EPO SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. Medical Care Benefits

<table>
<tr><th colspan="3">EPO Plan</th></tr>
<tr><th><u>BENEFITS and PROVISIONS</u></th><th>MERCY NETWORK</th><th>OUT-OF-NETWORK</th></tr>
<tr><td rowspan="2">Calendar Year Deductible</td><td>Individual = $650
Family = $1,300</td><td>No Out-of-Network benefits available</td></tr>
<tr><td colspan="2">Note: In-Network and Out-of-Network Deductibles are separately tracked.</td></tr>
<tr><td>Deductible Carry-Over</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="2">Out-of-Pocket Maximum per Calendar Year (Medical and Rx co-pays, co-insurance and deductibles count towards the Out-of-Pocket Maximum) 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>.

Note the exceptions to this provision shown at right do not apply to and are not affected by this provision.</td><td>$2,650 per Individual
$5,300 per Family</td><td>No Out-of-Network benefits available</td></tr>
<tr><td colspan="2"><u>Medical Expenses Not Included</u> under this provision are as follows:
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.</td></tr>
<tr><td>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.</td><td colspan="2">TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD</td></tr>
<tr><td>Annual Maximum</td><td colspan="2">Unlimited</td></tr>
<tr><td>Claims Filing Limit</td><td colspan="2">All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.</td></tr>
<tr><td>Coordination of Benefits</td><td colspan="2">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.</td></tr>
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II. Prescription Drug Benefits

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Separate Retail Prescription Deductible per Calendar Year	Not Applicable	
Prescription Drug Card Program (*up to 30-day supply through participating pharmacies)* *Note: Non-preferred Brand drugs are not covered under this Plan.*	• $15 co-pay per Generic prescription, • $35 co-pay per Brand prescription, • $75 co-pay per Specialty prescription. ***Annual Deductible Does not apply. Once the Out-of-Pocket Maximum has been met**, the Plan will pay 100% for **covered** prescription drugs for the remainder of the Calendar Year.*	
Mail Order Drug Benefit (up *to 90-day supply per prescription)* *Note: Non-preferred Brand drugs are not covered under this Plan.*	• $35 co-pay per Generic prescription, • $85 co-pay per Brand prescription. ***Annual Deductible does not apply. Once the Out-of-Pocket Maximum has been met**, the Plan will pay 100% for **covered** prescription drugs for the remainder of the Calendar Year.*	
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.	

Contraception and contraceptive counseling - The Butler Health Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered at no cost to you as the plan participant. Brand and Non-Formulary contraceptives will remain covered, but you will be responsible for the standard copay. For additional information about your contraceptive benefits, including the applicable copay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at www.express-scripts.com.

III. Preventative Care Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
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, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.		
Preventive Care Services (*must be billed with a routine diagnosis)* 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). This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI's, PET or other similar tests)	100% Deductible Waived	No Out-of-Network benefits available
Routine Vision Exam *(one exam paid every 24 months)* *Note: Routine visions exams from birth to age 5 are payable under the "Preventive Care Services" benefit above.*	$15 co-pay, then 100% Deductible Waived	Paid same as In-Network
Breast Pumps and Supplies *(includes breast pumps and supplies purchased through a retail supplier)* *Limited to a maximum payment of $450 (includes pump and supplies) per person per pregnancy.*	100% Deductible Waived	100% Deductible Waived
Family Planning - Permanent Procedures for Women *Includes: Sterilization.*	100% Deductible Waived	No Out-of-Network benefits available
Family Planning – Temporary Procedures *(including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal)*	100% Deductible Waived	No Out-of-Network benefits available
Flu Shots and Health Screenings	100% Deductible Waived	No Out-of-Network benefits available

IV. Physician Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Primary Care Medically Necessary Physician Office Visit (*Exam charge including diagnostics performed during the office visit limited to X-rays and laboratory services.*) *Primary Care Physicians limited to: general practitioner, family practitioner, general internist, pediatrician, OB-GYN, urgent care physician, and all covered Mental Health providers.* *Co-pay applies to exam charge only.*	$15 co-pay per exam, then 100% Deductible Waived	No Out-of-Network benefits available

IV. Physician Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Specialist Medically Necessary Physician Office Visit (*Exam charge including diagnostics performed during the office visit limited to X-rays and laboratory services.*) *If any wellness care is done in a specialist physician's office, such services will be subject to related Plan maximums.* *Co-pay applies to exam charge only.*	$30 co-pay per exam, then 100% Deductible Waived	No Out-of-Network benefits available
Allergy or B-12 Injections (*when done in conjunction with an office visit co-pay)*	100% Deductible Waived	No Out-of-Network benefits available
Allergy or B-12 Injections *(when not done in conjunction with an office visit co-pay)*	80% Deductible Waived	No Out-of-Network benefits available
Outpatient *(independent laboratories)* **Diagnostic Testing and Interpretation** (*limited to X-rays and laboratory services)*	100% Deductible Waived	No Out-of-Network benefits available
	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 *(independent laboratories)* **Diagnostic Testing and Interpretation** for *MRI, CAT and PET scan services, and other generally accepted diagnostic tests*	80% After the Deductible	No Out-of-Network benefits available
Nutritional Counseling (up to 3 visits are covered when prescribed by your physician and a medical condition exists)	$15 co-pay per visit, then 100% Deductible Waived	No Out-of-Network benefits available
Physician Charges for Surgery *(regardless of where performed)*	80% After the Deductible	No Out-of-Network benefits available
Second Surgical Opinion *(not required)(includes associated lab tests and x-rays)*	$30 co-pay per office visit (for exam charge only) Deductible Waived; related outpatient diagnostic charges paid as shown above	No Out-of-Network benefits available
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% After the Deductible	No Out-of-Network benefits available
Other Therapy Services *(dialysis, radiation, chemotherapy and respiratory therapy)*	80% After the Deductible	No Out-of-Network benefits available
Chiropractic Services *(maximum of 24 visits per Participant per Calendar Year)*	$15 co-pay per visit, then 100% Deductible Waived	No Out-of-Network benefits available
Urgent Care Facility Services *(professional and facility services provided; includes non-routine care by Student Health Facilities)*	$40 co-pay per visit, then 100% Deductible Waived	No Out-of-Network benefits available
Other Physician Services *(except as may be stated differently in the Benefit Book)*	80% After the Deductible	No Out-of-Network benefits available

V. Facility Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY 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* • *Necessary services and supplies including, but not limited to intensive care unit and a cardiac care unit* • *Admissions through the Emergency Room for Tier 2 providers will be payable at the Tier 1 level*	80% After the Deductible	No Out-of-Network benefits available
Outpatient Surgical Center Services and Ambulatory Surgical Facility *(including Birthing Centers)*	80% After the Deductible	No Out-of-Network benefits available
Emergency Room Services (*professional and facility services provided; co-pay will be waived if admitted)*	$200 co-pay, then paid at 100% Deductible Waived	
Routine Outpatient Facility Diagnostic Testing (*limited to X-rays and Lab Tests)*	100% Deductible Waived	No Out-of-Network benefits available
Non-Routine Outpatient Facility Diagnostic Testing (*limited to X-rays and Lab Tests)*	80% Deductible Waived	No Out-of-Network benefits available
Outpatient Facility Diagnostic Testing *(MRI, CAT and PET scan services, and other generally accepted diagnostic tests)*	80% After the Deductible	No Out-of-Network benefits available
Other Outpatient Facility Services	80% After the Deductible	No Out-of-Network benefits available
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. 60 day limit per Calendar Year)*	80% After the Deductible	No Out-of-Network benefits available
Hospice Care *(appropriate Inpatient and Outpatient services applicable when the patient is not expected to live more than six months)*	80% After the Deductible	No Out-of-Network benefits available
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 inpatients*	80% After the Deductible	No Out-of-Network benefits available

VI. Mental Health Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Mental Health Services (Mental/Nervous, Alcohol and Drug Abuse)		
Inpatient *(pre-certification applies)*	80% After the Deductible	No Out-of-Network benefits available
Outpatient *(Note: medication management office visits will also be paid under this benefit)*	$15 co-pay per visit for individual sessions, then 100% Deductible Waived $15 co-pay per visit for group sessions, then 100% Deductible Waived	No Out-of-Network benefits available

VII. Other Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Ambulance Service *(ground or air as Medically Necessary)*	80% After the Deductible	Paid at In-Network Level
Durable Medical Equipment *(purchase or rental- up to purchase price – of Durable Medical Equipment)*	80% After the Deductible	No Out-of-Network benefits available
Hearing Aids for routine hearing loss *(devices only; subject to a maximum payment of $500 for both ears within a 3 year replacement cycle; fittings are not covered)*	100% After the Deductible	No Out-of-Network benefits available
Smoking/Tobacco Cessation Treatment *(limited to hypnosis and smoking/tobacco cessation sessions by qualified organizations. Prescription smoking cessation medications are covered under the Prescription Drug Card benefit. Not covered treatment includes gum, books, tapes, videos and mail order programs)*	50% Deductible waived	No Out-of-Network benefits available
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% After the Deductible	No Out-of-Network benefits available
Orthotics *(custom made when Medically Necessary – does not include corrective shoes)*	80% After the Deductible	No Out-of-Network benefits available
Wigs after Chemo or Radiation therapy *(limited to a Calendar Year maximum payment of $200)*	80% After the Deductible	No Out-of-Network benefits available
Well Newborn Care (*other than as covered under the Wellness Care benefit, includes but is not limited to Nursery Care Services and Circumcision)*	80% After the Deductible	No Out-of-Network benefits available
Blood and Blood Products *(if not donated or replaced)***, Intravenous Injections and Solutions**	80% After the Deductible	No Out-of-Network benefits available

VII. Other Services

EPO Plan		
BENEFITS and PROVISIONS	**MERCY NETWORK**	**OUT-OF-NETWORK**
Organ Transplant Coverage *(covered transplants are listed in the Benefit Book; per Transplant Donor Coverage Maximum of $5,000)*	80% After the Deductible	No Out-of-Network benefits available
Infertility Treatment *(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	No Out-of-Network benefits available
Jaw Joint Treatment *(covered Services include one jaw joint appliance but will not include orthodontic related expenses even if Medically Necessary*)	80% After the Deductible	No Out-of-Network benefits available
Orthopedic Equipment and Appliances	80% After the Deductible	No Out-of-Network benefits available
Maternity Services *(covered same as any Illness and includes charges for prenatal, delivery and postpartum services)*	80% After the Deductible	No Out-of-Network benefits available
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% After the Deductible	No Out-of-Network benefits available
Men's Voluntary Sterilization *(but not the reversal of such procedures)*	80% After the Deductible	No Out-of-Network benefits available
Cosmetic Surgery *(limited to surgical charges for reconstructive surgery following mastectomy, as mandated by the Women's Health and Cancer Rights Act, or to treat an accidental Injury or birth defect)*	80% After the Deductible	No Out-of-Network benefits available
Gastric Bypass surgery	Not Covered	Not Covered
Services provided by a non-patient selected Out-of-Network Physician while being treated in a In-Network Hospital	Not Applicable	Paid same as In-Network
Other Covered Services and Items	80% After the Deductible Unless included under a previous category	No Out-of-Network benefits available unless included under a previous category