

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY**  
**Network Only Plan**  
**Schedule of Benefits Effective January 1, 2009**

| Schedule of Benefits                       |                   |
|--|-------------------|
| Service                                    | Network Only Plan |
| <b>Calendar Year <u>Deductible</u></b>     |                   |
| Individual                                 | \$200             |
| Individual + 1 Dependent                   | \$400             |
| Family                                     | \$600             |
| <b>Annual <u>Out-of-Pocket Maximum</u></b> |                   |
| (Excludes Deductible)                      |                   |
| Individual                                 | \$2,000           |
| Individual + 1 Dependent                   | \$4,000           |
| Family                                     | \$6,000           |

| Covered Medical Expenses   |   |
|--|---|
| Hospital Expenses  |   |
| <b>Inpatient Facility</b><br>Pre-Certification required for all inpatient admissions or penalty of 50% to \$500 will apply | \$200 Copay per confinement; 100% thereafter  |
| <b>Outpatient Facility</b>   | 80% after Deductible                          |
| Physician Expenses   |   |
| <b>Inpatient Surgery/Anesthesia</b>  | 80% after Deductible                          |
| <b>Inpatient Visits</b>  | 80% after Deductible                          |
| <b>Outpatient Surgery/Anesthesia</b>   | 80% after Deductible                          |
| <b>Second/Third Opinions</b>   | 80% after Deductible                          |
| <b>Physician Office Visits</b>   | 100% after \$15 Copay (\$25 Specialist)       |
| Other Covered Expenses   |   |
| <b>Acupuncture</b>   | 100% after \$25 Copay                         |
| <b>Allergy Injections</b>  | 80% after Deductible                          |
| <b>Ambulance</b>   | 80% after Deductible                          |
| <b>Birthing Facility</b>   | 80% after Deductible                          |
| <b>Chiropractic</b>  | 80% after Deductible                          |
| <b>Diagnostic, X-ray/Lab</b>   | 100% after Deductible                         |
| <b>Durable Medical Equipment</b>   | 80% after Deductible                          |
| <b>Emergency Room Care – Medical Emergencies</b>   | 100% after \$100 Copay                        |
| <b>Emergency Room Care – For Non-Emergencies</b>   | 80% after Deductible                          |
| <b>Home Health Care</b>  | 80% after Deductible                          |
| <b>Hospice Care</b>  | 100%  |
| <b>Infertility Testing</b>   | 80% after Deductible                          |
| <b>Physical Therapy</b>  | 80% after Deductible                          |
| <b>Pre-Admission Testing</b>   | 80% after Deductible                          |
| <b>Private Duty Nursing</b>  | Private duty nursing is not a covered benefit |
| <b>Radiation Therapy</b>   | 80% after Deductible                          |
| <b>Skilled Nursing Facility</b>  | 80% after Deductible                          |
| <b>Urgent Care Centers</b>   | 80% after Deductible                          |
| <b>All Other Eligible Expenses</b>   | 80% after Deductible                          |

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| Preventive Care   |  |
|---|--|
| Routine Physical Exams<br>\$500 per calendar year, age 19+  | 100% after \$15 Copay  |
| Routine Mammography - No Maximum  | 100% after \$15 Copay  |
| Routine Colonoscopy - No Maximum  | 100% after \$15 Copay  |
| Well-Child Care Under age 19  | 100% after \$15 Copay  |
| Mental Health & Substance Abuse   |  |
| Inpatient Hospital<br>maximum of 60 days per calendar year  | 80% after Deductible   |
| Inpatient Physician Visit   | 80% after Deductible   |
| Outpatient  | \$35 copay per visit, then 100%  |
| Prescription Drugs  |  |
| Retail Pharmacy (30 day supply)   | Generic: \$10 copay<br>Formulary: \$30 copay<br>Non-Formulary: \$50 copay  |
| Mail Order Pharmacy (90 day supply)   | Generic: \$20 copay<br>Formulary: \$60 copay<br>Non-Formulary: \$100 copay |
| <b>Applies to Retail and Mail:</b><br><b>Brand Drug when Generic is available:</b> member pays generic co-pay, plus the difference between the brand and the generic product<br><b>Non-Sedating Antihistamines:</b> Covers all OTC non-sedating antihistamines and generic versions at the generic co-payment (\$10 retail). This benefit includes: OTC Claritin and loratadine (by various companies). Prescription required. No coverage for Brand Name prescription non-sedating antihistamines. If you choose prescription Allegra, Claritin, Clarinex, of Zyrtec, you will pay the entire amount.<br><b>Proton Pump Inhibitors (ulcer drugs):</b> Covers Prilosec OTC at the generic copayment. Prescription required. |  |
| Annual Maximum Benefits   |  |
| When the annual out-of-pocket maximum is reached, plan payments made at 80% will increase to 100%. This does not include your deductible; co-pays paid to in-network providers; prescription drug copays; inpatient and outpatient charges for mental illness and substance abuse treatment; any benefit reduction for not following Hospital Pre-admission Certification requirements; and non-covered expenses, including charges that exceed usual, customary and reasonable charges, or out-of-network benefits.  |  |
| Service   | Maximum Benefit  |
| Lifetime Maximum<br>All Covered Expenses  | \$2,000,000  |
| Home Health Care  | 100 visits per Calendar Year   |
| Hospice Care  | 180 days per lifetime  |
| Infertility Testing   | \$1,000 per Calendar Year  |
| Acupuncture   | \$2,000 per Calendar Year  |
| Chiropractic  | \$2,000 per Calendar Year  |
| Routine Physical  | \$500 per Calendar Year  |
| Mammogram   | No annual maximum  |
| Skilled Nursing Facility  | 100 days per Calendar Year   |
| Mental Health/Substance Abuse<br>Inpatient Hospital   | maximum of 60 days per calendar year                                       |
| <b>THIS IS JUST A SUMMARY.</b><br><b>REFER TO THE PLAN DOCUMENT FOR FURTHER DETAILS.</b>  |  |