

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY HEALTH BENEFIT PLAN

| Summary of Benefits | |
|---|--|
| <p>Important Note: 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. Your 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 (e.g., plans may require prior authorization, or use of specified Providers or facilities).</p> <p>Payments for Out-of 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 the allowable amount as contracted between the Provider and the PPO Network in the amounts specified in the summary shown below. Covered Services are subject to the Calendar Year Deductible and Pre-certification as indicated.</p> | |
| <p>Pre-certification Requirement - 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 member. Please refer to Section 5.</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 | |
| Individual | \$200 |
| Individual and 1 Dependent | \$400 |
| Family (Employee and 2 or more Dependents) | \$600 (No more than \$200 per Individual can be applied toward the Family Deductible) |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM | |
| Individual | \$2,000 |
| Individual and 1 Dependent | \$4,000 |
| Family (Employee and 2 or more Dependents) | \$6,000 |
| <p>The Out-of-Pocket Maximum is the amount you are responsible for paying for a covered service. Expenses for the following services do not count towards the Out of Pocket Maximum: deductibles, co-payments, pre-certification penalties and non-covered services.</p> | |

| TYPE OF EXPENSE | PPO Provider (In-Network) | Non-PPO Provider (Out-of-Network) |
|--|--|--|
| Hospital and Other Facility Expenses | | |
| Inpatient * - includes room, board and ancillary services | \$200 copay, then 100%* | Not Covered |
| Inpatient Newborn | \$200 copay, then 100% | Not Covered |
| Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year) | 80%* After deductible | Not Covered |
| Rehabilitation Facility* | 80%* After deductible | Not Covered |
| Emergency Room - Accidental or medical emergency | \$100 copay, then 100% Copay waived if admitted | \$100 copay, then 100% Copay waived if admitted |
| Emergency Room - for HIV screening | 100% | 100% |
| Emergency Room - non-emergency | 80% After deductible | Not Covered |
| Outpatient | 80% After deductible | Not Covered |
| Ambulatory Surgical Facility | 80% After deductible | Not Covered |
| Professional Expenses | | |
| Anesthesia (In and Outpatient) | 80% After deductible | Not Covered |
| Emergency Care in Emergency Room | 100% | 100% |
| Emergency Care in Emergency Room - for HIV screening | 100% | 100% |
| Non-emergency Care in Emergency Room | 80% After deductible | Not Covered |
| Physician hospital visit | 80% After deductible | Not Covered |
| Physician office visit – Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist, Psychologist) | \$25 copay per visit, then 100% | Not Covered |
| Physician office visit - Specialist | \$35 copay per visit, then 100% | Not Covered |
| Second Surgical Opinion | 80% After deductible | Not Covered |
| Surgery (In and Outpatient) | 80% After deductible | Not Covered |

* Pre-certification from InforMed is required. Contact them prior to admittance to an In Network hospital or facility or a penalty of 50% up to a maximum of \$500 will apply. Please call 866-475-1256.

| TYPE OF EXPENSE | PPO Provider (In-Network) | Non-PPO Provider (Out-of-Network) |
|---|--|--|
| Other Eligible Expenses | | |
| Acupuncture (maximum of \$2,000 per calendar year) | \$35 copay per visit, then 100% | Not Covered |
| Allergy shots/serum (if billed separately from office visit) | 80% After deductible | Not Covered |
| Allergy Testing - Primary Care Physician - Specialist | \$25 copay, then 100% \$35 copay, then 100% | Not Covered |
| Ambulance | Not available In-Network, seek Non-Network Provider | \$75 Copay, then 100% of Allowed Benefit |
| Cardiac Rehabilitation | 80% After deductible | Not Covered |
| Chiropractic Care (maximum of \$2,000 per calendar year) | 80% After deductible | Not Covered |
| Durable Medical Equipment | 80% After deductible | Not Covered |
| Home Health Care (maximum of 100 visits per calendar year) | 80% After deductible | Not Covered |
| Home Infusion Therapy | 80% After deductible | Not Covered |
| Hospice Care (maximum of 180 days per Lifetime) | 100% | Not Covered |
| Infertility Testing (maximum of \$1,000 per calendar year) | 80% After deductible | Not Covered |
| Laboratory tests, x-rays and diagnostic tests, including specialty imaging | 100% After deductible | Not Covered |
| Orthotics | 80% After deductible | Not Covered |
| Patient Education (includes diabetes management and ostomy care) | 80% After deductible | Not Covered |
| Pre-Admission Testing | 80% After deductible | Not Covered |
| Private Duty Nursing | Not Covered | Not Covered |
| Prosthetics | 80% After deductible | Not Covered |
| Renal Dialysis | 80% After deductible | Not Covered |
| Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech | 80% After deductible | Not Covered |
| Urgent Care Center | \$50 copay, then 100% | Not Covered |
| All Other Eligible Expenses | 80% After deductible | Not Covered |

| | PPO Provider (In-Network) | Non-PPO Provider (Out-of-Network) |
|---|---|--|
| Maternity Related Services | | |
| Inpatient Hospital* | \$200 copay, then 100%* | Not Covered |
| Birthing Center | 80% After deductible | Not Covered |
| Anesthesia | 80% After deductible | Not Covered |
| Physician's Charges for Delivery | 80% After deductible | Not Covered |
| Pre or post natal office visits (not billed with delivery) | \$25 copay per visit – PCP \$35 copay per visit - Specialist, then 100% | Not Covered |
| Laboratory tests, x-rays, diagnostic tests, specialty imaging | 100% After deductible | Not Covered |
| Organ Transplants | | |
| Inpatient Hospital* | 80%* After deductible | Not Covered |
| Anesthesia | 80% After deductible | Not Covered |
| Transplant Procedure (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow, peripheral stem cell) | 80% After deductible | Not Covered |
| Laboratory tests, x-rays, diagnostic tests | 100% After deductible | Not Covered |
| PREVENTIVE CARE | | |
| Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010. | 100% | Not Covered |
| Mental Health and Substance Abuse | | |
| Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility * | \$200 copay per confinement, then 100%* | Not Covered |
| Inpatient Physician Visits | 80% After deductible | Not Covered |
| Outpatient | \$25 copay per visit, then 100% | Not Covered |

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| PRESCRIPTION DRUGS | Retail (30-day supply) | Mail Order (90-day supply) |
|--|-----------------------------------|---------------------------------------|
| Generic Drugs | \$10 | \$20 |
| Formulary Brand Drugs | \$35 | \$70 |
| Non-formulary Brand Drugs | \$70 | \$140 |
| NOTE: A Brand Drug that has a Generic alternative is a Multisource Brand. If you are prescribed a Multisource Brand and you purchase a Brand Drug, when a Generic is available, you will pay the Generic Copay plus the difference in price between the Brand and the Generic. You will be required to pay this difference, even if your doctor writes "Dispense as Written". | | |
| Over-the-Counter Option | | |
| Non-sedating antihistamines and Prilosec (Please refer to Notes #7 & #8 below) | Generic copay of \$10 | |

Note:

1. Benefits for services provided by a Network Provider are payable as shown in the Schedule of Benefits. To obtain In-Network benefits you must use a participating In-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 In-Network Providers to Out-of-Network Providers will be considered as Out-of-Network services and are not covered expenses. In order to receive In-Network benefits, ask your Physician to refer you to an In-Network Provider. However:
 - a. If you utilize an In-Network facility and receive services from a Provider who does not participate with the Network, or
 - b. If Medically Necessary services are not available In-Network (because the PPO does not contract with the appropriate specialty) the charges will be considered at the In-Network benefit level outlined in the Summary of Benefits and treated as an In-Network Provider subject to the Reasonable and Customary Allowance. All other limitations, requirements and provisions of this Plan will apply.

This exception does not apply in the event of situations in which you and/or your Physician had the opportunity to select an In-Network Provider and exercised the right to receive services from a Non-Network Provider.

3. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.
4. Anesthesia, x-rays, laboratory, emergency room services, and other diagnostic services received at a PPO facility and rendered and billed by a Provider who is not a Member of the PPO will be paid at the In-Network benefit level. This exception does not apply in the event of consultations and situations in which you and/or your Physician selected or had the opportunity to select a PPO Physician and exercised the right to receive services from a non-PPO Provider.
5. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network laboratory for analysis and results, the Plan will pay the Network level of benefits.
6. Prescription drugs purchased overseas are not covered.
7. Guidelines for Non Sedating Antihistamines - Non Sedating Antihistamines are available in prescription and Over the Counter form. Your doctor can prescribe either form. The following guidelines explain the benefits:
 - Over the Counter (OTC) – Benefits are provided for all OTC non-sedating antihistamines at the generic Copayment. This benefit includes OTC Claritin and

Loratadine (by various companies). Keep in mind that in order for the OTC drug to be covered, you must have a prescription from your Physician.

- Brand Prescriptions – Benefits are not provided for prescribed non-sedating antihistamines. If you choose to purchase prescription Allegra, Claritin, Clarinex, or Zyrtec, you will have to pay the entire amount for the prescription.
8. Benefits are provided for OTC Prilosec, when prescribed by your Physician.
 9. If the Employee or his/her Dependent receives emergency accident care or emergency medical care at an Out-of-Network facility/provider, eligible expenses will be covered at the In-Network benefit level specified in the Schedule of Benefits. If the Employee or his/her Dependent is admitted on an emergency basis to the facility, benefits for eligible expenses for that admission will be paid at the In-Network benefit level specified in the Schedule of Benefits.
 10. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by an Out-of-Network provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a Licensed 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 Schedule of Benefits. A fee schedule, approved by NCAS, may be used by the Plan in determining the amount of the Allowed Benefit.