



## Bankers Health Trust

Medical Benefits for Group **001N47** – Provider Network Plan Effective 7/1/08

	Network	Non-Network
<b>Calendar Year /Policy Deductible &amp; Out-Of-Pocket (including deductible)</b>		
Annual Deductible Single:	\$400	\$400
Family:	\$800	\$800
Annual Out-of-Pocket Single:	\$2,000	\$4,000
Family:	\$4,000	\$8,000

Expenses eligible to accumulate towards a member's Out-Of-Pocket Maximum include Deductible and Co-Insurance only. Member copays (Prescriptions, Office Visits, In-Patient Hospital, etc.) and expenses resulting from Non-Precertification penalties or charges for ineligible benefit types are not counted towards the Out-Of-Pocket maximum.

The Family Deductible and Out-of-Pocket Maximum are satisfied by a combination of all covered family members.

### Preventive Care

Routine Physical Exams including: -Gynecological exam and Pap Smears -Routine Mammograms -Routine Prostate Screening & Lab -Total Serum Cholesterol -Adult Immunizations	\$20 copay then 100%	*70% R & C after deductible
Routine Pediatric Care & Immunizations	\$20 copay then 100%	*70% R & C after deductible

### Doctor's Services

Office Visits	\$20 copay then 100%	*70% R & C after deductible
Chiropractic Care & Manual Spinal Manipulation (36 visits/cy)	80% after deductible	*60% R & C after deductible
Inpatient Physician Hospital Care including: -Surgery -Maternity -Chemo/Radiation	80% no deductible 80% no deductible 80% no deductible	*60% R & C after deductible *60% R & C after deductible *60% R & C after deductible
Outpatient Physician Hospital Care including: -Surgery -Maternity -Chemo/Radiation	80% after deductible 80% after deductible 80% after deductible	*60% R & C after deductible *60% R & C after deductible *60% R & C after deductible
Emergency Room Physician	100%	*100% R & C

### Hospital Services – Inpatient\*\*

Room and Board	80% no deductible	*80% R & C no deductible
Surgical Facility	80% no deductible	*80% R & C no deductible
Maternity Services	80% no deductible	*80% R & C no deductible
Newborn Care	80% no deductible	*80% R & C no deductible
Miscellaneous Hospital Charges & Supplies	80% no deductible	*80% R & C no deductible

**An Inpatient co-pay of \$400 applies to any In-patient admission (hospital, psychiatric, substance abuse) one (1) per person per calendar year.**

### Hospital Services - Outpatient

Surgical Facility & Supplies**	80% after deductible	*80% R & C after deductible
Clinic Service/Infirmary	80% after deductible	*80% R & C after deductible
Emergency Room Facility Charge	\$50 copay then 100%	\$50 copay then *100%

### Mental Health

#### Inpatient\*\*

Hospital/ Lic. Treatment Ctr./ Doctor's Services	80% no deductible	*80% R & C no deductible
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**(One (1) Inpatient Day= Two (2) day Treatment Sessions limited to 31 days/cy or Equivalent)**

#### Outpatient (40 visits/cy)

Office Visits & Outpatient Mental Facility	50% no deductible	*50% R & C no deductible
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### Alcohol and Drug Abuse Care

#### Inpatient\*\*

Hospital/ Lic. Treatment Center	80% no deductible	*80% R & C no deductible
Doctor's Services	80% no deductible	*60% R & C after deductible

#### Outpatient

Outpatient Treatment Ctr/ Clinic Services/Office	80% after deductible	*80% R & C after deductible
Outpatient Physician Hospital Visit/Care	80% after deductible	*60% R & C after deductible
Physician Office Visit	\$20 copay then 100%	*70% R & C after deductible



	<b>Network</b>	<b>Non-Network</b>
<b>Other Services</b>		
Ambulance	80% no deductible	*80% R & C no deductible
Anesthesia	80% no deductible	*80% R & C no deductible
Diagnostic Lab, X-Rays & Clinical Tests	80% no deductible	*80% R & C no deductible
Asthma Education (\$200/cy)	80% after deductible	*80% R & C after deductible
Diabetes Education & Training	80% after deductible	*80% R & C after deductible
Durable Medical Equipment (\$3,000/cy)	80% after deductible	*80% R & C after deductible
Private Duty Nursing	80% after deductible	*80% R & C after deductible
Home Health Care (\$10,000/cy)	80% after deductible	*80% R & C after deductible
Hospice Services	80% after deductible	*80% R & C after deductible
Skilled Nursing Facility (100 days/cy)	80% after deductible	*80% R & C after deductible
Inborn Errors in Metabolism (Special foods limit: \$3,000/cy)	80% after deductible	*80% R & C after deductible
Nicotine Replacement Therapy	80% after deductible	*80% R & C after deductible
Physical & Occupational Therapy (60 visits combined/cy)	80% after deductible	*80% R & C after deductible
Speech Therapy (40 visits/cy)	80% after deductible	*80% R & C after deductible
Prosthetics	80% after deductible	*80% R & C after deductible
Hearing Aids (birth-age 5)	up to \$1,400 per ear every 36 months	

**Infertility Benefit**

Infertility Treatment (\$50,000/lifetime maximum- \$45,000 for medical; \$5,000 for prescription drugs)		
Hospital Care**; Lab & X-Ray	80% no deductible	*80% R & C no deductible
Physicians Care	50% after deductible	*30% R & C after deductible

**Vision Care Benefit**

Routine Vision Exam (1 exam every 2 calendar years)	\$20 copay then 100%	*70% R & C after deductible
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**Prescription Drug Benefit through Caremark**

Retail up to 30 day supply:	\$12.50 Generic/ \$30 Preferred Brand \$50 Non-Preferred Brand
Mail Order: up to 90 day supply	\$25 Generic/ \$60 Preferred Brand \$100 Non-Preferred Brand

\* Plan participant is responsible for paying the amounts above Reasonable & Customary allowance when using a Non-network provider.

\*\*UTILIZATION REVIEW/HOSPITAL PRE-CERTIFICATION/LARGE CASE MANAGEMENT is provided by Care Management Services (CMS). The CMS toll-free number is located on your ID card. If you fail to follow the pre-admission certification requirements, you will be responsible for the first \$300 of otherwise covered charges of a hospital or other facility for each admission.

**Individual Lifetime Maximum-\$3,000,000**

**NOTES:**

a) This summary does not describe all terms, conditions and limitations. Refer to your Plan Document or contact your Benefits Manager for details.

b) Charges for the following and other mental health illnesses are excluded from this Plan's Mental Health benefit limitations: psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia & anorexia); & substance abuse-related disorders (including nicotine replacement therapy). Charges for these illnesses are paid the same as any other illness, in accordance to this Plan. Every one day of inpatient treatment will reduce the number of remaining day treatment days by two days. Conversely, every two days of day treatment will reduce the number of remaining inpatient treatment days by one day.

c) Covered expenses for outpatient diagnostic testing, lab and X-ray, prescription medicine, as well as services rendered for medical management of prescription medicines are excluded from the Mental Health maximum allowances defined above. They are inclusive with this Plan's Annual Out-Of-Pocket Maximum and the Maximum Lifetime Benefit, as defined herein. Covered expenses incurred as a result of inpatient and/or outpatient mental health (except for the mental health illness listed above) are excluded from the Out-Of-Pocket Maximum as defined herein.