spouse is not required to pay more than 50% of the premium for coverage.

When the Spouse has enrolled in a plan maintained by his/her Employer, coverage for the Spouse under this Plan will then be secondary to the coverage provided by the Spouse's Employer's plan. (See "Other Important Points"— "Coordination of Benefits"). The Employee will provide all information required to administer this provision through the initial enrollment form or through the COB Questionnaire form. Until the Claim Administrator has received all required documentation, any claims for the Spouse will be denied or returned to the sender. If a Spouse has coverage available through his/her employment but fails to enroll for such coverage, Spouse benefits paid by the Plan retroactive to the date on which the Spouse became eligible for coverage through his/her employment will be recovered up to a maximum of $5,000 per calendar year. Upon administrative notice of non-compliance, the Spouse is no longer eligible for primary coverage under this Plan and must be enrolled and covered under his/her Employer's plan.

When Both Spouses Are Eligible
If you and your Spouse are both eligible Employees working for the same or different BHP Participating Employers, the two of you may select, as appropriate: Two single plans, one family plan (or Employee + 1 plan) covering all family members, or one single plan and one family plan.

Certain limitations apply:

1. Your eligible Children can be enrolled as Dependents of either you or your Spouse, but not both.
2. No one may be enrolled in the Plan as both an Employee and a Dependent.

Child

Your Children may qualify as Dependents under the plan. In order for a Child (See Definitions—Child) to be eligible for Dependent coverage, the following requirements apply:

1. The Child must have the same principal place of residence as you for at least half of the year.
2. The Child must be unmarried.
3. The Child must rely on you for at least one half of the Child's support.
4. The Child must be under 19 years of age, or if the Child is a Full-Time Student (See Definitions—Full-Time Student), 25 years of age. As required under tax law, if the Child is over the age of 18, or 23 if a Full-Time Student, then the Child must have the same principal place of residence as you and be a member of your household. A Full-Time student who is away at school is considered to reside with you as a member of your household.
5. An exception to the age requirement applies if your Child became disabled at any time before the Child turned 19 years of age or while the Child was enrolled as a Participant, including under COBRA Continuation Coverage (See Index—Continuation of Coverage (COBRA)). If your Child is disabled, your Child will be eligible for coverage if the following requirements are met:
    a. You enroll him/her and give the Claim Administrator satisfactory written medical certification of his/her handicap (at your expense) within 31 days after the later of either (1) his/her 19th birthday or (2) the date on which he/she would otherwise cease to be enrolled as a Participant or to be covered under COBRA continuation coverage; and
    b. Thereafter, you give the Claim Administrator satisfactory written medical certification of his/her handicap (at your expense) from time to time upon request.

Child for Whom There Is a Qualified Medical Child Support Order

Any Child for whose health care you or your Spouse is responsible according to the terms of a Qualified Medical Child Support Order is also an eligible Child.

Upon receipt of a medical child support order, the Plan Administrator will promptly notify the Employee and each child who is the subject of such an order of its receipt and of the Plan's procedures for determining whether it is a Qualified Medical Child Support Order (See Definitions —QMSCO), and will notify the Employee and child affected by such an order of its determination. Copies of this notice will be sent to any person designated by such notices. In the case of a National Medical Support Notice, all communications by the Plan Administrator must also be sent to the issuing agency.

Upon determination that an order is a QMCSO, a Child who is the subject of such an order will be treated as a Participant under this Plan, without regard to any provisions in this Plan limiting eligibility for coverage on the basis of financial support, residency, or enrollment date. If any additional contribution from an Employee is required to provide coverage for such Child, the Employer will automatically withhold such additional contribution from the Employee's compensation.

Any benefits paid under this Plan pursuant to a QMCSO in reimbursement for covered expenses paid by a Child who is the subject of such an order or by such Child's custodial parent or legal guardian shall be paid to such Child or his custodial parent or legal guardian.

Be sure to let your Employer know when there is a change in any of your personal information, such as your marital status, the number of your Dependents, their names and birth dates, etc. This is your responsibility. We cannot know who your Dependents are unless you tell us.

Source of Injury Restrictions

Note that the Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

Wellness Vs. Risk Factors

Note also that the Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

VI. When Coverage Starts

Initial Enrollment

Once you have been hired as an eligible Employee of a Participating Employer, you qualify for enrollment in the Plan. In order to enroll, you will have to fill out an enrollment form and elect the type of coverage you wish to carry within 31 calendar days after your date of hire. If you do not enroll yourself or any of your Dependents in the Plan when first eligible to do so, but you decide to do so at a later time, you will have to wait until the next Open Enrollment unless there is a qualifying event. Also, once you have elected a Plan Option, you will have to wait until the next Open Enrollment to switch to a different one.

Coverage for the Employee begins on the Employee's starting date or on another beginning date, as determined by the Participating Employer. You will have to fill out an enrollment form within 31 calendar days after your date of hire naming each eligible Dependent for whom you want to obtain coverage. If you enroll one or more of your eligible Dependents in the Plan when you are hired, their coverage will begin on the same date as yours. For example, your Spouse and the Children you now have will be covered by the Plan at the same time as you if you enroll them as your Dependents when you are hired.

If you wish to enroll your Spouse and your Spouse is employed (other than by a BHP Participating Employer), then your Spouse's Employer will be required to complete a COB Questionnaire form providing information on available medical coverage. Claims for a Spouse will not be processed until this form has been completed and returned to the Claim Administrator. If medical coverage is available to your Spouse through his/her employment, BHP will only pay your Spouse's claims as secondary coverage. (See "Who Can Be Covered"—"Spouse.")

Under some circumstances, medical conditions existing when you enroll may be subject to payment limitations. If you have a Certificate of Creditable Coverage, you may be able to obtain a waiver of pre-existing condition limitations. (See "What Is Not Covered"—"Pre-Existing Conditions.")

Open Enrollment

The Open Enrollment is 30 days in the fall of each year. Please check with your Employer to find out for when the Open Enrollment is scheduled. Elections made during the Open Enrollment become effective on January 1 of the following year. Once you have elected a Plan Option, you will have to wait until the next Open Enrollment to switch to a different one. Also, if you do not enroll yourself or any of your Dependents in the Plan when eligible to do so during the Open Enrollment, you will have to wait until the next Open Enrollment unless there is a qualifying event.

Under some circumstances, medical conditions existing when you enroll may be subject to payment limitations. If you have a Certificate of Creditable Coverage, you may be able to obtain a waiver of pre-existing condition limitations. (See "What Is Not Covered"—"Pre-Existing Condition.")

If you wish to enroll your Spouse and he/she is employed (other than by another BHP Participating Employer), his/her Employer will be required to complete a COB Questionnaire form providing information on available medical coverage. Claims for the Spouse will not be processed until this form has been completed and returned. If medical coverage is available to your Spouse through his/her

employment, the Plan will only pay his/her claims as secondary coverage. (See "Who Can Be Covered"—" Spouse.")

Special Enrollment

There are certain qualifying events that permit an employee to enroll in the Plan outside of the Open Enrollment. If you do not enroll yourself or any of your Dependents in the Plan when eligible to do so after a qualifying event, but you decide to do so at a later time, you will have to wait until the next Open Enrollment unless there is another qualifying event. Also, once you have elected a Plan Option, you will have to wait until the next Open Enrollment to switch to a different one.

The following are qualifying events:

Acquiring a New Dependent

An Employee who is not covered by the Plan may elect to become covered when the Employee acquires a new Dependent. This includes marriage, birth, and adoption. Individuals who first become eligible for coverage as your Dependents while you are enrolled in the Plan may generally be enrolled for coverage as soon as they qualify. The following guidelines apply:

1. Employee or Employee+1 Coverage: If you enroll a Dependent within 31 days after he or she first becomes eligible, and you also make any necessary changes in your coverage election, Plan coverage will be effective as of the date on which the individual qualified as your Dependent. Please note that enrolling a new Dependent will also require a change in your coverage election if you currently have Employee or Employee+1 coverage.
2. Newborn Provision for Employee or Employee+1 Plans: Newborns are covered from the moment of birth as long as they are properly enrolled in the Plan within 60 days after birth; however, no claims will be paid for a newborn until the newborn is enrolled in the Plan. Please note that enrolling a newborn will also require a change in your coverage election if you currently have Employee or Employee+1 coverage. You have 60 days after the birth of your child in which to enroll your child and change your coverage election. If enrollment, including any necessary coverage election, is not completed within this 60-day period, you will not be able to enroll your Dependent in the Plan until the next Open Enrollment.
3. Family Coverage: If you have family coverage, your new Dependents are covered from the moment they qualify. Newborns are covered from the moment of birth; however, please remember to enroll your Newborn or other new Dependent in the Plan within 60 days immediately following the birth or other qualifying event. No claims will be paid for a Newborn or other new Dependent, even if you have family coverage, until the Dependent is enrolled in the Plan.

In addition, a child for whom a Qualified Medical Child Support Order has been issued is eligible to enroll as a Dependent if you apply for enrollment within 31 days after the Order is issued.

Loss of Medical Coverage Under Another Health Care Plan

You may qualify for Special Enrollment if you lose Medical coverage because of any of the following events:

- your divorce;
- your legal separation;

- your Spouse's death;
- your spouse's termination of employment, or reduction in hours of employment;
- your relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- your reaching the Lifetime limit for all benefits under other coverage (the Special Enrollment period in this instance would be 31 days after the earliest date that a claim is denied due to reaching the lifetime limit).
- your plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals.

If you chose not to enroll in the Plan because you were covered by your Spouse's health care plan and if, for one of the reasons above, your Spouse's coverage ends or your coverage ends under your Spouse's plan, you can enroll yourself and your Dependents in this Plan within the 31-day period immediately after your Spouse's coverage has terminated. You may also qualify for special enrollment if you previously qualified for COBRA Continuation of Coverage under another plan, but COBRA coverage has been exhausted under that plan. If eligible for any of the above reasons, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

Note that Special Enrollment may also be available, under certain circumstances, to Employees who decline coverage without having coverage under another plan. For this provision to apply, the Employee must subsequently enroll in other coverage, lose that coverage, and in the interim have had an opportunity for Open Enrollment or Special Enrollment under this Plan, but again chose not to enroll. If eligible for this reason, enrollment in the Plan will also be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

If you do not enroll within the 31 days immediately after coverage ends under your Spouse's plan, you will have to wait until the next Open Enrollment to enroll. It is your responsibility to notify your Employer of termination of coverage under your Spouse's plan within 31 days of termination.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

VII. When Coverage Ends

Coverage ends for any Employee at midnight on the last day of the calendar month in which the Employee ceases to qualify for coverage under the Plan. Coverage ends for a Dependent at midnight on the day in which the Dependent ceases to qualify for coverage under the Plan.

Participant

A Participant ceases to qualify for coverage under the Plan upon the occurrence of any of the following events:

1. The Participant is no longer eligible to participate in the Plan. (See — "Who Can Be Covered")
2. The Employee fails to make a required contribution.
3. The Plan is terminated.
4. The Participant enters the U.S. Armed Forces on active duty, subject to the continuation and reinstatement provisions of the Uniformed Services Employment and Reemployment Act of 1994, as amended.
5. In the case of a Dependent:
    a. The Employee ceases to qualify for coverage; or
    b. The Employee elects to discontinue coverage for the Participant.

Dependent

A Dependent ceases to qualify for coverage under the Plan upon the occurrence of any of the following events:

1. Marriage of the Dependent.
2. The Dependent's 19th Birthday, unless the Dependent is a Full-Time Student or is an eligible disabled person.
3. The Dependent, over age 19, ceases to be a Full-Time Student, unless the Plan receives satisfactory evidence that the Dependent will continue his/her studies as a Full-Time Student within one semester of the Dependent's graduation.
4. The Dependent's 25th Birthday, unless the Dependent is an eligible disabled person.

Extension in the Case of Disability

If you are totally disabled at the time coverage ends and you are not covered by another plan, the Plan will continue to pay covered charges, but only those that are related to your disabling condition, until the later of:

1. The date on which your disability ends;
2. The expiration of 12 months from the date your coverage would otherwise have ended; or
3. The date as of which you become covered by another group health care plan which will cover charges for your disabling condition.

You will be considered to be totally disabled if:

1. You are not engaging in any work for wage or profit (including self-employment); and
2. You are under the regular care of a Doctor for the disabling condition; and

3. You meet whichever of the following tests is applicable:

    a. In the case of an Employee, you are unable, because of an Illness or Injury, to perform any of the duties associated with any job for which you are qualified by education, training, and experience; or
    b. In the case of a Dependent, you are unable, because of an Illness or Injury, to do the kinds of things a person of the same age and sex does.

Death of an Employee—Family Security Benefits

If you die while you are an active regular Employee of a Participating Employer, coverage for your covered Dependents can continue if they sign up for COBRA benefits. (See "When Coverage Ends"—"COBRA-Continuation of Coverage "). Your Dependents will not have to pay the monthly cost of their coverage for the first 12 months of the COBRA continuation period. After 12 months, your Dependents can be covered for an additional 24 months, but they will have to pay the full monthly cost of their coverage. Coverage for your Dependents during this time will be governed by the COBRA provisions.

Leaves of Absence, Reductions in Force, and Layoffs

If you are not working because of a lay-off, reduction in force, or approved leave of absence, your coverage *may* be continued depending on your Employer's rules. Check with your Employer's office to find out what happens to your health care coverage in these circumstances.

Reinstatement of Coverage

If your coverage has ended because you did not make a required monthly contribution within 31 calendar days of its due date, you may be able to have your coverage reinstated if you fill out an enrollment form for yourself and each Dependent you want to be covered. Your coverage will be subject to approval by your Employer and, if approved, your coverage will be effective according to your Employer's internal policies applicable to such situations.

Also, note that in addition to previously covered Dependent children continuing uninterrupted coverage by attaining Full-Time Student status, a dependent child over the standard limiting age but under the Full-Time Student limiting age may be immediately added to the Plan as an eligible Dependent if the child meets all other eligibility criteria and is a Full-Time Student at the time of initial eligibility. A dependent child who was formerly an eligible Dependent as a Full-Time Student, but who then became ineligible due to dropping of Full-Time Student status will be immediately reinstated as an eligible Dependent upon reinstatement of Full-Time Student status, providing he/she is under the limiting age for Full-Time Students and meets all other eligibility requirements. See also definition of "Full-Time Student."

Family and Medical Leave Act

An Employee who qualifies for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under the Plan for up to 12 weeks during any 12 month period. The following summary is informational only, and your entitlement to continuation coverage will be determined in accordance with the requirements of the FMLA.

I

Contributions

During this leave, the Employer will continue to pay the same portion of premium as if the Employee were active. The Employee will be responsible to continue payment for eligible Dependents' coverage and any remaining Employee contributions. If the covered Employee fails to make the required contribution during a FMLA leave within 30 days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the Employee returns to active work as if coverage had not terminated, provided the Employee makes any necessary contributions and enrolls for coverage within 31 days of his/her return to active work.

Repayment Requirement

The Employer may require Employees who fail to return from a leave under FMLA to repay any contributions paid by the Employer on the Employee's behalf during an unpaid leave. This repayment will be required only if the Employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or to events beyond the Employee's control.

Military Leaves

If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if you are absent for 30 days or less, your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

COBRA—Continuation of Coverage

The Plan includes a continuation of the health coverage option, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. The following summary is informational only, and your entitlement to continuation coverage will be determined in accordance with the requirements of COBRA.

Eligibility

A Participant may choose to continue coverage at his/her own expense upon the occurrence of any of the following events that would otherwise cause the Participant to lose coverage:

1. Death of the covered Employee.
2. Termination of the covered Employee's employment (other than termination for gross misconduct) or reduction of the covered Employee’s employment.
3. Divorce or legal separation of the covered Employee from the employee’s spouse.
4. A Dependent Child ceasing to meet the eligibility requirements of the Plan. (See “Who Can Be Covered”—“Eligible Child.”)
5. The last day of leave under the Family and Medical Leave Act of 1993.
6. The call-up of an Employee reservist to active duty.

A Spouse or Dependent Child newly acquired during continuation coverage is eligible to be enrolled as a Dependent. The normal enrollment requirements of the Plan apply to enrollees during continuation coverage. A Dependent acquired and enrolled after the original qualifying event, other than a Child born to or placed for adoption with the covered Employee, is not eligible for separate continuation coverage if a subsequent event results in the Dependent’s loss of coverage.

Notification Requirements

When eligibility for continuation of coverage results from a Spouse being divorced or legally separated from a covered Employee, or from a Child's loss of Dependent status, the Employee or Dependent must notify the Employer of that event within 60 days of the event. Failure to provide such notice to the Employer will result in a forfeiture of the right to continuation of coverage.

If any of the events listed above occurs, you will get a notice from the Claim Administrator which will give you information about continuation of coverage. Each person who was covered under the Plan prior to the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. The coverage will be the same as the health coverage for all active Employees covered by the Plan. You will have to decide before the end of 60 days from the date of the notice from the Claim Administrator whether or not you want to elect continuation of coverage. This 60-day period begins on the later of the following:

1. The date coverage under the Plan would otherwise end, or
2. The date the person receives the notice from the Employer of his or her rights to continuation of coverage.

Cost of Continuation Coverage

Your monthly cost will be an amount up to 102% of the monthly cost to provide coverage for active Employees and their families. Within 45 days after the date you notify the Employer that you have chosen to continue coverage, you must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continuation of coverage begins through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day of each month. If full payment is not received within 30 days of any due date, coverage will be canceled retroactively to the due date.

When continuation of coverage is elected and the contributions are paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Subsequent Qualifying Events

Once you are covered under continuation of coverage, it is possible for a second qualifying event to occur, including:

1. Death of an Employee
2. Divorce or legal separation from an Employee
3. A Child's loss of Dependent status

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a Child born to or placed for adoption with a covered Employee during a period of continuation coverage is eligible to continue coverage again as a result of a subsequent qualifying event. Any other Dependent acquired during continuation of coverage is not eligible to continue coverage as a result of a subsequent qualifying event.

End of Continuation Coverage

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen months from the date continuation of coverage began because of a reduction of hours or termination of employment of the Employee.
2. Thirty-six months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or a Child's loss of Dependent status.
3. The end of the period for which contributions are paid if the Participant fails to make a payment on the date specified by the Employer.
4. The date coverage under the Plan ends and the Employer offers no other group health benefit plan.
5. The date the Participant first becomes entitled to Medicare after the qualifying event.
6. The date the Participant first becomes covered under any other group health plan after the qualifying event, with the exception of the pre-existing provision below.

Disabilities Occurring During Continuation Coverage

If you are disabled at the time you qualify for continuation coverage, or at any time within the first 60 calendar days after you become eligible for continuation coverage because you quit working for a Participating Employer or because you are no longer a regular Employee, the Plan coverage may be continued for up to 29 months or, in some cases, 36 months. In order to qualify for an extended period of continuation coverage:

1. Your disability must be determined under Title 2 (Old Age, Survivors and Disability Insurance) or Title 16 (Supplemental Security Income) of the Social Security Act, and
2. You must give your Employer written notice of your disability determination under the Social Security Act during the first 18 months of your continuation coverage and within 60 days after you receive notification of your disability determination from Social Security. If Social Security

should determine that you are no longer disabled, you must give your Employer notice within 30 days after you receive notice of the determination.

If you meet the above conditions, Plan coverage will be continued from the date you quit working or your classification is changed until the first of the month more than 30 days after you receive a final determination from Social Security that you are no longer disabled. If another qualifying event should occur following your termination or change of classification (for example, a divorce), the maximum period for continuation coverage may be extended to 36 months. If Plan coverage is continued because of disability for longer than 18 months, you may have to pay an extra amount (up to 150% of the monthly cost of coverage) for each month of coverage after the 18th month.

Plan Coverage Can End Earlier.

It will stop immediately for any of the following reasons:

1. The Plan is terminated in its entirety.
2. You do not make a payment you are supposed to.
3. You become covered under any other group health plan without restriction for the care of any Pre-Existing Condition you may have. If you become enrolled in another group health care plan during your COBRA continuation period that has a Pre-Existing Conditions limitation and you have a Pre-Existing Condition as defined by that plan, this Plan will continue to pay its charges, but only for your preexisting condition, for the remainder of your COBRA continuation period or until you become eligible for benefits without restriction under your new plan, whichever happens first. All other charges will be paid according to your new plan.
4. You become entitled to Medicare benefits.
5. Your ex-husband or ex-wife remarries and becomes covered under another group health plan.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage will be provided by the Claim Administrator within a reasonable time after termination of any person's coverage under the Plan, or within a reasonable time after the Claims Administrator learns of any such coverage termination (See "What Is Not Covered"—"Pre-Existing Conditions")

VIII. How Claims Are Administered

How Payments Are Made

In-Network

Plan payments are based on the negotiated pricing of your Preferred Provider Organization (PPO) network. Your Co-Payment and Co-Insurance is calculated on the net price negotiated (after the discount is applied). Your Provider may not bill you for any amount over the negotiated fee. To verify that your Provider is In-Network, contact your health care Provider's office or call the PPO phone number on your medical identification card.

Out-of-Network

Plan payments are based on the Usual and Customary charge for the care, service, or treatment you receive. The Claim Administrator determines the Usual and Customary charge. It is based on what other Doctors and Hospitals in the area charge for the same type of treatment. If your actual Out-of-Network charges are more than the Usual and Customary charges, you will have to pay the difference between your actual charges and the Usual and Customary charges. Extra amounts you have to pay because your charges are more than the Usual and Customary charges will not count toward your Out-of-Pocket Maximum.

Co-payment or Co-Pay

You are required to pay a fixed amount for specific In Network services, such as Doctor's office visits. The Co-Payments do not count toward your annual Out-of-Pocket Maximum. (See —"Standard Schedule of Benefits").

Co-Insurance

You are required to pay a percentage of most charges. These initial payments are called Co-Insurance. The Co-Insurance percentages differ depending on the type of service, and on whether the service is In-Network or Out-of-Network. The Plan also provides that the aggregate Co-Insurance amount you must pay within a year will not exceed certain specified amounts. This maximum amount of Co-Insurance you are required to pay is your Out-of-Pocket Maximum. There are different Out-of-Pocket Maximums for In-Network and Out-of-Network charges, and there is also a separate Out-of-Pocket Maximum for prescription drugs. (See —"Standard Schedule of Benefits").

Important Co-Insurance Points

Co-Insurance is accumulated on a calendar year basis. Your Co-Insurance totals applying toward your Out-of-Pocket Maximum are reset to zero each January 1.

Any amounts you pay for care, service, or treatment that are not covered by the Plan do not count toward your annual Out-of-Pocket Maximum.

Extra charges you have to pay because your Out-of-Network actual charges are more than the Usual and Customary charges covered by the Plan do not count toward your annual Out-of-Pocket Maximums.

Any extra amounts you have to pay because you did not follow a special rule or procedure, such as pre-admission notification—that is, any amounts you have to pay which are in the nature of a penalty—do not count toward your annual Out-of-Pocket Maximums.

If your Spouse fails to comply with the Plan's requirements related to enrolling in an available medical plan through his/her employment, then special Co-Payment and/or penalty provisions will apply. (See "Who Can Be Covered"—"Spouse.")

Maximum Benefit

Lifetime Maximum Benefit

The Plan will pay its covered charges, up to a maximum of $5 million during the entire time you are covered by the Butler Health Plan.

Annual Maximum Benefit

In addition to the $5 million Maximum Benefit, some of the individual benefits provided by the Plan are limited to a maximum payment either on a calendar year basis or over the entire time you are covered by the Plan. (See — " Standard Schedule of Benefits.")

How to File a Claim

You must fill out and file a Claim Form before the Plan can pay its part for your care, service, or treatment. The Hospital or Physician from whom you receive services may fill out this claim form as a service to you. However, if the Hospital or Physician does not provide this service, you will be responsible for submitting the Claim Form. You can get these forms from your Employer's office. If you have any questions about how to fill out the form or where to send it, please inquire in your Employer's office or call our Claim Administrator. You cannot combine claims for more than one family member on the same Claim Form. You must complete a separate Claim Form for yourself and each Dependent who has covered charges. Canceled checks, balance due statements, photocopies, payment receipts, and cash register receipts cannot be accepted as a claim filing. The Claim Administrator may require you to submit medical records or other information or to be examined by a Physician of its choice when necessary to determine any claim.

All claims, except prescription claims, must be sent to our Claim Administrator. (See — "Welcome to BHP" — for address.)

Preservice Claims

A Preservice Claim is any claim for benefits under the Plan for which the Plan can deny or reduce benefits solely on the basis that the Participant has failed to seek or obtain approval from the Plan before obtaining the services or supplies that are the subject of the claim. All Hospital admissions must be certified by the utilization review firm (see "Precertification" shown on back of ID card) in advance of the proposed confinement. The following are exceptions to this requirement:

1. Emergency Hospital admissions need not be preauthorized, but they must be reported to the utilization review firm within two working days after an admission.

2. Pre-certification is not required for outpatient surgery, but it is available to you, and it is recommended.
3. Pre-certification is not required for maternity admissions.

Benefits for Hospital confinement will be reduced by $200 if pre-certification is not obtained.

The Participant, or his/her representative, must contact the utilization review firm at the number on the back of the medical benefit identification card at least 48 hours prior to admission, in order to request certification. A Preservice Claim is considered filed on the date the utilization review firm actually receives all the following information, as applicable:

1. Name and Member ID number of the Employee and the name of the patient;
2. Name of the Physician or facility providing the service;
3. Date and duration of the proposed service;
4. Proposed charge for each visit or service and nature of treatment, service or supply;
5. The patient's diagnosis or a description of his/her symptoms or medical condition as required;
6. For prescription drugs, the name of drug, and pharmacy receipts; and
7. For services performed by other than a Physician, name and professional status of the Provider.

This information may be provided orally, in writing, or though any electronic transmission that the Plan is required by law to accept. The utilization review firm may require a Participant to submit additional information or to obtain a second medical opinion when it deems it necessary to determine a Preservice Claim.

The Plan does not determine benefits before a service or supply in question is provided. Pre-certification from the utilization review firm does not establish eligibility under the Plan, does not guarantee benefits, and does not establish Plan coverage for treatment of any Pre-Existing Condition during the Pre-Existing Condition waiting period. Any approval of a service or supply before the service or supply is provided only means that the Plan will not reduce benefits otherwise available due to a Participant's failure to obtain that approval.

With respect to this Plan, all pre-service claims are routed to and processed by the firm contracted to provide utilization review services to the Plan. The phone number of that firm is indicated on the back of your ID card (see "Precertification"). That firm has put in place procedures to ensure that initial claims (this includes phone calls as required for utilization review) are decided within a maximum of 15 days from receipt. If a pre-service claim determination (i.e., the finding of the utilization review firm with respect to the applicability of a particular service under the Plan) is an "Adverse Benefit Determination" (see next page for details) and if that finding is disputed by the party or parties submitting the claim, such appeal must be put in writing and submitted to the utilization review firm. The utilization review firm will then ensure that its initial finding is reviewed and a decision as to the appeal is decided within a maximum of 30 days from receipt.

Where applicable, the same rights and requirements that apply to post-service claims procedures and post-service appeal procedures as shown on the following pages will also apply to pre-service claims procedures and pre-service appeal procedures. However, any reference to "Plan Administrator" shall be replaced with "utilization review firm" in the case of pre-service claims or appeals issues.

Postservice Claims

A Postservice Claim is any claim for benefits under the Plan that is not a Preservice Claim. Postservice Claims may be filed by sending to the Claim Administrator completed claim forms and other needed information it reasonably requires to establish the claim within 90 days after the date the claims are incurred. All information regarding a Postservice Claim must be provided in writing or via an electronic transmission that the Plan is required by law to accept. Failure to file a claim within 90 days will not invalidate or reduce the claim if:

1. It was not reasonably possible to file the claim within that time; and
2. The claim was filed as soon as was reasonably possible.

In every case, the claim must be filed no later than 15 months from the date the claim was incurred. Claims are incurred on the date the service or supply is provided. Upon termination of the Plan or if an Employer or class of employees withdraws from the plan, claims must be filed within 30 days after termination. Claims that are not timely filed may be denied.

A Postservice Claim is considered filed on the date the Claim Administrator actually receives all of the following information:

1. Name and Member ID Number of the Employee and the name of the patient;
2. Name of the Physician or facility providing the service;
3. Date and duration of each service;
4. Charge for each visit or service and nature of treatment or service;
5. Diagnosis;
6. For prescription drugs, the name of drug; and
7. For services performed by other than a Physician, name and professional status of Provider of service.

In the event of any dispute regarding the provision of, or payment for, prescription drugs, a claim is not considered to have been made until the Participant advises the Plan of the dispute in accordance with the appropriate provisions of this booklet. If the Claim Administrator receives a claim that must be forwarded to a PPO for repricing or other action, the claim will not be considered filed before it is completed and returned by the PPO.

To File a Claim for Hospital Charges

Take your Plan identification card with you when you go to the Hospital. The Hospital will have you sign an Assignment of Benefits Form when you are admitted. This form gives us your permission to pay the Hospital directly for its services. The Hospital will then bill the Plan for its charges after you have been sent home.

To File a Claim for Doctors' Charges

You will have to fill out your part of a Claim Form and take it with you to your Doctor, who then must fill out the Doctor's part of the form. If you want the Plan to pay the Doctor directly, you must sign the "Authorization to Pay Benefits to Provider" statement on your claim form. If you do not sign this part, you will have to pay your Doctor yourself and then the Plan will reimburse you for your covered charges. After you and your Doctor have completed the form, send it to the address on the form. The Claim Administrator will accept the Physician's claim form or computerized billing.

To File a Claim for Prescription Drug Charges

Take your prescription benefit identification card with you to a participating retail pharmacy. The pharmacy will process your prescription drug claim through the Pharmacy Benefit Manager, and you will only pay the required Co-Insurance amount. Our Pharmacy Benefit Manager will bill the Plan for the amount the Plan will pay.

To be reimbursed for covered prescription drug charges that you paid yourself, fill out the prescription Claim Form available from your Employer, attach copies of your pharmacy receipts, then mail to the Pharmacy Benefit Manager. Be sure to include the name and Member ID Number of the Employee and the name of the patient. You will receive a check from the Pharmacy Benefit Manager for the amount the Plan pays.

In the event of any dispute regarding the provision of, or payment for, prescription drugs, a claim is not considered to have been made until the Participant advises the Plan of the dispute in accordance with the appropriate provisions of this booklet.

To File a Claim for Other Covered Charge

To be reimbursed for other charges you have paid yourself, fill out a Claim Form and attach the bills you have paid. It is important to send original invoices (bills) whenever possible. Please keep copies of all bills and correspondence for your records. Send all necessary information to the address on your medical benefit identification card.

Secondary Filing When Covered by Multiple Insurance Plans

When the Plan is the secondary payor for your Dependents, file a claim with the primary medical and/or pharmacy plan for payment of its benefit. Once you have received the Explanation of Benefits (EOB) from the primary payor, you may submit a Claim Form, with a copy of the Explanation of Benefits, to the Claim Administrator for secondary payment consideration of medical claims and the Pharmacy Benefit Manager for secondary payment consideration of prescription claims.

<u>Notice of Benefit Determination</u>

Each time you send in a claim, an Explanation of Benefits (EOB) form will be mailed to your home. This form explains the total amount billed, the amount paid, and who was paid. If any further information is needed, this request will also appear on the form. Please review this form carefully each time you file a claim so you will understand how your claim has been processed. If for any reason the Claim Administrator fails to act on your claim within the applicable time frames described in this section of the booklet the claim will be deemed to be denied.

Urgent Preservice Claims

In order to receive urgent care claims services, the urgent care service cannot be performed unless it has been authorized. This Plan has no such requirement in order for services to be rendered and therefore urgent care claims and urgent care claims appeals would not apply.

Postservice Claims

For Postservice Claims, the Claim Administrator will notify the Participant of its decision no later than 30 days after it receives the claim. The Claim Administrator may extend this period for an additional 15 days if needed for reasons beyond its control by notifying the Participant within the initial 30-day period of the circumstances requiring the extension and the date of the expected decision.

If the extension is required because the Participant has not submitted information needed to decide the claim, the notice of extension will specifically describe the information required and give the Participant at least 45 days after receipt to provide it. The time for making a decision will not run from the date the notice of extension is sent to the Participant to the date the Participant provides the requested information.

If You Find Billing Errors

If you find a billing error that results in an overpayment and have it corrected, we will share the difference between the original charge and the correct amount with you. The Plan will pay you 50% of the difference up to a maximum payment of $1,000. Here's how the program works:

Each time you receive care, service, or treatment (other than prescription drugs) be sure to get an itemized bill. Check this bill carefully to be sure that you actually received all the care or items you are being charged for. If you find a mistake in the amount billed or if you did not actually receive all of the care or items listed, take your bill to the Hospital, your Doctor, or the store where you bought the covered items, and ask for a corrected bill. Send a copy of the original bill and the corrected bill to the Claim Administrator. After verifying that you qualify, the Claim Administrator will send you a check for 50% of the difference between the erroneous and correct amounts, up to a maximum of $1,000.

Concurrent Review

After admission to the Hospital, the utilization review firm will continue to evaluate the Participant's progress through concurrent review. Concurrent review can eliminate unnecessary services and shorten confinements while improving quality of care and reducing costs to Participants and the Plan. If the utilization review firm disagrees with the length of confinement recommended by the Physician, the Participant and the Physician will be advised of this. If the utilization review firm determines that continued confinement is no longer Medically Necessary, additional days will not be certified, and benefits for those days will be denied.

If the Plan has approved an ongoing course of treatment to be provided over a specified period of time or number of treatments, any decision by the Plan to reduce or terminate that period or number of treatments may be appealed as provided in the Appeals Procedure section of this booklet. The Claim Administrator will notify the Participant of the Plan’s intent to reduce or terminate the benefit sufficiently in advance of the action to permit the Participant to appeal and obtain a determination before the benefit is reduced or terminated. In addition to appealing reduction or termination of benefits, a Participant may ask the Plan to extend treatment beyond what was originally approved.

Case Management

In cases where the Participant's condition is, or is expected to be, of a serious nature, the Plan may

arrange for review and/or case management services from a professional qualified to perform such services. The Plan has the right to alter or waive the normal Plan provisions when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the Participant, but the Plan will generally provide a greater benefit when case management is used. Services authorized by the Plan Administrator under this provision may be limited by the terms of the authorizations or prospectively reduced or terminated by the Plan Administrator at any time and for any reason upon reasonable written notice. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Participant or any other Participant. Appeals of case management decisions are handled as described in the section of this booklet on Appeal Procedure.

Appeal Procedure

If you file a claim and it is denied in whole or in part, or if your request for pre-certification is denied, and you disagree with the determination, you, or your authorized representative, can appeal the denial. A request for appeal must be in writing and must be sent by first class mail to the Claim Administrator. An appeal must be filed within 180 days after the Participant receives the Claim Administrator's notice of denial. An appeal will be considered filed on the date it is received. An appeal for claims filed beyond the timely filing date will not be considered. To appeal a decision, follow these steps:

1. Write to the appropriate administrator (Claim Administrator or Pharmacy Benefit Manager) asking for reconsideration of your claim. Be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. (See—"Welcome to BHP"—for addresses.) You will receive a benefit determination on review from the Claim Administrator.
2. If you are not satisfied with the Claim Administrator's benefit determination on review of your appeal, write to the appropriate administrator (Claim Administrator or Pharmacy Benefit Manager) asking to have the Plan Sponsor review your claim. Again, be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. You must send this request to the appropriate administrator (Claim Administrator or Pharmacy Benefit Manager) within 180 calendar days after you receive your Explanation of Benefits Form, or within 30 days after you receive the benefit determination on review of your appeal from the Claim Administrator, whichever is later.

In connection with your appeal, you have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits; and
2. Review and obtain without charge copies of documents, records and other information relevant to the claim being appealed.

The Claim Administrator will send the request to the Plan Administrator, and the Plan Sponsor will then make a full and fair review of the claim, taking into account everything you have submitted. The Plan Administrator may require the Participant to submit additional information to make the review.

In making a decision, the Plan Sponsor will:

1. Not give deference to the initial claim determination.

2. Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.
3. Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

The Plan Sponsor will make a final decision in writing. That decision will be given:

1. In the case of a Preservice Claim, within 15 days after the date the Claim Administrator receives the request for review.
2. In all other cases, within 30 days after the date the Claim Administrator receives the request for review.

Appeals of concurrent care claims are treated as appeals of Preservice, or Postservice claims, as applicable.

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with respect to you or any other Participant. If for any reason the Plan Sponsor fails to act within these time frames, the appeal will be deemed to be denied. The decision of the Plan Sponsor is final and binding on all parties.

Plan Sponsors' Discretion

In considering appeals, and in all other matters related to the Plan, the Plan Sponsor has full authority and discretion to:

1. Administer, interpret, apply, and construe the Plan.
2. Determine all questions of fact and law that may arise under the Plan.
3. Determine all issues of coverage and eligibility.
4. Determine all benefits and authorized disbursements.

Lawsuits Against the Plan

A Participant who disagrees with the decision of the Plan Administrator after an appeal may have the right to bring a civil action under Section 502(a) of ERISA. No action at law or in equity may be brought to recover under the Plan:

1. If the Participant fails to exhaust the Appeal Procedure; or
2. Before final denial of a claim in accordance with that Procedure; or
3. Later than three years after the date the claim is finally denied.

IX. Other Important Points

Cost of Plan Coverage

The Plan is currently funded by premiums paid by your Employer to the Butler Health Plan Trust. The amount of the premium is based on a contract between BHP and your Employer. Your Employer may require you to pay some or all of the premium attributable to your coverage. Please check with your Employer's office to find out what, if any, part of the monthly premium you are required to pay. If you are represented by a union, your coverage is provided in accordance with the terms of your union contract.

The funds contributed to the Trust are used to pay the benefits described in this Plan Document and the costs of administering the Plan. Plan costs are based on the amount paid for claims over the preceding year(s), stop-loss insurance premiums, and administrative costs.

Plan Participants who are on continuation coverage (See “When Coverage Ends”—"COBRA-Continuation of Coverage”) are responsible for paying the entire monthly cost of their coverage.

All Participants in the Plan are responsible for paying:

1. Deductibles,
2. Co-Payments and Co-Insurance, and
3. Charges for care, service, treatment, and supplies that are not covered by the Plan.

Third Party Liability

The Plan has reimbursement and subrogation rights. These rights apply when a Participant (You or any Dependent) suffers an Illness or Injury caused by the act or omission of a third party. If someone else is responsible for an Illness or Injury suffered by a Participant, the Participant is required to repay the Plan from any recovery the Participant receives. If necessary, the Plan is permitted to file a lawsuit in the Participant’s name, or allow the Plan to intervene in a lawsuit the Participant files.

If the Plan pays Benefits because of an Injury or Illness, and if the Participant has the right to recover any amount for that Illness or Injury from any third party or insurer (including uninsured or underinsured motorist coverage), the Plan has a specific and first right of reimbursement from any full or partial payment the Participant obtains, up to the total amount of Benefits the Plan has paid, and regardless of whether the payment is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement. Each Participant, by acceptance of such Benefits, agrees to the Plan’s reimbursement and subrogation rights as described in this section, and grants the Plan an equitable lien on any recovery. The Plan’s right to reimbursement exists regardless of the manner in which the recovery is structured or worded, and even if the Participant has not been fully compensated for all of the damages or expenses related to the Injury or Illness.

The Plan will not pay attorneys fees or costs associated with a claim or lawsuit without express written authorization from the Plan. The Plan’s right to subrogation or reimbursement will not be affected or reduced by the make whole doctrine, the fund doctrine, the common fund doctrine, comparative/contributory negligence, collateral source rule, attorney’s fund doctrine, regulatory diligence or any other equitable defenses.

Once a Participant has any reason to believe that the Participant may be entitled to recovery from any third party, the Participant must notify the Plan. At that time, the Participant must sign a subrogation/reimbursement agreement that confirms the Plan's subrogation rights and the Plan's right to reimbursement. If the Participant fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits until the agreement is signed; or, if the Plan nevertheless pays benefits, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement. Each Participant has an obligation, because of the Plan's payments on the Participant's behalf, to cooperate with the Employer and the Claim Administrator.

Subrogation

The Plan shall have subrogation rights with respect to benefits paid for Illness or Injury caused by the act or omission of a third party. The Plan may make and pursue a claim directly against any party or insurer who is obligated to make payments of any kind as a result of the Illness or Injury.

Coordination of Benefits

Some of our Employees, or their Dependents, may also be covered by some other group health care plan. In this case, the Plan may pay part of the expense and the other plan may pay part of it, also. The benefits paid by all the plans covering any one person will be combined so that as much of the charge as possible will be paid. The combination of benefits paid by all of the plans covering any one person will not be more than the actual charge. To be sure all plans covering you and your Dependents are considered, we require that you let your Employer's office know whenever there are any changes in your personal information.

Some special rules are used to decide which plan will pay what part of the charge. The primary plan determines its benefits first. The secondary plan determines its benefits next. Here are the coordination of benefits rules:

1. If this Plan is the primary payor, it will determine and pay its benefits without regard to any other plan.
2. If this Plan is the secondary payor, it will pay the difference between what the primary plan has paid and your actual charge, subject to any Maximum Benefit provisions and exclusions that are part of this Plan. However, under no circumstances will this Plan pay more as secondary payor than it would have paid as primary payor.

The following coordination of benefits rules are used in determining which plan is the primary payor and which plan is secondary:

1. The following plans will automatically be considered a primary payor:
    a. A Plan that does not have a coordination of benefits provision or a plan that coordinates benefits according to different rules.
    b. A program or plan required by law (other than Medicare), for example, Workers' Compensation.
    c. Any type of automobile insurance coverage.
2. If a Participant under this Plan is also covered by Medicare, this Plan will generally be the primary payor, and Medicare will be secondary (subject to applicable laws and regulations).

3. For Dependent Children, if both parents are covered by employer-sponsored group health plans that cover their Children as Dependents:
    a. The plan of the parent whose birthday is earliest in the year will be primary payor.
    b. If both parents have the same birthday (not taking into consideration the year), the plan that has covered the Dependent Child for the longest period of time will be the primary payor.
    c. If the other plan covering a Dependent Child does not have a coordination of benefits provision based on birth dates, then the father's plan will be primary.
4. If the parents of a Dependent Child are divorced or legally separated:
    a. If a court decree places financial responsibility for health care expenses of the Child on either parent, that parent's plan will be the primary payor.
    b. If there is no court decree placing financial responsibility for health care expenses of the Child on either parent:
        i. The plan of the custodial parent will be the primary payor.
        ii. If the custodial parent has remarried, the plan of the custodial parent will be primary, the plan of the stepparent will be secondary, and the plan of the non-custodial parent will determine its benefits.
5. A plan covering a person as an employee will pay its benefits before a plan covering the same person as a Dependent.
6. A plan covering a person as an active employee (or Dependent of an active employee) will pay its benefits before a plan covering a laid-off or retired employee.
7. A plan covering a person as a laid off or retired employee will pay its benefits before a plan covering the same person as a Dependent of an active employee.
8. If none of the above rules determine the order of payment, the plan which has covered the person for the longest period of time will be the primary payor.

If you have any questions about these rules, please call the Claim Administrator.

Right of Recovery

If, at any time, payments made under the Plan to or on behalf of a Participant or any of his covered Dependents exceed benefits actually payable, the Plan has the right to:

1. Recover the excess payments from any person or entity to or for whom the payments were made or from any organization or plan from which similar benefits remain payable; or
2. Offset payments due or that may become due under the Plan with respect to expenses incurred by the Participant or any of his covered Dependents to the extent of the overpayment.

Right to Examine

If you have filed a claim for benefits under the Plan, the Plan or the Claim Administrator may require that you have a Doctor of its choice examine you. In this case, the Plan will pay the full cost of the examination.

Assignment

Benefits provided under the Plan shall not be assignable without the consent of the Plan Administrator. The Participant may authorize the Plan Administrator to pay benefits directly to the Hospital, Physician, or other party providing medical treatment. Any such payments will discharge the Plan to the extent of

payment made. Claim payments may not be attached or otherwise subject to seizure by any creditor of a Participant.

Payment for covered charges incurred by a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant, or his or her beneficiary, as required by an applicable state plan for medical assistance approved under Title XIX of the Social Security Act ("State Plan") pursuant to section 1912(a)(1)(A) (as in effect on the date of enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that an individual is eligible for or provided medical assistance under a State Plan shall not be taken into account in enrolling such individual as a Participant or beneficiary or in determining the entitlement or amount of any benefits due under the Plan.

To the extent that a State Plan has made payment for items that would be covered charges of a Participant under the Plan, payment of benefits hereunder shall be made in accordance with any State law that provides that the State has acquired the rights with respect to such Participant to such payment.

Misrepresentation

If an Employee or Dependent (or anyone acting on behalf of either) makes a false statement or withholds information, and as a result coverage is provided that would otherwise not have been, or a claim is paid that would otherwise not have been paid, the Plan has the right to:

1. Recover any amounts paid as a result of the misrepresentation;
2. Terminate coverage immediately; and
3. Recover its damages, including legal fees, from the Employee or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Facility of Payment

The Plan will pay its benefits directly to your service Provider (for example, your Doctor or a Hospital) if you sign a valid assignment of benefits. There is an “Authorization to Pay” on the Plan’s claim form. This is where you should sign if you want the Plan to pay your service Provider directly.

If the Claim Administrator determines that a valid release cannot be given for payment of Plan benefits, the Claim Administrator has the discretion to pay the individual who has assumed responsibility for your principal support and care.

If you should die before benefit payments have been made, the Claim Administrator may honor assignments you made before your death. Any payment made by the Claim Administrator in accordance with this provision shall fully satisfy its liability for payment.

Plan Modification and Amendment

The Plan Sponsor may modify or amend the Plan from time to time at their sole discretion, and any such amendments or modifications that affect Participants will be communicated to them.

Plan Termination

The Plan Sponsor may terminate the Plan at any time. If the Plan is terminated, your rights to benefits will be limited to claims incurred and due up to the date of termination.

No Effect on Employment

Nothing contained in this Plan shall be considered to guarantee a right to continued employment or to interfere with the right of a Participating Employer to discharge an Employee at any time.

ERISA Rights

As a Participant in the Plan, you have certain rights and protections under the Employee Retirement Income Security Act (ERISA). These are:

1. You may look at and read all Plan documents and papers, including insurance contracts, and copies of all reports and papers filed by the Plan with the U.S. Department of Labor. You may look at these papers in your Employer's office or at the Plan Administrator's office. There is no cost to you for looking at them.
2. You may get copies of all Plan documents and other Plan information from the Plan Administrator. You must ask for them by writing to the Plan Administrator. You will be charged for each page copied for you at the current commercial rate for copies at the time the copies are made.
3. You may get a copy of the Plan's annual report. Your Employer is required by law to give you a copy of the annual report if you ask for one.
4. The people who are responsible for the operation of the Plan and who, in fact, operate it are called "fiduciaries." By law they have a duty to operate the Plan carefully and to protect your interests. No one may fire you or discriminate against you in any way to stop you from getting benefits under the Plan or for taking advantage of the rights listed above.
5. If you have a claim and either the whole claim or part of it is not paid, the Claim Administrator must tell you, in writing, why it can't be paid. You may also ask the Plan Administrator and the Plan Sponsor to consider your claim again.

In order to protect these rights:

1. If you ask for Plan documents and papers and you do not get them within 30 days, you may file a lawsuit in federal court. The court could order the Plan Administrator to give you the materials and also to pay you as much as $110 each day until you get them, unless the court finds that the Plan Administrator had good reasons for not sending them to you.
2. You can file a lawsuit in federal court if your claim is not paid, either in whole or in part, if after you have filed your claim you do not get a written response from the Claim Administrator explaining why the claim was not paid.
3. If the Plan fiduciaries do not use the Plan's money as they should, or if you are discriminated against for taking advantage of any of the rights listed in this section, you may get help from the U.S. Department of Labor or you can file a lawsuit in a federal court. The court will decide who will have to pay the legal fees and costs. If you file a lawsuit and the court finds that there is no reason to believe that you have a case, you may be ordered to pay the fees and costs. If the court finds that you do have a case, the people you sue may be ordered to pay the fees and costs.

4. If you have any questions about the Plan, call or write the Plan Administrator. If you have any questions about the rights described above, you can call or write either the Plan Administrator or the nearest office of the U.S. Labor-Management Services Administration (part of the Department of Labor).
5. The Plan has been established for Employees of the various Employers participating in the Butler Health Plan, and their Dependents. You can get a list of Participating Employers by writing to the Plan Administrator at the address shown in Miscellaneous Plan Information. The Plan is funded by contributions made to the Butler Health Plan Trust by Participating Employers and certain Employees. You can get a list of the names and addresses of Plan Sponsors by writing to the Plan Administrator shown in Miscellaneous Plan Information.

HIPAA Privacy Standards

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids for providing health insurance coverage or modifying, amending, or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for administration purposes, including payment and healthcare operations, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Document or as Required by Law as defined in the Privacy Standards;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization that meets the requirements of the Privacy Standards;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Service ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, or, if such return or destruction is not feasible, then limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following persons under control of the Plan Sponsor shall be given access to the PHI: Administrative Director, Associate Director, and Administrative Assistant of the Plan and Treasurers, Business Managers, and/or Human Resources Managers, and Benefit Representatives designated by Treasurers, Business Managers, and/or Human Resources Managers of the Participating Employers.
    b. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
    c. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan's Privacy Officer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations under the Privacy Standards. "Plan Administration" functions include, but are not limited to, quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan Document has been amended to incorporate the above provisions, and
2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan and information about an individual's present or former enrollment in the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsors hereby authorize and direct the Plan, through the Plan's Administrative Director, to disclose PHI to stop-loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards and the Plan's Privacy Policy.

HIPAA Security Standards

The Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Health Plan.
2. Ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect the information.
4. Report to the Health Plan any Security Incident of which it becomes aware.

Summary of Material Modifications

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the summary plan description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

X. Miscellaneous Information

Name of the Plan:	Butler Health Plan
Type of Benefit Plan:	Medical
Plan Administrator:	Butler Health Plan 1910 Fairgrove Avenue, Suite C Hamilton, Ohio 45011 (513) 942-6262
Plan Sponsor:	Butler Health Plan Board of Trustees Butler Health Plan 1910 Fairgrove Avenue, Suite C Hamilton, Ohio 45011
Medical Plan Number:	501
Pharmacy Plan Number:	908
Employer ID Number:	31-1151537
Plan Administration:	Contract Administered
Claim Administrator:	Allied Benefit Systems, Inc. P.O. Box 909786-60690 Chicago, IL 60690 1-800-288-2078
Utilization Review Firm:	Healthspan, Preferred (under "Precertification" on back of ID card) 1-513-551-1420 or 1-800-972-7726
Pharmacy Benefit Manager:	CVS Caremark P.O. Box 2860 Pittsburgh, PA 15238-2860 1-866-498-2247
Agent for Service of Legal Process:	Administrative Director Butler Health Plan 1910 Fairgrove Avenue, Suite C Hamilton, Ohio 45011 * Note: Legal process may also be served on any of the plan trustees.
Plan Fiscal Year:	January 1–December 31
Plan Effective Date:	September 1, 1992
Plan Currently Restated:	January 1, 2008

XI. Definitions

As used in this Plan Document, and for purposes of Plan coverage, the following words and phrases have the meanings assigned to them, unless otherwise required by context:

1. *Ambulatory Surgical Center* A public or private facility, other than a Doctor's or dentist's office, that is either free-standing or a distinct part of a Hospital, and that:
    a. Is established, equipped, and operated to perform surgical procedures.
    b. Is supervised by an organized staff of Doctors.
    c. Provides full-time services of at least one registered nurse.
    d. Is properly licensed by all applicable regulatory agencies.
    e. Has at least two operating rooms and two recovery rooms.
    f. Maintains medical records for each patient.
    g. Has a written transfer agreement with one or more Hospitals in the area.
    h. Does not have facilities for patients to stay overnight.
2. *Assignment of Benefits*: Your authorization to the Claim Administrator to pay Plan benefits directly to your service Provider (for example, your Doctor or a Hospital).
3. *Birthing Center*: A legally licensed facility that is equipped and operated to provide prenatal care and to perform uncomplicated spontaneous delivery and immediate postpartum care.
4. *Co-Insurance*: The percentage of covered charges you must pay after you have met your annual Deductible. Co-Insurance payments count toward your Out-of-Pocket Maximum.
5. *Co-Pay or Co-Payment*: A cost sharing arrangement in which the Member pays a fixed amount for a specific service, such as $10 for a prescription drug or $25 for a Doctor visit. The Co-Pays do not count toward the annual Out-of-Pocket Maximum.
6. *Child/Children*:
    a. Any natural Child of yours.
    b. Any natural Child of your Spouse.
    c. A Child legally adopted by you or your Spouse if the Child was placed for adoption before the Child's 18th birthday.
    d. A Child who has been, and continues to be, legally placed for adoption with you or your Spouse before the Child's 18th birthday.
    e. Any Child for whom you or your Spouse is legal guardian or has legal custody, if that Child has the same principal place of residence as you and is a member of your household.
7. *Cosmetic Surgery*: A treatment or surgery is "cosmetic" if it is designed to change the texture, shape or structure of any part of the body that is considered normal, allowing for age and ethnic origin, and is not Medically Necessary due to accident or Illness.
8. *Creditable Coverage*: Medical insurance coverage within the meaning of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that may, under the terms of HIPAA, allow you to obtain a waiver of some or all of a Pre-Existing Condition waiting period that would otherwise apply to you. Acceptable ways to establish Creditable Coverage are through a Certificate of Creditable Coverage or an affidavit with supporting documentation if no certificate is available. Types of Creditable Coverage are:
    a. Coverage under another employer-sponsored health plan;
    b. Coverage under Medicare or Medicaid;
    c. Individual health coverage;
    d. Coverage under state-risk pool; or
    e. Coverage through Tri Care (coverage for Dependents of military personnel).

9. *Custodial Care*: Any type of service that is designed essentially to assist you in the activities of daily living, whether or not you are disabled. Such services include assistance in walking, getting in and out of bed, bathing, dressing, feeding; preparation of special diets; and supervision over medication that can normally be self-administered and is Medically Necessary.
10. *Deductible*: The amount the member pays each calendar year before the plan covers health care costs or specified services.
11. *Dependent*: Any person who qualifies for Plan coverage by virtue of meeting the requirements. (See — "Who Can Be Covered")
12. *Diagnostic Service*: A test or procedure used to detect or monitor symptoms of a specific disease or Illness.
13. *Doctor or Physician*: A legally licensed M.D., D.O., chiropractor, optometrist, podiatrist, dentist or oral surgeon who is practicing within the scope of his or her license.
14. *Electronic Protected Health Information*: This term has the same meaning as ascribed to it in 45 C.F.R. Part 160 and Part 164.
15. *Employer*: See the definition of "Participating Employer."
16. *Experimental*: Experimental or investigative treatments, services, medications and supplies are those that have not been recognized as effective according to generally accepted medical standards and practices, or that had not been approved by the appropriate governmental agency at the time you received them.
17. *Full-Time Student*: Any person who is enrolled as a student at an appropriately licensed or accredited educational institution for 12 credit hours per grading period or on a full-time basis as defined by the institution (except for normal school breaks within an academic year or between two consecutive academic years). Note that a student may elect to continue full-time studies during an extended normal break period (i.e., summer vacation) and substitute either a standard academic quarter or academic semester as a replacement break period if such break is completed within twelve months of the beginning of the next year's summer vacation.
18. *Hospital*: An institution (other than a hotel, rest home, nursing home, convalescent home, facility for Custodial Care or care of the aged or mentally ill, or an institution primarily for treatment of drug addiction or alcoholism) that:
    a. Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Health Care Organizations, or
    b. Is an accredited behavioral health facility that does not provide other medical services, or
    c. Is a legally operated facility that:
        i. Is supervised by a staff of Doctors; and
        ii. Provides 24-hour nursing service; and
    d. Provides general inpatient medical care and treatment for sick and injured people using medical, diagnostic and surgical facilities that are under its control; and
    e. Provides specialized inpatient medical care and treatment for sick and injured people using medical and diagnostic facilities (including X-ray and laboratory) that are under its control or are available to it under a written agreement with another Hospital or service Provider that specializes in these services.
19. *Illness*: A physical or mental disease or infirmity that interferes with normal bodily functions. It includes pregnancy and pregnancy-related conditions.
20. *Injury*: Bodily damage caused by sudden, accidental, external means.
21. *Intermediate Care Facility*: A facility that is licensed as a skilled nursery facility and approved as such by Medicare.
22. *Jaw Joint Treatments*: Treatments of temporomandibular joint syndrome (TMJ) and craniomandibular disorders or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves, and other tissues related to that joint.

23. *Lifetime Benefit Maximum*: The total amount of benefits payable by the plan for an enrollee during his or her lifetime.
24. *Maximum Benefit*: The plan will pay a maximum amount for a service for a specified period or the entire time that you are in the plan. When the Maximum Benefit is paid, the plan will pay no more benefit for the specified service.
25. *Medically Necessary*: Care, service, or treatment that is recommended or prescribed by your Doctor as necessary for your treatment and is in accordance with accepted medical standards. The Claim Administrator determines whether or not a particular type of care, service, or treatment is Medically Necessary taking into consideration the nature of your condition.
26. *Named Fiduciary*: The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Plan Sponsor. In exercising its fiduciary responsibilities, the Plan Sponsor shall have the discretionary authority to determine eligibility for benefits, review denied claims for benefits, interpret Plan provisions, construe disputed Plan terms and select managed care options. The Plan Sponsor shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously. Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously
27. *Out-of-Pocket Maximum*: The amount an enrollee must pay in Co-Insurance each year before the plan covers remaining expenses for that year at 100%.
28. *Participan*t: Any individual entitled to participate in the Plan, under the requirements set forth in this Plan Document, either as an eligible Employee of a Participating Employer or as an eligible Dependent.
29. *Participating Employer or Employer*: Any employer participating under the terms and provisions of the Butler Health Plan.
30. *Physician*: See the definition of "Doctor."
31. *Plan*: Butler Health Plan
32. *Plan Option*: A type of medical plan offered by the Butler Health Plan. Each Plan Option has different coverage, cost and design as defined in each Medical Plan Document.
33. *Pre-Existing Condition*: Any Illness, Injury, or related condition for which you received treatment during the three months immediately before you became covered by the Plan. For the purposes of this provision, "treatment" means advice, a physical examination, diagnosis, prescription for medication, or administration of medication.
34. *Premium*: The monthly cost you pay to BHP for your coverage. Your Employer pays a portion of this cost. You pay a portion of the cost through payroll deduction.
35. *Privacy Rule*: The rules set forth in 45 CFR Part 160 and Part 164, Subparts C and E.
36. *Provider*: A person or other entity licensed where required and performing services within the scope of such license. Covered professional Providers may include but are not limited to:
    a. Certified Chemical Dependency Counselor
    b. Certified Clinical Supervisor
    c. Certified Registered Nurse Anesthetist
    d. Certified Registered Nurse Practitioner
    e. Chiropractor
    f. Clinical Laboratory
    g. Clinical Licensed Alcoholism and Substance Abuse Counselor
    h. Clinical Licensed Social Worker
    i. Dentist
    j. Doctor of Philosophy in Psychology
    k. Licensed Professional Clinical Counselor

l. Midwife
m. Nurse (R.N., L.P.N., L.V.N.)
n. Occupational Therapist
o. Physical Therapist
p. Physician (See definition of "Doctor")
q. Podiatrist
r. Psychiatrist
s. Psychologist
t. Respiratory Therapist
u. Speech Therapist

37. *Qualified Medical Child Support Order (QMCSO)*: Any judgment, decree, or order issued by a court of competent jurisdiction that satisfies the requirements for a QMCSO as set forth in section 609(a) of ERISA; or a National Medical Support Notice (NMSN) issued by a state agency that administers child support enforcement programs and that satisfies the requirements of rules developed pursuant to the Child Support Performance and Incentive Act of 1998.
38. *Security Incident*: This term has the same meaning as ascribed to it in 45 C.F.R. Part 160 and Part 164.
39. *Usual and Customary Charge (U/C)*: The amount usually charged by Doctors or suppliers of services or supplies so long as it is not more than the general level of charges made by others providing the same services or supplies in the geographic area to treat an Illness or Injury of comparable severity. "Area" means a county or such other area as is necessary to obtain a representative cross-section of the charges.
40. *You, Your, Yours, Yourself*: These and similar terms refer, as appropriate to context, to any person covered as a Participant under the Plan. However, in the section "Who Can Be Covered" these terms refer only to the Employee who is either covered or eligible for coverage.

ADDENDUM I

(CLASSIC)

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INDEX (CLASSIC)

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ADDENDUM II

(CLASSIC)

Summary Schedule

2008 SUMMARY SCHEDULE – CLASSIC OPTION

Note that provisions in Plan Document take precedence over any provisions in this Summary Schedule.

I. Medical Deductibles, Out of Pocket Maximums and Cost Containment Penalties

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Calendar Year Deductible *(does not apply to benefits with co-pay applied).*	Waived	Individual = $500 Employee + 1 = $1.000 Family = $1,500
Out-of-Pocket Maximum per Calendar Year *(**AFTER** Deductible).* After amount is reached, 100% level of benefits applies for that Calendar Year. In-Network and Out-of-Network maximums are separately tracked**.** ***Note that any amount you pay under the Prescription Drug Card or Mail Order Drug Programs*** *(see separate Drug Deductible and Out of Pocket Maximum in next section)* ***and the exceptions to this provisions shown at right do not apply to and are not affected by this provision***	$1,500 per Individual $3,000 per Employee + 1 $4,500 per Family	$2,000 per Individual $4,000 per Employee + 1 $6,000 per Family
	Medical Expenses Not Included under this provision are as follows: • In Network Office Visit Co-Pay • Calendar Year Deductible • Emergency Room Deductible • Non-Compliance Penalty • Non-covered charges, charges in excess of any Plan maximum or limit, charges in excess of U&C charges for out of network providers. ***Patient's portion of co-insurance for 1) chiropractic services, 2) infertility treatment, 3) jaw/joint treatment, 4) smoking/tobacco cessation, 5) treatment of a Pre-Existing Condition***	
Benefits subject to a $200 "Non-Compliance Penalty" per occurrence ***(after Deductible)*** when pre-certification procedures are not followed in regard to Inpatient Hospital admissions	**TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD**	
Lifetime Benefit Maximum	$5,000,000 Lifetime Maximum Per Person for All Benefits Paid	

II. Prescription Drugs (utilizing Plan's contracted pharmacy vendor for retail/mail order drugs)

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Separate Retail Prescription Deductible per Calendar Year	$25 Per Individual per Calendar Year	
Annual Out of Pocket Prescription Maximum	$750 per Individual, $2,250 per family - after deductible(s) Note that only the 20% co-insurance for generic and preferred brand drugs count toward the annual out of pocket maximum	
Prescription Drug Card Program *up to 30-day supply through participating pharmacies.*	• 20% co-pay per Generic prescription, • 20% co-pay per Preferred Brand prescription, • 40% co-pay per Non-Preferred Brand prescription	
Mail Order Drug Benefit *up to 90-day supply per prescription.*	• 20% co-pay per Generic prescription, • 20% co-pay per Preferred Brand prescription, • 40% co-pay per Non-Preferred Brand prescription	
Limitation on filling maintenance drugs at a retail pharmacy	A maximum of 3 fills are allowed at retail for a new maintenance drug. After that, the drug must be filled through mail order only.	
Specialty Pharmacy up to 30 day supply	Provides injectable and other specialty medications to members with free delivery to patient's home or physician's office. Retail co-pay applies.	
Brand when generic is available	Patient must pay the cost difference between the brand and generic drug in addition to your co-pay or co-insurance	
Prior Authorizations	Patient may call the pharmacy benefit manager with questions regarding quantity limitations or prior authorizations	

III. Wellness Care

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Routine Well Baby Care (first two years of life) including routine tests and examinations.	80% *See "Note" under "Routine Tests and Exams" below.	60% *See "Note" under "Routine Tests and Exams" below.
Routine Tests and Exams *(other than as stated below in this section)* **for Participants over age two, up to a maximum payment of $150 per Participant per Calendar Year.**	80%*	60%*
	* However, note that tests performed at Lab Card draw sites are payable at 100% - no Deductible. Also, note that any provider may, at the request of the Participant, utilize the Lab Card program which provides services for interpretation of lab tests/x-rays that are payable at 100% by the Plan with no Deductible.	
Immunizations *(for children and adults),* **including flu shots**	80%	60%
School Flu Shots and Health Screenings *(provided at school site wellness events for covered employees and spouses)*	100%	100% Deductible Waived.
Mammograms and associated exam *(one baseline from age 35-39; one per Calendar Year, thereafter)*	80% *See "Note" under "Routine Tests and Exams" above.	60% *See "Note" under "Routine Tests and Exams" above
Pap Smears and associated exam *(one per Calendar Year for females age 18 and over))*	80% *See "Note" under "Routine Tests and Exams" above	60% *See "Note" under "Routine Tests and Exams" above
PSA Tests *(one per Calendar Year for males age 50 and over)*	80% *See "Note" under "Routine Tests and Exams" above	60% *See "Note" under "Routine Tests and Exams" above
Hearing Aids for routine hearing loss *(devices only; subject to a maximum payment of $500 for both ears within a 3 year replacement cycle; associated routine hearing exams and fittings are not covered). Note that Medically Necessary services/supplies for hearing loss unrelated to aging process are covered as any other Illness.*	80%	60%
Smoking/Tobacco Cessation Treatment *limited to hypnosis and smoking/tobacco cessation sessions by qualified organizations. Nicotine patch costs will be covered for a maximum of six weeks per Calendar Year. Prescription drugs are also covered. Not covered treatment includes gum, books, tapes, videos and mail order programs. Maximum payment of $300 per Participant per Lifetime.*	50%	50% Deductible Waived.
Colorectal screenings *(including annual digital rectal exam and occult blood test for Participants over age 30; additional sigmoidoscopy once every five years or routine colonoscopy once every ten years for Participants over age 50)*	80% *See "Note" under "Routine Tests and Exams" above	60% *See "Note" under "Routine Tests and Exams" above

IV. Physician Services

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Medically Necessary Physician Office Visit (*Exam charge only*)	$25 co-pay per visit, then 100%	60%
Allergy or B-12 Injections when done in conjunction with an office visit co-pay (see above)	100% Deductible Waived	60%
Allergy or B-12 Injections when not done in conjunction with an office visit co-pay	80%	60%
Outpatient *(including office and independent laboratories)* **Diagnostic Testing and Interpretation** (*including X-rays and laboratory services,. MRI, CAT and PET scan services, and other generally accepted diagnostic tests).*	80%*	60%*
	Includes tests and interpretation when performed in the absence of symptoms, but due to documented family history of disease (with "family" meaning parents, grandparents and siblings) * However, note that tests performed at Lab Card draw sites are payable at 100% - no Deductible. Also, note that any provider may, at the request of the Participant, utilize the Lab Card program which provides services for interpretation of lab tests/x-rays that are payable at 100% by the Plan with no Deductible.	
Contraceptive Management *(for contraceptive devices that can only be obtained from a Physician and associated services).*	$25 co-pay per office visit (for exam charge only); device payable at 80% after Deductible; related outpatient diagnostic charges paid as shown above	60%
Physician Charges for Surgery and Anesthesia, *regardless of where performed.*	80%	60%
Second Surgical Opinion (not required). *Includes associated lab tests and x-rays.*	$25 co-pay per office visit (for exam charge only); related outpatient diagnostic charges paid as shown above	60%
Physical, Speech, Occupational, Biofeedback and Inversion Therapy *(maximum of 26 visits per Calendar Year per each therapy type, without medical certification as to the need for additional visits).* **Specific conditions apply..**	80%	60%
Other Therapy Services*, radiation, chemotherapy and respiratory therapy)*	80%	60%
Chiropractic Services *(maximum payment of $1,000 per Participant per Calendar Year). Includes x-ray and lab charges billed by chiropractor.*	80%	60%
Urgent Care Facility Services *(professional and facility services provided; this includes non-routine care by Student Health Facilities)*	80%	60% (unless care is for an Injury, or, if Illness, if patient is more than 50 miles from residence – in these circumstances, in-network benefits will apply.
Other Physician Services *(except as may be stated differently in the Plan Document)*	80%	60%

V. Facility Services

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Inpatient Hospital Services • *Room and board not to exceed the semi-private room rate unless when required due to Medically Necessary isolation purposes, and* • *Necessary services and supplies including, but not limited to, n intensive care unit and a cardiac care unit*	80%	60%
Hospital Emergency Room Care (separate $100 deductible per occurrence applies in addition to provision shown at right unless patient is admitted, if care is for an Injury, or if illness meets definition of "medical emergency" in which case, the $100 deductible is waived Also, if treated for non-emergency illness, the $100 deductible will not apply if patient is more than 50 miles from residence, or if patient was given a written referral to the hospital by his doctor .	80% Deductible Waived (see also provisions at left)	
Outpatient Facility Diagnostic Testing	80%*	60%*
	* However, note that tests performed at Lab Card draw sites are payable at 100% - no Deductible. Also, note that any provider may, at the request of the Participant, utilize the Lab Card program which provides services for interpretation of lab tests/x-rays that are payable at 100% by the Plan with no Deductible.	
Other Outpatient Facility Services *(including Ambulatory Surgical Centers and Birthing Centers)*	80%	60%
Home Health Care when provided by a licensed home health care agency in accordance with a written treatment plan prepared by the patient's attending Physician.	80%	60%
Hospice Care *(appropriate Inpatient and Outpatient services applicable when the patient is not expected to live more than six months)*	80%	Paid at In-Network Level
Extended Care Facility (also known as Skilled Nursing Facility) – *Includes:* ▪ *room, board and floor nursing care (up to the facility's semi-private room rate)* ▪ *physical, occupational or speech therapy* ▪ *drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patients*	80%	60%

VI. Mental Health Services

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Mental Health Services (Mental/Nervous, Alcohol and Drug Abuse)		
Inpatient *(Pre-certification applies)*	80%	60%
Outpatient *(note that medication management office visits will also be paid under this benefit)*	80%	60%

VII. Other Services

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Ambulance Service *by ground or air as Medically Necessary*	80%	Paid at In-Network level
Durable Medical Equipment *(purchase or rental- up to purchase price – of Durable Medical Equipment)*	80%	60%
Prosthetics *(for purchase of internal or external prosthetic appliances used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth).*	80%	60%
Orthotics *(custom made when Medically Necessary – does not include corrective shoes)*	80%	60%
Wigs after Chemo or Radiation therapy *(limited to a Calendar Year maximum payment of $200)*	80%	60%
Well Newborn Care *(professional and facility services, including circumcision, while the mother is confined for a normal delivery))*	80%	60%
Blood and blood products *(if not donated or replaced)*, **intravenous injections and solutions**	80%	60%
Organ Transplant Coverage *(covered transplants are listed in the Plan Document)* **Per Transplant Donor Coverage Maximum of $5,000**	80%	60%
Morbid Obesity Treatment *(includes surgical treatment of morbid obesity if Medically Necessary and subject to the condition of morbid obesity having persisted for at least 5 years, and that documented Physician supervised treatment has been unsuccessful for 24 months or longer).*	80%	60%
Infertility Treatment *(including in-vitro fertilization, artificial insemination, GIFT or ZIFT, and prescription drugs related to treatment of infertility).* Limited to a Lifetime Maximum of $15,000 per Participant, split evenly ($7,500 each) between medical treatment and fertility related drugs through the Drug Card program.	80%	60%

VII. Other Services, continued

BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Jaw Joint Treatment *(up to a maximum payment of $1,000 per Calendar Year without pre-determination of Medical Necessity).* Covered Services include one jaw joint appliance but will not include orthodontic related expenses even if Medically Necessary.	80%	60%
Orthopedic Equipment and Appliances	80%	60%
Maternity Services *(covered same as any Illness and includes charges for prenatal, delivery and postpartum services)*	80%	60%
Dental Related Treatment *(includes services required in connection with an accidental non-biting or chewing Injury to sound natural teeth or jaw, and performed within 6 months of the accident)*	80%	60%
Voluntary Sterilization *(but not the reversal of such procedures)*	80%	60%
Cosmetic Surgery *limited to surgical charges for reconstructive surgery following mastectomy (as mandated by the Womens' Health and Cancer Rights Act) or to treat an accidental Injury or birth defect.*	80%	60%
Pre-Existing Conditions *(if pre-existing conditions apply, covered expenses are limited to 50% of in-network charges up to a maximum payment of $5,000 per condition during the first 12 months of coverage.*	50%	Not Applicable
Services provided by a non-patient selected Out of Network Physician while being treated at a Network Hospital	Not Applicable	Paid same as In-Network
Other Covered Services and Items *(see Plan Document for further details of covered services as well as exclusions and limitations applicable).*	80% Unless included under a previous category or as further detailed in the full Plan Document.	60% Unless included under a previous category or as further detailed in the full Plan Document.