

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

Amendment 2

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

1. **Throughout the entire document** – The Managed Care Vendor has changed. All references to:

Hines & Associates - (800) 670-7718

are REPLACED with:

InforMed - (866) 475-1256

2. **Section 2, Summary of Benefits**– All references to R&C have been replaced with Allowed Benefit. A description of Allowed Benefit is included under Notes (Note #8.) as follows:

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.

3. **Section 2, Summary of Benefits, Individual Calendar Year Maximums** – This section is AMENDED to comply with the Mental Health Parity and Addiction Equity Act of 2008 as follows:

The following maximum no longer applies and is REMOVED:

INDIVIDUAL CALENDAR YEAR MAXIMUMS	
Mental Health and Substance Abuse Inpatient	60 days

4. **Section 2, Summary of Benefits, Summary of Benefits, Calendar Year Out-of-Pocket Maximum** – The description is AMENDED to reflect the removal of in and outpatient treatment of mental health and substance abuse disorders and is REPLACED with the following:

CALENDAR YEAR OUT-OF-POCKET MAXIMUM
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.

5. Section 2, Summary of Benefits, Other Eligible Expenses, Urgent Care –

This section has been amended to INCREASE the In-Network copay as follows:

Other Eligible Expenses		
Urgent Care	\$35 copay, then 100%	Not Covered

6. Section 2, Summary of Benefits, Mental Health and Substance Abuse – This section is AMENDED to reflect an INCREASE to all Out-of-Network benefits and a decrease to the In-Network Outpatient copay as follows:

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
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*	\$15 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 and before all outpatient visits to an In-Network provider. Please call 866-475-1256.		

7. Section 4, Enrollment, Special Enrollment Period - This section is AMENDED and REPLACED with the following:

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, 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.

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.

Note: Participants who join the Plan during a Special Enrollment Period will be subject to a 12-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.

8. Section 4, Enrollment, Special Enrollment Period – The following provisions are ADDED to this section:

- e. In order to care for the spouse, child, parent or next-of-kin of an employee, if such spouse, child, parent or next-of-kin is a service member and was injured during active duty;
- f. Because of a "qualifying exigency" (as defined under DOL regulations) arising because the employee's spouse, son, daughter, or parent is on active duty (or has been notified a call or order to active duty) in the Armed Forces in support of a "contingency operation" (a specified military operation).

9. Section 4, Enrollment – The following is ADDED to this section following "Leave of Absence (Other than Family Medical Leave Act absence):

Leave of Absence for Full-time Students – If a Dependent is unable to maintain full-time student status because of a severe illness or injury, benefits will be continued until the earlier of: one year after the first day of the leave of absence or the date on which the coverage would otherwise terminate. At the end of this period, the Dependent's coverage will be deemed to have terminated for the purposes of Continuation of Coverage under COBRA. Proof of incapacity must be submitted to the Plan within 31 days after the first day of the leave of absence.

The foregoing amendment is effective January 1, 2010.

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
PPO Health Benefit Plan

12/04/09
Date

By: *Christina M. Beyer*
Authorized Signature