

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
Preferred Provider Organization (PPO) Plan
Schedule of Benefits Effective January 1, 2009

Schedule of Benefits		
Service	PPO (In-Network)	Non-PPO (Out-of-Network)
Calendar Year <u>Deductible</u>		
Individual	\$200	\$300
Individual + 1 Dependent	\$400	\$600
Family	\$600	\$900
Annual <u>Out-of-Pocket Maximum</u>		
(Excludes Deductible)		
Individual	\$1,000	\$2,000
Individual + 1 Dependent	\$2,000	\$4,000
Family	\$3,000	\$6,000
Covered Medical Expenses		
Hospital Expenses		
Inpatient Facility		
Pre-Certification is required for all inpatient admissions or a penalty of 50% to \$500 will apply	\$100 Copay per confinement 100% up to \$5,000; 90% thereafter	70% of R&C after Deductible
Outpatient Facility	100%	70% of R&C after Deductible
Physician Expenses		
Inpatient Surgery/Anesthesia	90%	70% of R&C after Deductible
Inpatient Visits	90% after Deductible	70% of R&C after Deductible
Outpatient Surgery/Anesthesia	90%	70% of R&C after Deductible
Second/Third Opinions	100%	100% of UCR
Physician Office Visits	100% after \$15 Copay	70% of R&C after Deductible
Other Covered Expenses		
Acupuncture	100% after \$15 Copay	70% of R&C after Deductible
Allergy Injections	100%	70% of R&C after Deductible
Ambulance	Not available in-network. Seek out-of-network providers.	70% of R&C after Deductible
Birthing Facility	100%	100% of R&C
Chiropractic	100% after \$15 Copay	70% of R&C after Deductible
Diagnostic, X-ray/Lab	90%	70% of R&C after Deductible
Durable Medical Equipment	90% after Deductible	70% of R&C after Deductible
Emergency Room Care – Medical Emergencies	100% after \$50 Copay	100% of R&C after \$50 Copay
Emergency Room Care – For Non-Emergencies	90% after Deductible	70% of R&C after Deductible
Home Health Care	100% after \$15 Copay per visit	70% of R&C after Deductible
Hospice Care	100%	70% of R&C after Deductible
Infertility Testing	90% after Deductible	70% of R&C after Deductible
Physical Therapy	100% after \$15 Copay	70% of R&C after Deductible
Pre-Admission Testing	100%	100% of R&C
Private Duty Nursing	Not available in-network. Seek Out-of-network providers.	70% of R&C after Deductible
Radiation Therapy	90% after Deductible	70% of R&C after Deductible
Skilled Nursing Facility	90%	70% of R&C after Deductible
Urgent Care Centers	100% after \$15 Copay	70% of R&C after Deductible
All Other Eligible Expenses	90% after Deductible	70% of R&C after Deductible
R&C defined as fees usually charged by providers of services for similar services in your geographic area.		

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Preventive Care		
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Routine Physical Exams \$500 per calendar year, age 19+	100% after \$15 Copay	70% of R&C after Deductible
Routine Mammography No annual maximum	100% after \$15 Copay	70% of R&C after Deductible
Routine Colonoscopy No annual maximum	100% after \$15 Copay	70% of R&C after Deductible
Well-Child Care Under age 19	100% after \$15 Copay	70% of R&C after Deductible
Mental Health Substance Abuse		
Inpatient Hospital maximum of 60 days per calendar year	\$100 Copay per confinement 100% up to \$5,000; 90% thereafter 60 days per calendar year maximum	50% of R&C after Deductible 60 days per calendar year maximum
Inpatient Physician Visits	90% after Deductible	50% of R&C after Deductible
Outpatient	\$20 copay visit, then 100%	75% of R&C after Deductible for the first 40 visits, 60% thereafter
Prescription Drugs		
Retail Pharmacy (30 day Supply)	Generic: \$7 copay Formulary: \$25 Formulary Non-Formulary: \$40 copay	
Mail Order Pharmacy (90 day supply)	Generic: \$14 copay Formulary: \$50 Formulary Non-Formulary: \$80 copay	
Applies to Retail and Mail: Brand Drug when Generic is available: member pays generic co-pay, plus the difference between the brand and the generic product		
Annual Maximum Benefits		
When the annual out-of-pocket maximum is reached, plan payments made at 90% or 70% will increase to 100%. This does not include your deductible; copays paid to in-network providers; prescription drug copays; inpatient and outpatient charges for mental illness and substance abuse treatment; any benefit reduction for not following Hospital Pre-admission Certification requirements; and non-covered expenses, including charges that exceed usual, customary and reasonable charges.		
Service	Maximum Benefit	
Lifetime Maximum for All Covered Expenses	\$2,000,000	
Home Health Care	100 visits per Calendar Year	
Hospice Care	180 days per lifetime	
Infertility Testing	\$1,000 per Calendar Year	
Acupuncture	\$2,000 per Calendar Year	
Chiropractic	\$2,000 per Calendar Year	
Routine Physical	\$500 per Calendar Year	
Mammogram	No Annual Maximum	
Skilled Nursing Facility	100 days per Calendar Year	
Mental Health/Substance Abuse Inpatient Hospital	60 day maximum	
THIS IS JUST A SUMMARY. REFER TO THE PLAN DOCUMENT FOR FURTHER DETAILS.		