

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
NETWORK ONLY HEALTH BENEFIT PLAN

Amendment 1

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** – This section is AMENDED to reflect the following changes:
- The \$100/\$200/\$300 Individual/Individual and 1 Dependent/Family Calendar Year Deductibles have increased to \$200/\$400/\$600
 - All \$100 inpatient facility copays have increased from \$100 to \$200 per confinement
 - All \$50 emergency room (In and Out-of-Network) copays have increased to \$100
 - All \$10 physician copays have increased to \$15
 - All \$20 specialist physician copays have increased to \$25

A REVISED SCHEDULE OF BENEFITS IS ATTACHED

The foregoing amendment is effective January 1, 2009.

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 Life Insurance Company
Network Only Health Benefit Plan

11/4/08
Date

By: 
Authorized Signature

**Network Only Plan
Summary of Benefits**

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).

Payments for Out-of Network Providers are based on the Reasonable and Customary (R&C) Allowance (see DEFINITIONS), 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.

Pre-certification Requirement - The items marked below with an asterisk (*) *require* 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.

INDIVIDUAL LIFETIME MAXIMUMS

Overall Medical Maximum	\$2,000,000
Hospice Care	180 days

INDIVIDUAL CALENDAR YEAR MAXIMUMS

Mental Health and Substance Abuse Inpatient	60 days
Acupuncture	\$2,000
Chiropractic Care	\$2,000
Home Health Care	100 visits
Infertility Testing	\$1,000
Routine Physical Exam (Age 19 and older)	\$500
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

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, non-covered services, and in and outpatient treatment of mental health and substance abuse disorders

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 - 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%
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 and OB/GYN)	\$15 copay per visit, then 100%	Not Covered
Physician office visit - Specialist	\$25 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 Hines required or a penalty of 50% up to a maximum of \$500 will apply

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of \$2,000 per calendar year)	\$25 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	\$15 copay, then 100% \$25 copay, then 100%	Not Covered
Ambulance	Not available In-Network, seek Non-Network Provider	\$75 Copay, then 100% of R&C
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	80% After deductible	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
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)	\$15 copay per visit, 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		
Children (up to age 19) -includes routine checkups, immunizations, vaccinations, and routine blood tests	\$15 copay per visit, then 100%	Not Covered
Adults (age 19 and older) -includes blood tests, routine immunizations, routine gynecological exams, electrocardiograms, x-rays, stress tests. (Calendar year maximum of \$500 per insured)	\$15 copay per visit, then 100%	Not Covered
Routine tests, x-rays, immunizations (billed separately from visit) (Applies to \$500 calendar year max)	100%	Not Covered
Routine Mammogram (Does not apply to \$500 calendar year max)	\$15 copay per visit, then 100%	Not Covered
Pap Smears (applies to \$500 calendar year max)	100%	Not Covered
Routine Colonoscopy (Does not apply to \$500 calendar year max)	\$15 copay per visit, then 100% - if done in Dr.'s office; 100% - if done in outpatient facility	Not Covered

* Pre-certification from Hines required or a penalty of 50% up to a maximum of \$500 will apply

	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility * (maximum of 60 days per calendar year)	80% After deductible	Not Covered
Inpatient Physician Visits	80% After deductible	Not Covered
Outpatient *	\$35 Copay per visit, then 100%	Not Covered
* Pre-certification from Hines is required. Contact them prior to admittance to an In -Network hospital or facility and before all outpatient visits to an In-Network provider. Please call 800-670-7718.		
PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	\$10	\$20
Formulary Brand Drugs	\$30	\$60
Non-formulary Brand Drugs	\$50	\$100
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	

* Pre-certification from Hines required or a penalty of 50% up to a maximum of \$500 will apply

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.