

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY**  
**NETWORK ONLY HEALTH BENEFIT PLAN**

**Amendment 5**

The Association Mutual Health Insurance Company Network Only Health Benefit Plan, effective January 1, 2008, is hereby amended as follows:

**1. Section 2, Summary of Benefits for Network Only Plan** – This section is AMENDED to reflect the following changes:

- a. **Individual Lifetime Maximums** – The \$2,000,000 Overall Medical Maximum is INCREASED to Unlimited;
- b. **Individual Calendar Year Maximums** – The Routine Physical Exam (Age 19 and older) maximum of \$500 no longer applies and is REMOVED;
- c. **Professional Expenses** - Physician Office Visit – Primary Care Physician (PCP): The copay is INCREASED to a \$25 copay per visit, then 100%;
- d. **Professional Expenses** - Physician Office Visit – Primary Care Physician (PCP): The definition of a PCP is expanded to include Psychiatrist and Psychologist;
- e. **Professional Expenses** – Physician office visit – Specialist: The copay is INCREASED to a \$35 copay per visit, then 100%;
- f. **Other Eligible Expenses** – Acupuncture: The copay is INCREASED to a \$35 copay per visit, then 100%;
- g. **Other Eligible Expenses** – Allergy Testing: The *Primary Care Physician* copay is INCREASED to a \$25 copay, then 100%, and the *Specialist* copay is INCREASED to a \$35 copay, then 100%;
- h. **Maternity Related Services** – Pre or post natal office visits (not billed with delivery): A copay distinction is ADDED for PCP, and the copay is INCREASED to a \$25 copay per visit – PCP;
- i. **Maternity Related Services** – Pre or post natal office visits (not billed with delivery): A copay distinction is ADDED for Specialist, and the copay is ADDED as a \$35 copay per visit, then 100% - Specialist;
- j. **Preventive Care** – All services and copays listed under Preventive Care are REMOVED and REPLACED with: Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010, and the PPO Provider (In-Network) benefit is 100%, and the Non-PPO Provider (Out-of-Network) benefit is Not Covered;
- k. **Mental Health and Substance Abuse** - Outpatient: The Pre-certification requirement is REMOVED;
- l. **Prescription Drugs** - Formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to \$35, and the Mail Order (90-day supply) copay has INCREASED to \$70;
- m. **Prescription Drugs** - Non-Formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to \$70, and the Mail Order (90-day supply) copay has INCREASED to \$140.

**2. Section 3, Definitions** – The following Definitions are ADDED to this section:

**Emergency Services** – Means, with respect to an emergency medical condition:

- a. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
- b. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

**Emergency Medical Condition** – Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. Serious impairment to bodily functions; or
- c. Serious dysfunction of any bodily organ or part.

**Essential Health Benefits** – has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Policy Year** – means the 12-month period that is designated as the policy year in the contract. If there is no designation of a policy year in the contract, then the policy year is the deductible or limit year used under the contract. If deductibles or other limits are not imposed on a yearly basis under the contract, the policy year is the calendar year.

3. **Section 4, Enrollment, Special Enrollment** - This section, as amended by Amendment #3, is AMENDED to reflect new enrollment provisions for Children under age 26 and Employees or Dependents whose coverage ended by reason of reaching a lifetime limit and is REPLACED with the following (the changes are shown in bold):

**Special Enrollment Period:** If you decline enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.

An Employee (or Dependent) who is eligible but not enrolled is allowed to enroll in the Plan at a date later than the initial enrollment period, if the Employee (or Dependent) was covered under a health plan (including COBRA, Medicaid or CHIP coverage) at the time coverage was initially offered and, if required by the Plan Administrator, the Employee stated in writing that the other coverage is the reason for declining enrollment and either;

- a) The other coverage that the Employee (or Dependent) had was COBRA coverage and the COBRA coverage was exhausted;
- b) The other coverage was under another group health plan and that coverage has terminated due to a loss of eligibility;
- c) The other coverage was under a Medicaid plan or Children's Health Insurance Program (CHIP) and the coverage was terminated as a result of loss of eligibility.

In addition:

- d) An Employee (or Dependent) who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Employee (or Dependent) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
- e) **A Child under age 26, who is eligible but not enrolled for coverage under the Plan will be eligible to enroll in the Plan at a date later than the initial enrollment period if the Child becomes eligible in accordance with the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act (PPACA), PHS Act Section 2714, Eligibility of children Until Age 26 (26 CFR 54.9815-2714, 29 CFR 2590.715-2714, 45 CFR 147.120).**
- f) **An Employee (or Dependent), whose coverage or benefits under this Plan ended by reason of reaching a lifetime limit will be eligible to enroll in the Plan at a date later than the initial enrollment period in accordance with the Patient Protection and Affordable Care Act.**

If the other coverage was COBRA coverage: the COBRA coverage is treated as being exhausted if COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or the cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the plan). Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

If the other coverage was not COBRA coverage: a loss of eligibility includes, but is not limited to, a loss of eligibility because of legal separation, divorce, death, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment or termination of employer contributions to the coverage. For coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "Loss of Eligibility" also includes a loss that occurs if coverage ceases because the

Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a "Loss of Eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other coverage or if the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

If the other coverage was Medicare or CHIP: The Employee must request enrollment in writing within 60 days of: the date the Medicaid or CHIP coverage terminates, or the date the Employee (or Dependent) becomes eligible for the premium assistance subsidy under Medicaid or CHIP.

"Loss of Eligibility" does not include: a loss of coverage because of failure of the Employee (or Dependent) to pay for coverage on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with coverage under the plan).

NOTE: When a loss of eligibility for other coverage (or exhaustion of COBRA coverage) occurs, the Employee must request enrollment in writing within 31 days of the loss or exhaustion of the other coverage. However, if the loss of coverage is based on reaching a lifetime limit, enrollment must be requested within 31 days after a claim is denied because of reaching the lifetime limit or, if the other coverage was COBRA coverage, within 31 days after a claim is incurred that would cause the individual to exceed the lifetime limit.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or Placement for Adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or Placement for Adoption. Coverage will be effective:

- In the case of a marriage, on a date specified by the Plan Administrator that is not later than the first day of the first month beginning after the date the Employee submits an election form electing coverage for the Employee and/or Dependent(s) under the Plan;
- In the case of a Dependent's birth, the date of such birth;
- In the case of a Dependent's adoption or Placement for Adoption, the date of such adoption, or Placement for Adoption.

A child who becomes an alternate beneficiary because of a recognized Qualified Medical Child Support Order is eligible to be added to the Plan provided that you request enrollment within 31 days.

**If you have a Child who becomes eligible due to the provisions of PPACA, you may enroll your Child, provided you request enrollment within 31 days of the date of eligibility or the date of the first day of the plan year beginning on January 1, 2011. Coverage will be effective on the date of eligibility or the first day of the plan year beginning on January 1, 2011.**

**If your or your Dependent's coverage or benefits ended by reason of reaching a lifetime limit and you (or your Dependent) become eligible for benefits not**

subject to a lifetime limit, you may enroll yourself (or your Dependent), provided you request enrollment within 31 days of the first day of the plan year beginning on January 1, 2011. Coverage will be effective on the first day of the plan year beginning on January 1, 2011.

Note: Participants age 19 and over, who join the Plan during a Special Enrollment Period, will be subject to a 10-month Pre-existing Waiting Period. This can be reduced by prior periods of Creditable Coverage under another health plan as of the enrollment date, if such coverage was earned without a Significant Break in Coverage.

3. **Section 4, Effective Date, Pre-existing Waiting Period** - The second paragraph of this section is REMOVED and REPLACED with the following:

This provision does not apply to pregnancy, nor to Participants under age 19 who are enrolled in the plan. In addition, genetic information may not be considered a pre-existing condition unless there is a diagnosis of the condition related to that information.

4. **Section 6, Your Benefits, Preventive Care for Adults and Preventive Child Care Services** – These sections are REMOVED and REPLACED with the following:

#### **Preventive and Wellness Services for Adults and Children**

##### **Medical-Surgical Benefits**

In compliance with section (2713) of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

A description of Preventive and Wellness Services can be found at: <http://www.healthcare.gov/law/about/provisions/services/lists.html>

**Limitations and Exclusions**

1. **Illness/Injury** – The above benefits apply only for those services related to Preventive Care. Coverage of services provided for the treatment of an Illness or an Injury is described under other provisions of the Certificate.
  2. **Routine Exams** – We will not Pay for routine exams related to insurance, licensing, employment, school, sports or camp.
5. **Section 7, General Limitations and Exclusions, Pre-existing Conditions** – The NOTE at the end of this section is REMOVED and REPLACED with the following:

NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Exclusion.

*A revised Summary of Benefits is attached.*

The foregoing amendment is effective January 1, 2011.

This amendment shall be attached to and form a part of the group Plan Document and material changes made herein shall be added to the Summary Plan Description. This amendment shall not be held to alter or affect any of the terms of such plan other than as specifically stated.

Association Mutual Health Insurance Company  
Network Only Health Benefit Plan

11/18/10  
Date

By:   
Authorized Signature

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY**

**NETWORK ONLY 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 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><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 member. Please refer to Section 5.</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>CALENDAR YEAR DEDUCTIBLE</b>	
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)
<b>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</b>	
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)
<b>Hospital and Other Facility Expenses</b>		
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
<b>Professional Expenses</b>		
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)
<b>Other Eligible Expenses</b>		
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

	<b>PPO Provider (In-Network)</b>	<b>Non-PPO Provider (Out-of-Network)</b>
<b>Maternity Related Services</b>		
Inpatient Hospital*	\$200 copay, then 100%*	Not Covered
Birth 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
<b>Organ Transplants</b>		
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
<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%	Not Covered
<b>Mental Health and Substance Abuse</b>		
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

\* 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.

<b>PRESCRIPTION DRUGS</b>	<b>Retail (30-day supply)</b>	<b>Mail Order (90-day supply)</b>
Generic Drugs	\$10	\$20
Formulary Brand Drugs	\$35	\$70
Non-formulary Brand Drugs	\$70	\$140
<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".		
<b>Over-the-Counter Option</b>		
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.