

# BUTLER HEALTH PLAN

## PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS

EFFECTIVE JANUARY 1, 2012

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

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<b>Calendar Year Deductible</b> <i>(does not apply to benefits with co-pay applied).</i>	Individual = \$500 Employee + 1 = \$1,000 Family = \$1,500	Individual = \$1,500 Employee + 1 = \$3,000 Family = \$4,500
	Note that In and Out of Network Deductibles are separately tracked.	
<b>Deductible Carry-Over</b>	N/A	
<b>Out-of-Pocket Maximum per Calendar Year</b> <u><b>(AFTER Deductible)</b></u> . After amount is reached, 100% level of benefits applies for that Calendar Year. <u>In-Network and Out-of-Network maximums are separately tracked.</u>	\$2,000 per Individual \$4,000 per Employee + 1 \$6,000 per Family	\$5,000 per Individual \$10,000 per Employee + 1 \$12,000 per Family
<b>Note that any amount you pay under the Prescription Drug Card or Mail Order Drug Programs and the exceptions to this provisions shown at right do not apply to and are not affected by this provision</b>	<u>Medical Expenses Not Included</u> under this provision are as follows: <ul style="list-style-type: none"> <li>• In Network Office Visit and Urgent Care Visit Co-Pay</li> <li>• Calendar Year Deductible</li> <li>• In-Network Emergency Room Deductible</li> <li>• Non-Compliance Penalty</li> <li>• Non-covered charges, charges in excess of any Plan maximum or limit, charges in excess of U&amp;C charges for out of network providers.</li> <li>• Patient's portion of co-insurance for 1) jaw/joint treatment, 2) smoking/tobacco cessation, 3) treatment of a Pre-Existing Condition</li> </ul>	
Benefits subject to a \$200 "Non-Compliance Penalty" per occurrence <i>(after Deductible)</i> when pre-certification procedures are not followed in regard to Inpatient Hospital admissions	<b>TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD</b>	
<b>Annual Benefit Maximum</b>	\$3,000,000	
<b>Lifetime Maximum</b>	Unlimited	
<b>Claims Filing Limit</b>	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.	
<b>Coordination of Benefits</b>	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (carve out). This Plan will only pay the difference of what the Plan would have paid if it was the Primary Payer.	

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

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Separate Retail Prescription Deductible per Calendar Year	Not Applicable	
Annual Out of Pocket Prescription Maximum	Not Applicable	
Prescription Drug Card Program up to 30-day supply through participating pharmacies.	<ul style="list-style-type: none"> <li>• \$15 co-pay per Generic prescription,</li> <li>• \$35 co-pay per Formulary Brand prescription,</li> <li>• \$55 co-pay per Non-Formulary Brand prescription</li> <li>• \$75 co-pay per Specialty prescription</li> </ul>	
Mail Order Drug Benefit up to 90-day supply per prescription.	<ul style="list-style-type: none"> <li>• \$35 co-pay per Generic prescription,</li> <li>• \$85 co-pay per Formulary Brand prescription,</li> <li>• \$135 co-pay per Non- Formulary Brand prescription</li> </ul>	
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	

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### III. Wellness Care

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<p><i>The Preventive Care Services benefit listed below, covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention and appear on the immunization schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA).</i></p>		
<p><b>Preventive Care Services</b> <i>(must be billed with a routine diagnosis)</i>            This plan includes coverage for physical exams, immunizations, tests, x-rays, pap smears and analysis, mammograms (age 40 and older, one per person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and sigmoidoscopies/colonoscopies (age 50 and older, every 5 Calendar Years, but not both).  <u>This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI's, PET or other similar tests)</u></p>	100% <u>Deductible Waived</u>	50% After the Deductible
<p><b>Routine Vision Exam</b> <i>(one exam paid every 24 months)</i>            Note routine vision exams from birth to age 5 are payable under the "Preventive Care Services" benefit above.</p>	\$25 co-pay, then 100%	Paid same as In-Network
<p><b>School Flu Shots and Health Screenings</b> <i>(provided at school site wellness events for covered employees and spouses)</i></p>	100% <u>Deductible Waived</u>	100% <u>Deductible Waived</u>

### IV. Physician Services

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<p><b>Primary Care Medically Necessary Physician Office Visit</b>  <i>(Exam charge only)</i></p> <p><i>Primary Care Physicians limited to: general practitioner, family practitioner, general internist, pediatrician, OB-GYN or urgent care physician.</i></p>	\$25 co-pay per visit, then 100%	50%
<p><b>Specialist Medically Necessary Physician Office Visit</b>  <i>(Exam charge only)</i>            If any wellness care is done in a specialist physician's office, such services will be subject to related plan maximums.</p>	\$40 co-pay per visit, then 100%	50%
<p><b>Allergy or B-12 Injections</b> when done in conjunction with an office visit co-pay (see above)</p>	100% <u>Deductible Waived</u>	50%

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## IV. Physician Services

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
Allergy or B-12 Injections when <u>not</u> done in conjunction with an office visit co-pay	80% <u>Deductible Waived</u>	50%
Outpatient (including office and independent laboratories) Diagnostic Testing and Interpretation (limited to X-rays and laboratory services)	100% <u>Deductible Waived</u>	50%
	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)	
Outpatient (including office and independent laboratories) Diagnostic Testing and Interpretation for MRI, CAT and PET scan services, and other generally accepted diagnostic tests	80%	50%
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	50%
Nutritional Counseling (up to 3 visits are covered when prescribed by your physician and a medical condition exists)	\$25 co-pay per visit, then 100%	50%
Physician Charges for Surgery and Anesthesia regardless of where performed.	80%	50%
Second Surgical Opinion (not required). Includes associated lab tests and x-rays.	\$35 co-pay per office visit (for exam charge only); related outpatient diagnostic charges paid as shown above	50%
Physical, Speech, Occupational, Biofeedback and Inversion Therapy (maximum of 20 visits per Calendar Year per each therapy type, without medical certification as to the need for additional visits). Specific conditions apply.	80%	50%
Other Therapy Services (dialysis, radiation, chemotherapy and respiratory therapy)	80%	50%
Chiropractic Services (maximum of 24 visits per Participant per Calendar Year).	\$25 co-pay per visit, then 100%	50%
Urgent Care Facility Services (professional and facility services provided; this includes non-routine care by Student Health Facilities)	\$40 co-pay per visit, then 100%	\$40 co-pay per visit, then 100% (limited to U&C for physician services)
Other Physician Services (except as may be stated differently in the Plan Document)	80%	50%

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## V. Facility Services

PPO Plan			
BENEFITS and PROVISIONS	IN NETWORK Tier 1	IN NETWORK Tier 2	OUT OF NETWORK
<b>Inpatient Hospital Services</b> <ul style="list-style-type: none"> <li>Room and board not to exceed the semi-private room rate unless when required due to Medically Necessary isolation purposes, and</li> <li>Necessary services and supplies including, but not limited to intensive care unit and a cardiac care unit</li> </ul>	80% After the Deductible	\$300 co-pay, then paid at 70% After the Deductible	50% After the Deductible
<b>Emergency Room Services</b> (professional and facility services provided) <i>Co-pay will be waived if admitted.</i>	\$150 co-pay, then paid at 100% <u>Deductible Waived</u>		
<b>Routine Outpatient Facility Diagnostic Testing</b> (limited to X-rays and Lab Tests)	100% <u>Deductible Waived</u>	100% <u>Deductible Waived</u>	50%
<b>Non-Routine Outpatient Facility Diagnostic Testing</b> (limited to X-rays and Lab Tests)	80% <u>Deductible Waived</u>	80% <u>Deductible Waived</u>	50%
<b>Outpatient Facility Diagnostic Testing</b> for MRI, CAT and PET scan services, and other generally accepted diagnostic tests)	80%	70%	50%
<b>Other Outpatient Facility Services</b> (including Birthing Centers)	80%	80%	50%
<b>Ambulatory Surgical Facility</b>	80%	80%	50%
<b>Home Health Care</b> when provided by a licensed home health care agency in accordance with a written treatment plan prepared by the patient's attending Physician. 60 day limit per Calendar Year.	80%	80%	50%
<b>Hospice Care</b> (appropriate Inpatient and Outpatient services applicable when the patient is not expected to live more than six months)	80%	80%	Paid at In-Network Level
<b>Extended Care Facility (also known as Skilled Nursing Facility) – Includes:</b> <ul style="list-style-type: none"> <li>room, board and floor nursing care (up to the facility's semi-private room rate)</li> <li>physical, occupational or speech therapy</li> <li>drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patients</li> </ul>	80%	80%	50%

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## VI. Mental Health Services

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<b>Mental Health Services (Mental/Nervous, Alcohol and Drug Abuse)</b>		
<b>Inpatient</b> ( <i>Pre-certification applies</i> )	80%	50%
<b>Outpatient</b> ( <i>note that medication management office visits will also be paid under this benefit</i> )	\$25 co-pay per visit for individual sessions, then 100% \$15 co-pay per visit for group sessions, then 100%	50%

## VII. Other Services

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<b>Ambulance Service</b> <i>by ground or air as Medically Necessary</i>	80%	Paid at In-Network Level
<b>Durable Medical Equipment</b> ( <i>purchase or rental- up to purchase price – of Durable Medical Equipment</i> )	80%	50%
<b>Hearing Aids for routine hearing loss</b> ( <i>devices only; subject to a maximum payment of \$500 for both ears within a 3 year replacement cycle; fittings are not covered</i> ).	100%	50%
<b>Smoking/Tobacco Cessation Treatment</b> <i>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.</i>	50% <u>Deductible waived</u>	50% <u>Deductible waived</u>
<b>Prosthetics</b> ( <i>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</i> ).	80%	50%
<b>Orthotics</b> ( <i>custom made when Medically Necessary – does not include corrective shoes</i> )	80%	50%
<b>Wigs after Chemo or Radiation therapy</b> ( <i>limited to a Calendar Year maximum payment of \$200</i> )	80%	50%
<b>Well Newborn Care</b> ( <i>other than as covered under the Wellness Care benefit</i> ) <i>includes but is not limited to Nursery Care Services and Circumcision.</i>	80%	50%
<b>Blood and blood products</b> ( <i>if not donated or replaced</i> ), <b>intravenous injections and solutions</b>	80%	50%

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## VII. Other Services

PPO Plan		
BENEFITS and PROVISIONS	IN NETWORK	OUT OF NETWORK
<b>Organ Transplant Coverage</b> (covered transplants are listed in the Plan Document) <b>Per Transplant Donor Coverage Maximum of \$5,000</b>	80%	50%
<b>Infertility Treatment</b> (any services for the promotion of conception including but not limited to: in-vitro fertilization, artificial insemination, GIFT or ZIFT, and prescription drugs related to treatment of infertility).	Not Covered	Not Covered
<b>Jaw Joint Treatment.</b> Covered Services include one jaw joint appliance but will not include orthodontic related expenses even if Medically Necessary.	80%	50%
<b>Orthopedic Equipment and Appliances</b>	80%	50%
<b>Maternity Services</b> (covered same as any illness and includes charges for prenatal, delivery and postpartum services)	80%	50%
<b>Dental Related Treatment</b> (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%	50%
<b>Voluntary Sterilization</b> (but not the reversal of such procedures)	80%	50%
<b>Cosmetic Surgery</b> 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%	50%
<b>Gastric Bypass surgery</b>	Not Covered	Not Covered
<b>Pre-Existing Conditions</b> (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. Pre-Existing Conditions do not apply to members or dependents under age 19.	50%	Not Applicable
<b>Services provided by a non-patient selected Out of Network Physician while being treated in a Network Hospital</b>	Not Applicable	Paid same as In-Network
<b>Other Covered Services and Items</b>	80% Unless included under a previous category	50% Unless included under a previous category

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