

# ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

## QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

| Summary of Benefits   |                                  |   |
|---|----------------------------------|---|
| <p><b>Important Note:</b> Do not rely on this chart alone. It is only a summary. The contents of this summary are subject to the provisions of the Certificate, which contains all terms, covenants and conditions of coverage. The Plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (for example, the Plan may require pre-certification or the use of specified Providers).</p> <p>Payments to Non-Network Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. In-Network payments are based on an allowance amount as contracted between the Provider and the network, at the benefit level specified in the summary below. Covered Services are subject to the Calendar Year Deductible and pre-certification requirement, as indicated.</p> |                                  |   |
| <p><b>Pre-Certification Requirement</b> - The items marked below with an asterisk (*) <i>require</i> pre-certification. The Participant is responsible for ensuring that the pre-certification process is initiated when necessary. Failure to pre-certify will result in a penalty to the Participant. Please refer to <i>Section 5 - Cost Containment Features</i>.</p>   |                                  |   |
| INDIVIDUAL LIFETIME MAXIMUMS  |                                  |   |
| Overall Medical Maximum   | Unlimited                        |   |
| Hospice Care  | 180 days                         |   |
| INDIVIDUAL CALENDAR YEAR MAXIMUMS   |                                  |   |
| Acupuncture   | \$2,000                          |   |
| Chiropractic Care   | \$2,000                          |   |
| Home Health Care  | 100 visits                       |   |
| Infertility Testing   | \$1,000                          |   |
| Skilled Nursing/Extended Care Facility  | 100 days                         |   |
| CALENDAR YEAR DEDUCTIBLE  | Network Provider<br>(In-Network) | Non-Network<br>Provider<br>(Out-of-Network) |
| Individual  | \$1,500                          |   |
| Individual and 1 Dependent  | \$3,000                          |   |
| Family<br>(Employee and 2 or more Dependents)   | \$3,000                          |   |
| <p>Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except Preventive Care, apply to the Deductible.</p> <p><u>Individual Deductible</u> – This Deductible must be met once each calendar year and applies to Covered Services indicated in the Summary of Benefits.</p> <p><u>Individual and 1 Dependent Deductible / Family Deductible</u> – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a</p>  |                                  |   |

| combination of family members.  |  |  |
|---|--|--|
| <b>CALENDAR YEAR<br/>OUT-OF-POCKET MAXIMUM</b>  | <b>Network Provider<br/>(In-Network)</b> | <b>Non-Network<br/>Provider<br/>(Out-of-Network)</b> |
| Individual  | \$2,000                                  | \$3,000  |
| Individual and 1 Dependent  | \$4,000                                  | \$5,000  |
| Family<br>(Employee and 2 or more Dependents)   | \$6,000                                  | \$7,000  |
| <p>The Out-of-Pocket Maximum is the amount you are responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, preventive care, expenses in excess of a benefit maximum, and charges in excess of the Allowed Benefit for Non-Network Providers.</p> <p><u>Individual Out-of-Pocket Maximum</u> – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.</p> <p><u>Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum</u> – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. Reduced limits for individual family members do not apply to the Out-of-Pocket Maximum. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for the remainder of the Calendar Year. The medical and prescription Coinsurance amounts will no longer apply.</p> |  |  |

| <b>TYPE OF EXPENSE</b>   | <b>Network Provider<br/>(In-Network)</b> | <b>Non-Network<br/>Provider<br/>(Out-of-Network)</b> |
|--|--|--|
| <b>Hospital and Other Facility Expenses</b>  |  |  |
| Inpatient * - includes room, board and ancillary services                          | 90%*<br>After Deductible                 | 70% of Allowed Benefit*<br>After Deductible          |
| Inpatient Newborn  | 90%<br>After Deductible                  | 70% of Allowed Benefit<br>After Deductible           |
| Skilled Nursing/Extended Care Facility*<br>(maximum of 100 days per calendar year) | 90%*<br>After Deductible                 | 70%* of Allowed Benefit<br>After Deductible          |
| Rehabilitation Facility*   | 90%*<br>After Deductible                 | 70% of Allowed Benefit *<br>After Deductible         |
| Emergency Room<br>- Accidental Injury or Medical Emergency                         | 90%<br>After Deductible                  | 90%<br>After Deductible                              |
| Emergency Room<br>- for HIV screening  | 100%                                     | 100%   |
| Emergency Room<br>- Non-Medical Emergency  | 90%<br>After Deductible                  | 70% of Allowed Benefit<br>After Deductible           |

|   |                         |  |
|---|-------------------------|--|
| Outpatient – includes all services billed by the Hospital   | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Ambulatory Surgical Facility  | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| <b>Professional Expenses</b>  |                         |  |
| Anesthesia (Inpatient and Outpatient)   | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Emergency Room<br>- Accidental Injury or Medical Emergency  | 90%<br>After Deductible | 90%<br>After Deductible                    |
| Emergency Room<br>- for HIV screening   | 100%                    | 100%                                       |
| Emergency Room<br>- Non-Medical Emergency   | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Physician hospital visit  | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Physician office visit – Primary Care Physician (PCP)<br>(PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist) | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Physician office visit - Specialist   | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Second Surgical Opinion   | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |
| Surgery (Inpatient and Outpatient)  | 90%<br>After Deductible | 70% of Allowed Benefit<br>After Deductible |

\* Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

| TYPE OF EXPENSE   | Network Provider<br>(In-Network)           | Non-Network<br>Provider<br>(Out-of-Network) |
|---|--|---|
| <b>Other Eligible Expenses</b>                                  |  |   |
| Acupuncture<br>(maximum of \$2,000 per calendar year)           | 90%<br>After Deductible                    | 70% of Allowed Benefit<br>After Deductible  |
| Allergy shots/serum<br>(if billed separately from office visit) | 90%<br>After Deductible                    | 70% of Allowed Benefit<br>After Deductible  |
| Allergy Testing<br>- Primary Care Physician<br>- Specialist     | 90%<br>After Deductible                    | 70% of Allowed Benefit<br>After Deductible  |
| Ambulance   | 90% of Allowed Benefit<br>After Deductible |   |
| Cardiac Rehabilitation  | 90%<br>After Deductible                    | 70% of Allowed Benefit<br>After Deductible  |
| Chiropractic Care<br>(maximum of \$2,000 per calendar year)     | 90%<br>After Deductible                    | 70% of Allowed Benefit<br>After Deductible  |

|   |                         |   |
|---|-------------------------|---|
| Durable Medical Equipment   | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Home Health Care<br>(maximum of 100 visits per calendar<br>year)              | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Home Infusion Therapy   | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Hospice Care<br>(maximum of 180 days per Lifetime)                            | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Infertility Testing<br>(maximum of \$1,000 per calendar year)                 | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Laboratory tests, x-rays and diagnostic<br>tests, including specialty imaging | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Orthopedic Appliance  | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Patient Education (includes diabetes<br>management and ostomy care)           | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Pre-Admission Testing   | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Private Duty Nursing  | Not Covered             | Not Covered                                   |
| Prosthetics   | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Renal Dialysis  | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Therapy – Chemotherapy, Radiation,<br>Physical, Occupational, Speech          | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| Urgent Care Center  | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |
| All Other Eligible Expenses   | 90%<br>After Deductible | 70% of Allowed<br>Benefit<br>After Deductible |

| TYPE OF EXPENSE           | Network Provider<br>(In-Network) | Non-Network<br>Provider<br>(Out-of-Network)    |
|---------------------------|----------------------------------|--|
| <b>Maternity Services</b> |                                  |  |
| Inpatient Hospital*       | 90%*<br>After Deductible         | 70% of Allowed<br>Benefit*<br>After Deductible |
| Birthing Center           | 90%<br>After Deductible          | 70% of Allowed Benefit<br>After Deductible     |
| Anesthesia                | 90%<br>After Deductible          | 70% of Allowed Benefit<br>After Deductible     |

|  |                          |  |
|--|--------------------------|--|
| Physician's Charges for Delivery   | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| Pre or postnatal office visits<br>(not billed with delivery)   | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| Laboratory tests, x-rays, diagnostic<br>tests, specialty imaging   | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| <b>Organ Transplants</b>   |                          |  |
| Inpatient Hospital*  | 90%*<br>After Deductible | 70% of Allowed<br>Benefit*<br>After Deductible |
| Anesthesia   | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| Transplant Procedure   | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| Laboratory tests, x-rays, diagnostic<br>tests  | 90%<br>After Deductible  | 70% of Allowed Benefit<br>After Deductible     |
| <b>Preventive Care</b>   |                          |  |
| Preventive and Wellness Services for<br>eligible adults and children in<br>compliance with PPACA**   | 100%                     | 70% of Allowed Benefit<br>After Deductible     |
| ** A description of these services can be found at:<br><a href="http://www.healthcare.gov/law/about/provisions/services/lists.html">http://www.healthcare.gov/law/about/provisions/services/lists.html</a> |                          |  |

\* Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

| TYPE OF EXPENSE   | Network Provider<br>(In-Network) | Non-Network<br>Provider<br>(Out-of-Network) |
|---|----------------------------------|---|
| <b>Mental Health and Substance Abuse</b>  |                                  |   |
| Inpatient Hospital or Residential Care<br>in a Hospital or Non-Hospital<br>Residential Facility*  | 90%*<br>After Deductible         | 70% of Allowed Benefit*<br>After Deductible |
| Inpatient Physician Visits  | 90%<br>After Deductible          | 70% of Allowed Benefit<br>After Deductible  |
| Outpatient  | 90%<br>After Deductible          | 70% of Allowed Benefit<br>After Deductible  |
| * Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256. |                                  |   |
| TYPE OF EXPENSE   | Retail<br>(30-day supply)        | Mail Order<br>(90-day supply)               |
| <b>Prescription Drugs</b>   |                                  |   |
| All prescription expenses are subject to the Deductible. After the Deductible has been satisfied, the following Coinsurance amounts will apply.   |                                  |   |
| Generic Drugs   | 90%<br>After Deductible          | 90%<br>After Deductible                     |
| Formulary Brand Name Drugs  | 90%<br>After Deductible          | 90%<br>After Deductible                     |
| Non-Formulary Brand Name Drugs  | 90%<br>After Deductible          | 90%<br>After Deductible                     |
| Over-the-Counter Drugs related to   | No Charge                        |   |

|  |  |
|--|--|
| Preventive and Wellness Services as specified by PPACA**   |  |
| **A description of these services can be found at:<br><a href="http://www.healthcare.gov/law/about/provisions/services/lists.html">http://www.healthcare.gov/law/about/provisions/services/lists.html</a>  |  |
| <b>NOTE:</b> A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the difference in price between the Brand Name drug and the Generic drug, after the Plan covers the cost of the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written". |  |

**Notes:**

1. Benefits for services provided by a Network Provider are payable as shown in the Summary of Benefits. To obtain In-Network benefits, you must use a Network Provider. Since Network Providers sometimes change, it is best to confirm that the Provider participates by calling the Provider prior to receiving services.
2. Referrals by Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider.
3. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician selected or had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.
4. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.
5. If a Participant is temporarily residing overseas, his/her claims will be paid at the Out-of-Network benefit level.
6. Prescription drugs purchased overseas are not covered.
7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Non-Network Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Provider must be the amount usually charged for similar services and supplies in the absence of a plan or insurance. Charges for Covered Services that do not exceed the Allowed Benefit will be reimbursed as specified in the Summary of Benefits. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

**PLAN PROVISIONS FOR THE QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN:**

**Deductible** – The Deductible is a specified dollar amount that must be paid for eligible expenses each calendar year, before the Plan will provide benefits. Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except Preventive Care, apply to the Deductible.

Individual Deductible – The Deductible for a Participant with individual coverage is shown in the Summary of Benefits. This Deductible must be met once each calendar year and applies to Covered Services indicated in the Summary of Benefits.

Individual and 1 Dependent Deductible / Family Deductible (Aggregate) – The Individual and 1 Dependent Deductible and the Family Deductible are shown in the Summary of Benefits. With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.

**Out-of-Pocket Maximum** – The Out-of-Pocket Maximum is the amount you are responsible for paying for a Covered Service. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, preventive care, expenses in excess of a benefit maximum, and charges in excess of the Allowed Benefit for Non-Network Providers.

Individual Out-of-Pocket Maximum – After a Participant with individual coverage meets the amount shown in the Summary of Benefits, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all eligible expenses for the remainder of that Calendar Year. The medical and prescription Coinsurance amounts will no longer apply.

Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – The Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum include Coinsurance expenses incurred by one or more family members. After the family's total out-of-pocket expenses reach the maximum amount shown in the Summary of Benefits, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all family members' eligible expenses for the remainder of that calendar year. The medical and prescription Coinsurance amounts will no longer apply.

**Prescription Coinsurance** - The amount (shown in the Summary of Benefits) that a Participant is required to pay for a covered prescription after the Deductible has been satisfied. Coinsurance is expressed as a percentage and continues to apply until the Out-of-Pocket Maximum is met.