

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 (*) <u>require</u> 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	\$2,000,000	
Hospice Care	180 days	
INDIVIDUAL CALENDAR YEAR MAXIMUMS		
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	
	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	\$15 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 required or a penalty of 50% up to a maximum of \$500 will apply

TYPE OF EXPENSE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of \$2,000 per calendar year)	\$15 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	\$15 copay per visit, 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)	\$15 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)	\$15 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	\$15 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	\$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)	\$15 copay per visit, 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		
Children (up to age 19) -includes routine checkups, immunizations, vaccinations, and routine blood tests	\$15 copay per visit, then 100%	70% of Allowed Benefit After deductible
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%	70% of Allowed Benefit After deductible
Routine tests, x-rays, immunizations (billed separately from visit) (applies to \$500 calendar year max)	100%	70% of Allowed Benefit After deductible
Routine Mammogram (does not apply to \$500 calendar year max)	\$15 copay per visit, then 100%	70% of Allowed Benefit After deductible
Pap Smear (applies to \$500 calendar year max)	100%	70% of Allowed Benefit After deductible
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	70% of Allowed Benefit After deductible

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

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% of Allowed Benefit 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.		
PRESCRIPTION DRUGS	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	\$7 copay	\$14 copay
Formulary Brand Drugs	\$25 copay	\$50 copay
Non-formulary Brand Drugs	\$40 copay	\$80 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".		

* Pre-certification from InforMed 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. 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.