

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY**

**PPO HEALTH BENEFIT PLAN**

<b>Summary of Benefits</b>		
<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 benefits 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><b>Pre-certification Requirement</b> - The items marked below with an asterisk (*) <u>require</u> 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.</p>		
<b>INDIVIDUAL LIFETIME MAXIMUMS</b>		
Overall Medical Maximum	Unlimited	
Hospice Care	180 days	
<b>INDIVIDUAL CALENDAR YEAR MAXIMUMS</b>		
Acupuncture	\$2,000	
Chiropractic Care	\$2,000	
Home Health Care	100 visits	
Infertility Testing	\$1,000	
Skilled Nursing/Extended Care Facility	100 days	
	<b>Network Provider (In-Network)</b>	<b>Non-Network Provider (Out-of-Network)</b>
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Individual	\$200	\$300
Individual and 1 Dependent	\$400	\$600
Family (Employee and 2 or more Dependents)	\$600 (No more than \$200 per Individual can be applied toward the Family Deductible)	\$900 (No more than \$300 per Individual can be applied toward the Family Deductible)
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b>		
Individual	\$1,000	\$2,000
Individual and 1 Dependent	\$2,000	\$4,000
Family (Employee and 2 or more Dependents)	\$3,000	\$6,000
<p>The Out-of-Pocket (OOP) 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, non-covered services.</p>		

<b>TYPE OF EXPENSE</b>	<b>Network Provider (In-Network)</b>	<b>Non-Network Provider (Out-of-Network)</b>
<b>Hospital and Other Facility Expenses</b>		
Inpatient * - includes room, board and ancillary services	\$100 copay, then 100% up to \$5,000, then 90% per confinement*	70% of Allowed Benefit* After deductible
Inpatient Newborn	\$100 copay, then 100% up to \$5,000, then 90% per confinement	70% of Allowed Benefit After deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90%*	70% of Allowed Benefit* After deductible
Rehabilitation Facility*	90%*	70% of Allowed Benefit* After deductible
Emergency Room - Accidental or medical emergency	\$50 copay, then 100% Copay waived if admitted	\$50 copay, then 100% Copay waived if admitted
Emergency Room - for HIV screening	100%	100%
Emergency Room - non-emergency	90% After deductible	70% of Allowed Benefit After deductible
Outpatient	100%	70% of Allowed Benefit After deductible
Ambulatory Surgical Facility	100%	70% of Allowed Benefit After deductible
<b>Physician Expenses</b>		
Anesthesia (In and Outpatient)	90%	70% of Allowed Benefit After deductible
Emergency Care in Emergency Room	100%	100%
Emergency Care in Emergency Room - for HIV screening	100%	100%
Non-emergency Care in Emergency Room	90% After deductible	70% of Allowed Benefit After deductible
Physician hospital visit	90% After deductible	70% of Allowed Benefit After deductible
Physician office visit - Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist)	\$20 copay per visit, then 100%	70% of Allowed Benefit After deductible
Physician office visit - Specialist	\$30 copay per visit, then 100%	70% of Allowed Benefit After deductible
Second Surgical Opinion	100%	100%
Surgery (In and Outpatient)	90%	70% of Allowed Benefit After deductible

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

<b>TYPE OF EXPENSE</b>	<b>Network Provider (In-Network)</b>	<b>Non-Network Provider (Out-of-Network)</b>
<b>Other Eligible Expenses</b>		
Acupuncture (maximum of \$2,000 per calendar year)	\$30 copay per visit, then 100%	70% of Allowed Benefit After deductible
Allergy shots/serum (if billed separately from office visit)	100%	70% of Allowed Benefit After deductible
Allergy Testing - Primary Care Physician - Specialist	\$20 copay, then 100% \$30 copay, then 100%	70% of Allowed Benefit After deductible
Ambulance	Not available In-Network Seek Non-Network Provider	70% of Allowed Benefit After deductible
Cardiac Rehabilitation	90% After deductible	70% of Allowed Benefit After deductible
Chiropractic Care (maximum of \$2,000 per calendar year)	\$30 copay per visit, then 100%	70% of Allowed Benefit After deductible
Durable Medical Equipment	90% After deductible	70% of Allowed Benefit After deductible
Home Health Care (maximum of 100 visits per calendar year)	\$20 copay per visit, then 100%	70% of Allowed Benefit After deductible
Home Infusion Therapy	90% After deductible	70% of Allowed Benefit After deductible
Hospice Care (maximum of 180 days per Lifetime)	100%	70% of Allowed Benefit After deductible
Infertility Testing (maximum of \$1,000 per calendar year)	90% After deductible	70% of Allowed Benefit After deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90%	70% of Allowed Benefit After deductible
Orthotics	90% After deductible	70% of Allowed Benefit After deductible
Patient Education – (includes diabetes management, ostomy care)	90% After deductible	70% of Allowed Benefit After deductible
Pre-Admission Testing	100%	100%
Private Duty Nursing	Not available In-Network Seek Non-Network Provider	70% of Allowed Benefit After deductible
Prosthetics	90% After deductible	70% of Allowed Benefit After deductible
Renal Dialysis	90% After deductible	70% of Allowed Benefit After deductible
Therapy – Physical	\$30 copay per visit, then 100%	70% of Allowed Benefit After deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% After deductible	70% of Allowed Benefit After deductible
Urgent Care Center	\$35 copay per visit, then 100%	70% of Allowed Benefit After deductible
All Other Eligible Expenses	90% After deductible	70% of Allowed Benefit After deductible

<b>TYPE OF EXPENSE</b>	<b>Network Provider (In-Network)</b>	<b>Non-Network Provider (Out-of-Network)</b>
<b>Maternity Related Services</b>		
Inpatient Hospital*	\$100 copay, then 100% up to \$5,000, then 90% per confinement*	70% of Allowed Benefit* After deductible
Birthing Center	100%	100%
Anesthesia	90%	70% of Allowed Benefit After deductible
Physician's Charges for Delivery	90%	70% of Allowed Benefit After deductible
Pre or post natal office visits (not billed with delivery)	\$20 copay per visit – PCP \$30 copay per visit - Specialist, then 100%	70% of Allowed Benefit After deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90%	70% of Allowed Benefit After deductible
<b>Organ Transplants</b>		
Inpatient Hospital*	\$100 copay, then 100% up to \$5,000, then 90% per confinement*	70% of Allowed Benefit* After deductible
Anesthesia	90%	70% of Allowed Benefit After deductible
Transplant Procedure (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow, peripheral stem cell)	90%	70% of Allowed Benefit After deductible
Laboratory tests, x-rays, diagnostic tests	90%	70% of Allowed Benefit After deductible
<b>PREVENTIVE CARE</b>		
Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010.	100%	70% of Allowed Benefit After deductible
<b>Mental Health and Substance Abuse</b>		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	\$100 copay, then 100% up to \$5,000, then 90% per confinement*	70% of Allowed Benefit* After deductible
Inpatient Physician Visits	90% After deductible	70% of Allowed Benefit After deductible
Outpatient	\$20 copay per visit, then 100%	70% of Allowed Benefit After deductible

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

<b>PRESCRIPTION DRUGS</b>	<b>Retail (30-day supply)</b>	<b>Mail Order (90-day supply)</b>
Generic Drugs	\$10 copay	\$20 copay
Formulary Brand Drugs	\$30 copay	\$60 copay
Non-formulary Brand Drugs	\$50 copay	\$100 copay
<b>NOTE:</b> 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".		

**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. The Copay in the Physician's office includes diagnostic services, injections, supplies, and allergy services performed in the office and billed by the Physician.
3. Referrals by Network Providers to Non-Network Providers will be considered as Non-Network services and supplies. In order to receive Network benefits, ask your Physician to refer you to listed Network Providers.
4. Anesthesia, x-rays, laboratory, emergency room services, and other diagnostic services received at a Network facility and rendered and billed by a Provider who is not a Member of the Network 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 Network Physician and exercised the right to receive services from a Non-Network 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. If a Participant is temporarily residing overseas, his/her claims will be paid at the Out-of-Network benefit level.
7. Prescription drugs purchased overseas are not covered.
8. 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.