

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

Amendment 4

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

1. **Section 2, Summary of Benefits for PPO Health Benefit 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. **Physician Expenses** - Physician Office Visit: The existing descriptor is REPLACED with the following: Physician office visit – Primary Care Physician (PCP) (PCP includes a General Practitioner, Family Practitioner, Internist, Pediatrician, OB/GYN, Psychiatrist and Psychologist), and the Network Provider (In-Network) benefit is a \$20 copay per visit, then 100%; the Non-Network Provider (Out-of-Network) remains the same at 70% of Allowed Benefit After Deductible;
 - d. **Physician Expenses** – The following sub-heading is ADDED to this section: Physician Office Visit (Specialist); and the Network Provider (In-Network) benefit is a \$30 copay per visit, then 100%; and the Non-Network Provider (Out-of-Network) benefit is 70% of Allowed Benefit after deductible;
 - e. **Other Eligible Expenses** - Acupuncture: The copay INCREASED to a \$30 copay per visit, then 100%;
 - f. **Other Eligible Expenses** - Allergy Testing: The following two distinctions are ADDED: *Primary Care Physician* and *Specialist*;
 - g. **Other Eligible Expenses** – Allergy Testing – Primary Care Physician: The Network Provider (In-Network) copay is ADDED as a \$20 copay, then 100%; and the Non-Network Provider (Out-of-Network) copay is 70% of Allowed Benefit After Deductible;
 - h. **Other Eligible Expenses** – Allergy Testing – Specialist: The Network Provider (In-Network) copay is ADDED as a \$30 copay, then 100%, and the Non-Network Provider (Out-of-Network) copay is 70% of Allowed Benefit After Deductible;
 - i. **Other Eligible Expenses** - Chiropractic Care: The copay has INCREASED to a \$30 copay per visit, then 100%;
 - j. **Other Eligible Expenses** – Home Health Care: The copay has INCREASED to a \$20 copay per visit, then 100%;
 - k. **Other Eligible Expenses** - Physical Therapy: The copay has INCREASED to a \$30 copay per visit, then 100%;
 - l. **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 \$20 copay per visit – PCP;

- m. **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 \$30 copay per visit, then 100% - Specialist;
- n. **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 Network Provider (In-Network) benefit is ADDED as 100%, and the Non-Network Provider (Out-of-Network) benefit is ADDED as 70% of Allowed Benefit After Deductible;
- o. **Mental Health and Substance Abuse** - Outpatient: The Pre-certification requirement is REMOVED, and the copay is INCREASED to a \$20 copay per visit, then 100%;
- p. **Prescription Drugs** - Generic Drugs: The Retail (30-day supply) copay has INCREASED to a \$10 copay, and the Mail Order (90-day supply) has INCREASED to a \$20 copay;
- q. **Prescription Drugs** - Formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to a \$30 copay, and the Mail Order (90-day supply) copay has INCREASED to a \$60 copay;
- r. **Prescription Drugs** - Non-formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to a \$50 copay, and the Mail Order (90-day supply) copay has INCREASED to a \$100 copay.

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 #2, 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 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). 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:

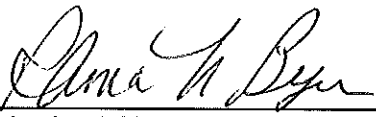
NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Exclusion.

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
PPO Health Benefit Plan

11/18/10 By: 
Date Authorized Signature

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO 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 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>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.</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 | |
| | Network Provider (In-Network) | Non-Network Provider (Out-of-Network) |
| CALENDAR YEAR DEDUCTIBLE | | |
| Individual | \$200 | \$300 |
| Individual and 1 Dependent | \$400 | \$600 |
| Family (Employee and 2 or more Dependents) | \$600 <small>(No more than \$200 per Individual can be applied toward the Family Deductible)</small> | \$900 <small>(No more than \$300 per Individual can be applied toward the Family Deductible)</small> |
| CALENDAR YEAR OUT-OF-POCKET MAXIMUM | | |
| 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> | | |

| TYPE OF EXPENSE | Network Provider (In-Network) | Non-Network Provider (Out-of-Network) |
|---|---|---|
| Hospital and Other Facility Expenses | | |
| 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 |
| Physician Expenses | | |
| 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.

| TYPE OF EXPENSE | Network Provider (In-Network) | Non-Network Provider (Out-of-Network) |
|--|---|--|
| Other Eligible Expenses | | |
| 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 |

| TYPE OF EXPENSE | Network Provider (In-Network) | Non-Network Provider (Out-of-Network) |
|--|--|--|
| Maternity Related Services | | |
| Inpatient Hospital* | \$100 copay, then 100% up to \$5,000, then 90% per confinement* | 70% of Allowed Benefit* After deductible |
| Birth 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 |
| Organ Transplants | | |
| 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 |
| PREVENTIVE CARE | | |
| 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 |
| Mental Health and Substance Abuse | | |
| 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.

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

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.