

SERFF Tracking Number: WWW-127921842 State: District of Columbia
 Filing Company: Association Mutual Health Insurance Company State Tracking Number:
 (AMHIC)
 Company Tracking Number: AMHIC2012
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan
 Project Name/Number: /

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
	AMHIC 2012 Rate Filing		New		AMHIC 2012 Rate Filing - Cover Letter.pdf AMHIC 2012 Rate Filing - NAIC Transmittal Document.pdf AMHIC 2012 Rate Filing - PPACA_Uniform Compliance Summary.pdf AMHIC 2012 Rate Filing - Rate Tables.pdf

December 22, 2011

William P. White, Commissioner
DC Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002

RE: AMHIC 2012 Premium Rate Filing (Company Filing Tracking Number: AMHIC2012)

Dear Sir:

In 2011 Towers Watson was retained by the Board of Directors of Association Mutual Health Insurance Company (AMHIC) to provide actuarial services, including the submission of this 2012 premium rate filing to the Department of Insurance, Securities and Banking.

Following is the information pertinent to the nature of the purpose of the filing:

- Rates effective dates: January 1, 2012 – December 31, 2012
- Type of product: Self-insured triple option (PPO/Network Only/Qualified HDHP) group health Hospital/Surgical/Medical Expense with Prescription Drug
- Projected group size: 47 participating groups with 1,613 employees and retirees
- Scope and purpose of filing: Annual rate revision (PPO and Network Only options) and initial rate filing (Qualified HDHP option)
- PPACA reform compliance status: PPACA-compliant non-grandfathered plan
- Average rate increase: -3.4% (ranging from -9.5% to 14.0 % under the PPO and -4.8% to 20.0% under the Network Only option, depending on each group's demographics change)

If you have any questions on this, please do not hesitate to contact me at 703-258-8054.

Sincerely,



Olga Samoilova, ASA, MAAA
Consulting Actuary
Towers Watson
(703)-258-8054
Olga.Samoilova@towerswatson.com

Enclosure

Cc: Rhona Byer, Association Mutual Health Insurance Company
Christopher Bartnik, Wells Fargo Insurance Services
Cara Jareb, Towers Watson

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	District of Columbia
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2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Association Mutual Health Insurance Company (AMHIC)	District of Columbia	Group Accident Health			33-1013490	AS004

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Olga Samoilova 901 N. Glebe Road Arlington, VA 22203	(703) 258-8054	(703) 258-8093	Olga.Samoilova@towerswatson.com

5.	Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6.	Company Tracking Number	AMHIC2012
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large
		Group	<input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9.	Type of Insurance (TOI)	H16G Group Health – Major Medical
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10.	Sub-Type of Insurance (Sub-TOI)	H16G.001C Any Size Group – Other
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11.	Submitted Documents	<div style="margin-bottom: 10px;"> <input type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other </div> <div style="margin-bottom: 10px;"> Rates <input checked="" type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ </div> <div> SUPPORTING DOCUMENTATION <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input checked="" type="checkbox"/> Actuarial Memorandum <input checked="" type="checkbox"/> Other <u>Certificates of Coverage, Plan Design Charts, Group Application Form</u> </div>
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12.	Filing Submission Date	12/22/2011	
13	Filing Fee (If required)	Amount _____	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval		
15.	Filing Description: 2012 premium rate submission		
<p>2012 premium rates submission to the District of Columbia Department of Insurance, Securities and Banking on behalf of the Association Mutual Health Insurance Company (AMHIC)</p>			

16.	Certification (If required)		
<p>I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>the District of Columbia</u></p>			
Print Name <u>Olga Samoilova</u>		Title <u>Consulting Actuary</u>	
Signature <u><i>Olga Samoilova</i></u>		Date: <u>12/22/2011</u>	

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		AMHIC2012		
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)		-3.4%		
Overall percentage rate impact for this filing		-3.4%		
	Document Name: AMHIC 2012 Rate Filing	Affected Form Numbers		Previous State Filing Number
	Description:			
01	2012 Active PPO premium rate increase of (5.0%). Particular groups' rate increases range from (9.5%) to 14.0% depending on each group's demographics change. Average rate increase is (4.4%).		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
02	2012 Retiree PPO premium rate increase of (5.0%).		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
03	2012 Active Network Only premium rate increase of 0.0%. Particular groups' rate increases range from (4.8%) to 20.0% depending on each group's demographics change. Average rate increase is 0.7%.		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
04	2012 Retiree Network Only premium rate increase of (5.0%).		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
05	2012 Active Qualified High Deductible Health Plan initial premium rates – increase information is not available		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
06	2012 Retiree Qualified High Deductible Health Plan initial premium rates – increase information is not available		<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request + ___% - ___% <input type="checkbox"/> Other _____	

LH RFA-1

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
 SMALL / LARGE GROUP HEALTH BENEFIT PLANS (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Association Mutual Health Insurance Company (AMHIC)		AMHIC2012	PPO/Network Only/QHDHP	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Appeals Process – Requires establishment of an internal claims appeal process and external review process.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Eliminate Lifetime Dollar Limits on Essential Benefits</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes [◇] <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011			

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number: PPO Amd. #4 Eff. 1/1/2011; Network Only Amd. #5 Eff. 1/1/2011</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.</p>

Association Mutual Health Insurance Company (AMHIC)
2012 Active Employee PPO and Network Only Plan Monthly Premium Rates

Group Size Adjustments: Small Groups, +2.7% / Large Groups, -2.2%

Active Employee Demographic Adjustments: Minimum, -20% / Low, -4% / Neutral, 0% / High, +4% / Maximum, +25%

Baseline; -5.00% PPO and 0.00% Network Only Base Rate Increase

	Base Rates	Percent Increase	Small Groups (under 50 employees)					Large Groups (50+ employees)				
			Minimum** Demgphcs	Low Demgphcs	Neutral Demgphcs	High Demgphcs	Maximum** Demgphcs	Minimum** Demgphcs	Low Demgphcs	Neutral Demgphcs	High Demgphcs	Maximum** Demgphcs
2011 Rates - PPO												
Single	\$682		\$560	\$672	\$700	\$728	\$876	\$534	\$640	\$667	\$694	\$834
Employee+Child(ren)	\$1,159		\$952	\$1,143	\$1,190	\$1,238	\$1,488	\$907	\$1,088	\$1,134	\$1,179	\$1,417
Employee+Spouse	\$1,266		\$1,040	\$1,248	\$1,300	\$1,352	\$1,625	\$991	\$1,189	\$1,238	\$1,288	\$1,548
Family	\$1,726		\$1,418	\$1,702	\$1,773	\$1,844	\$2,216	\$1,350	\$1,621	\$1,688	\$1,756	\$2,110
2011 Rates - Network Only												
Single	\$475		\$390	\$468	\$488	\$507	\$610	\$372	\$446	\$465	\$483	\$581
Employee+Child(ren)	\$850		\$698	\$838	\$873	\$908	\$1,091	\$665	\$798	\$831	\$865	\$1,039
Employee+Spouse	\$929		\$763	\$916	\$954	\$992	\$1,193	\$727	\$872	\$909	\$945	\$1,136
Family	\$1,265		\$1,039	\$1,247	\$1,299	\$1,351	\$1,624	\$990	\$1,188	\$1,237	\$1,287	\$1,546
2012 Renewal Rates - PPO*												
Single	\$648	-5.0%	\$532	\$639	\$665	\$692	\$832	\$507	\$608	\$634	\$659	\$792
Employee+Child(ren)	\$1,101	-5.0%	\$905	\$1,085	\$1,131	\$1,176	\$1,413	\$861	\$1,034	\$1,077	\$1,120	\$1,346
Employee+Spouse	\$1,203	-5.0%	\$988	\$1,186	\$1,235	\$1,285	\$1,544	\$941	\$1,129	\$1,177	\$1,224	\$1,471
Family	\$1,640	-5.0%	\$1,347	\$1,617	\$1,684	\$1,752	\$2,105	\$1,283	\$1,540	\$1,604	\$1,668	\$2,005
Increase from 2011 to 2012		-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%	-5.0%
2012 Renewal Rates - Network Only												
Single	\$475	0.0%	\$390	\$468	\$488	\$507	\$610	\$372	\$446	\$465	\$483	\$581
Employee+Child(ren)	\$850	0.0%	\$698	\$838	\$873	\$908	\$1,091	\$665	\$798	\$831	\$865	\$1,039
Employee+Spouse	\$929	0.0%	\$763	\$916	\$954	\$992	\$1,193	\$727	\$872	\$909	\$945	\$1,136
Family	\$1,265	0.0%	\$1,039	\$1,247	\$1,299	\$1,351	\$1,624	\$990	\$1,188	\$1,237	\$1,287	\$1,546
Increase from 2011 to 2012		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2012 New Rates - CDHP												
Single	\$398	n/a	\$327	\$392	\$409	\$425	\$511	\$311	\$374	\$389	\$405	\$487
Employee+Child(ren)	\$712	n/a	\$585	\$702	\$731	\$760	\$914	\$557	\$668	\$696	\$724	\$870
Employee+Spouse	\$779	n/a	\$640	\$768	\$800	\$832	\$1,000	\$609	\$731	\$762	\$792	\$952
Family	\$1,060	n/a	\$871	\$1,045	\$1,089	\$1,132	\$1,361	\$829	\$995	\$1,037	\$1,078	\$1,296

Association Mutual Health Insurance Company (AMHIC)
2012 Retiree PPO and Network Only Plan Monthly Premium Rates

Retiree Rates (Not Adjusted for Demographics)

Prescription Drug Program Savings; -5.00% PPO and -5.00% Network Only Base Rate Increase

2011 Retiree Rates	PPO		Network Only			
Retiree	\$682		\$577			
Retiree + Child(ren)	\$1,044		\$885			
Retiree + Spouse	\$1,364		\$1,154			
Retiree + Medicare Spouse	\$993		\$867			
Retiree + Family	\$1,726		\$1,462			
Retiree + Medicare Spouse + Family	\$1,355		\$1,175			
Medicare Retiree	\$311		\$290			
Medicare Retiree + Child(ren)	\$673		\$598			
Medicare Retiree + Spouse	\$993		\$867			
Medicare Retiree + Medicare Spouse	\$622		\$580			
Medicare Retiree + Family	\$1,355		\$1,175			
Medicare Retiree + Medicare Spouse + Family	\$984		\$888			
2012 Retiree Rates	PPO		Network Only		CDHP	
Retiree	\$648	-5.0%	\$548	-5.0%	\$398	n/a
Retiree + Child(ren)	\$992	-5.0%	\$841	-5.0%	\$609	n/a
Retiree + Spouse	\$1,296	-5.0%	\$1,096	-5.0%	\$796	n/a
Retiree + Medicare Spouse	\$943	-5.0%	\$824	-5.0%	\$579	n/a
Retiree + Family	\$1,640	-5.0%	\$1,389	-5.0%	\$1,007	n/a
Retiree + Medicare Spouse + Family	\$1,287	-5.0%	\$1,117	-4.9%	\$790	n/a
Medicare Retiree	\$295	-5.1%	\$276	-4.8%	\$181	n/a
Medicare Retiree + Child(ren)	\$639	-5.1%	\$569	-4.8%	\$392	n/a
Medicare Retiree + Spouse	\$943	-5.0%	\$824	-5.0%	\$579	n/a
Medicare Retiree + Medicare Spouse	\$590	-5.1%	\$552	-4.8%	\$362	n/a
Medicare Retiree + Family	\$1,287	-5.0%	\$1,117	-4.9%	\$790	n/a
Medicare Retiree + Medicare Spouse + Family	\$934	-5.1%	\$845	-4.8%	\$573	n/a

Notes:

- * Rates on these exhibits include administrative costs and plan design changes as described in the Benefit Summary exhibit.
- ** Minimum and Maximum rate categories only apply to new groups that joined in 2006 or after. Groups with 200 or more lives will be experience rated, in order to determine which of the rate categories above they will fall into.

SERFF Tracking Number: WWW-127921842 State: District of Columbia
 Filing Company: Association Mutual Health Insurance Company State Tracking Number:
 (AMHIC)
 Company Tracking Number: AMHIC2012
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other
 Product Name: Self-Insured Triple Option (PPO/Network Only/Qualified HDHP) Group Health Plan
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Actuarial Justification Comments: Attachments: AMHIC 2012 Rate Filing - Actuarial Memorandum.pdf AMHIC 2012 Rate Filing - Attachment 1 - Plan Design Charts.pdf AMHIC 2012 Rate Filing - Attachment 2 - Group Application.pdf AMHIC 2008 Certificate of Coverage - PPO.pdf AMHIC 2008 Certificate of Coverage - Network Only.pdf</p>	Item Status:	Status Date:
<p>Bypassed - Item: Rate Summary Worksheet Bypass Reason: AMHIC falls below the "subject to review" threshold Comments:</p>	Item Status:	Status Date:
<p>Bypassed - Item: Consumer Disclosure Form Bypass Reason: AMHIC falls below the "subject to review" threshold Comments:</p>	Item Status:	Status Date:

**Association Mutual Health Insurance Company
(AMHIC)**

2012 Premium Rate Filing

January 2012

Association Mutual Health Insurance Company
(AMHIC)

2012 Premium Rate Filing

I. Actuarial memorandum:

- A. The type of policy is a self-insured triple option plan (PPO/Network Only/Qualified HDHP) with benefits described in the Attachment - 1. 2008 PPO and Network Only Certificates of Coverage with 2009, 2010 and 2011 Amendments are also attached as separate files. There are no benefit coverage changes for 2012 plan year under the PPO and Network Only options. Two new programs are added:
- Health Ticket – online provider directory and plan benefit information
 - Nurse Line – access to a 24/7, 365 days a year Nurse Line through a toll-free number

There will also be a new QHDHP option added effective January 1, 2012. Qualified High Deductible Health Plan (QHDHP) option is a federally qualified Health Saving Account (HSA) compatible plan. Certificate of Coverage for the QHDHP option is not complete yet and will be provided to DISB upon request as soon as it is finalized.

The initial rates for the QHDHP option were set based on the actuarial value of the plan design relative to the existing PPO and Network Only options. The enrollment in the QHDHP option is expected to be very low, particularly in the first year, thus the impact of this new offering on the overall 2012 projected claims and premiums is minimal.

- B. The policy is guaranteed renewable with rate adjustments for group size, experience, and demographic mix.
- C. This is an open block of business.
- D. The general marketing method is solicitation via AMHIC's captive manager, Wells Fargo Insurance Services, to affiliated associations.
- E. The underwriting includes simple questionnaire to determine the prospective group's eligibility (Attachment - 2) and a group's census file to determine which rate category the group falls into. Prospective new groups with 200 or

more employees are assigned to one of the rate categories based on their claim experience, if available.

- F. There are no issue age limits.
- G. The rates were determined based on the actual incurred claims experience of the plan trended forward to 2012 using the aggregate medical and prescription drug annual trend factors, and actual administrative expenses including stop loss charges. In addition, premium taxes and income taxes are assessed. Premiums along with investment income on assets are projected to cover all expenses and create a small contribution to surplus in order to maintain the net asset level of 5 months of the following year's projected expenses for the fund. Gains are released via dividends or reduced premiums in the coming year.
- H. There were no rate development methodology changes for 2012 rates.
- I. – L. Not applicable.
- M. The projected average annual per capita premium in 2012 is \$9,646. This represents a 3.4% decrease from the 2011 average per capita premium of \$9,982. The active employee rate increase for each group is also determined based on the group's demographics change and ranges from (9.5%) to 14% under the PPO and from (4.8%) to 20% under the Network Only plan. Retiree rates are not demographic-adjusted and will decrease by 5% under both PPO and Network Only plans.
- N. The anticipated 2012 loss ratio is 81.1%, which is calculated by dividing projected incurred claims by the anticipated gross premium for 2012. The anticipated loss ratio is presumed reasonable.
- O. The annual interest rate of 2% was assumed in development of an investment income estimate. This assumption has a minimal impact on proposed rates.
- P. The trend assumptions used in 2012 rate development are 10.0% medical and 7.0% prescription drug annual trend rate factors after adjusting for the large claims, expected reinsurance recoveries, and prescription drug rebates but before any plan design changes. After the plan design changes taken into account, the projected annual trend factors are 10.0% medical and 7.0% prescription drug.
- Q. Of 1,613 employees enrolled in the PPO or Network Only as of August 2011, 309 (or 19.2%) were not participants a year earlier or as of August 2010.
- R. Not applicable.
- S. I, Olga Samoilova, ASA, MAAA, Consulting Actuary with Towers Watson, certify that to the best of my knowledge and judgment this rate submission is in compliance with the applicable laws and regulations of the District of Columbia and the benefits are reasonable in relation to the premiums.

II. District of Columbia loss ratio analysis.

- A. The submitted rates were developed based on the medical and prescription drug monthly claim lag triangles incurred and paid through July 2011 trended forward to 2012.
- B. The average per capita gross premiums earned were \$9,374 in 2010, \$9,982 in 2011 (projected), and \$9,646 in 2012 (projected). The premiums earned net of reinsurance were \$8,919 in 2010, \$9,449 in 2011 (projected), and \$9,034 in 2012 (projected).
- C. The per capita claim cost incurred in 2010 was \$7,069 (completed), \$7,266 in 2011 (projected), and \$7,825 in 2012 (projected).
- D. The number of claims information was not available. The claims data was analyzed in aggregate, which is a generally accepted practice for the medical and prescription drug claims.
- E. The loss development factors were determined based on aggregate monthly claim payment patterns.
- F. Based on the average gross premium and average claim numbers above, the 2010 loss ratio is 75.4%, the 2011 projected loss ratio is 72.8%, and the 2012 projected loss ratio is 81.1%.
- G. Permissible loss ratio (equal to the target gross loss ratio at the time of pricing) was 83.3% in 2010 (reflecting 11.4% expense ratio and 1.2% profit & contingency provision), 83.8% in 2011 (reflecting 10.7% expense ratio and 0.9% profit & contingency provision), and 81.1% in 2012 (reflecting 10.0% expense ratio and 2.2% profit & contingency provision). The difference between 100% and the sum of permissible loss ratio, expense ratio, and profit margin is due to the reinsurance premiums offset and investment income. For the purpose of the above calculations expenses include administrative costs and premium and income taxes. Net premiums along with investment income on assets are projected to cover all claims and expenses and to create a small surplus for the fund in order to partially restore a targeted minimum net asset level equal to nearly three months of claims. The implicit contingency provision was used in the form of somewhat conservative trend factors in the incurred claim projection development.
- H. As of August 2011 1,613 employees and retirees in the District of Columbia were enrolled in the PPO and Network Only plans, which is deemed fully credible group size for the purpose of the medical rate development.
- I. A (3.4%) overall rate change was determined by setting the 2012 projected premiums along with investment income on assets equal to claims and expenses plus a small surplus.

III. District of Columbia experience.

- A. The total gross premiums earned were \$14,922,052 in 2010, \$15,692,000 in 2011 (projected), and \$15,183,000 in 2012 (projected). The premiums earned net of reinsurance were \$14,197,911 in 2010, \$14,854,000 in 2011 (projected), and \$14,219,000 in 2012 (projected).
 - B. 1,613 employees from 47 employer groups were enrolled in the PPO and Network Only options as of August 2011.
 - C. In 2010 the average rate increase was 6.4% ranging from (10.5%) to 21.5% based on the group's demographics change. In 2011 the average rate increase was 1.6% ranging from (15%) to 22% under the PPO and from (7%) to 30% under the Network Only plan based on the group's demographics change. In 2012 the average rate increase is (3.4%) ranging from (9.5%) to 14% under the PPO and from (4.8%) to 20% under the Network Only plan based on the group's demographics change.
- IV. Rate tables – attached as a separate file. AMHIC reserves the right to increase rates above those presented herein for any new association group whose experience warrants such an increase.

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 (No more than \$200 per Individual can be applied toward the Family Deductible)	\$900 (No more than \$300 per Individual can be applied toward the Family Deductible)
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.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY 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 benefit, 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. Please refer to Section 5.</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
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
<p>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 and non-covered services.</p>	

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 - for HIV screening	100%	100%
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%
Emergency Care in Emergency Room - for HIV screening	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, OB/GYN, Psychiatrist, Psychologist)	\$25 copay per visit, then 100%	Not Covered
Physician office visit - Specialist	\$35 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 InforMed is required. Contact them prior to admittance to an In 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	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of \$2,000 per calendar year)	\$35 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	\$25 copay, then 100% \$35 copay, then 100%	Not Covered
Ambulance	Not available In-Network, seek Non-Network Provider	\$75 Copay, then 100% of Allowed Benefit
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 Center	\$50 copay, then 100%	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
Birthing 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)	\$25 copay per visit – PCP \$35 copay per visit - Specialist, 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		
Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010.	100%	Not Covered
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	\$200 copay per confinement, then 100%*	Not Covered
Inpatient Physician Visits	80% After deductible	Not Covered
Outpatient	\$25 copay per visit, then 100%	Not Covered

* Pre-certification from InforMed is required. Contact them prior to admittance to an In 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	\$20
Formulary Brand Drugs	\$35	\$70
Non-formulary Brand Drugs	\$70	\$140
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	

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.
 10. 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.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

QUALIFIED HIGH DEDUCTIBLE HEALTH 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. The 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 (for example, the Plan may require pre-certification or the use of specified Providers).</p> <p>Payments to Non-Network Providers are based on the Allowed Benefit, as determined by the Claims Administrator, in the amounts specified in the summary shown below. In-Network payments are based on an allowance amount as contracted between the Provider and the network, at the benefit level specified in the summary below. Covered Services are subject to the Calendar Year Deductible and pre-certification requirement, 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 Participant. Please refer to <i>Section 5 - Cost Containment Features</i>.</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	
CALENDAR YEAR DEDUCTIBLE	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Individual	\$1,500	
Individual and 1 Dependent	\$3,000	
Family (Employee and 2 or more Dependents)	\$3,000	
<p>Eligible expenses will be applied to both the In-Network and Out-of-Network Deductibles. Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except Preventive Care, apply to the Deductible.</p> <p><u>Individual Deductible</u> – This Deductible must be met once each calendar year and applies to Covered Services indicated in the Summary of Benefits.</p> <p><u>Individual and 1 Dependent Deductible / Family Deductible</u> – With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a</p>		

combination of family members.		
CALENDAR YEAR OUT-OF-POCKET MAXIMUM	Network Provider (In-Network)	Non-Network Provider (Out-of-Network)
Individual	\$2,000	\$3,000
Individual and 1 Dependent	\$4,000	\$5,000
Family (Employee and 2 or more Dependents)	\$6,000	\$7,000
<p>The Out-of-Pocket Maximum is the amount you are responsible for paying for a Covered Service. Eligible expenses will be applied to both the In-Network and Out-of-Network Out-of-Pocket Maximums. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, preventive care, expenses in excess of a benefit maximum, and charges in excess of the Allowed Benefit for Non-Network Providers.</p> <p><u>Individual Out-of-Pocket Maximum</u> – After the Individual Out-of-Pocket Maximum is satisfied, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all eligible expenses for the remainder of the calendar year. The medical and prescription Coinsurance amounts will no longer apply.</p> <p><u>Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum</u> – Both the Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum can be satisfied by one or more family members. Reduced limits for individual family members do not apply to the Out-of-Pocket Maximum. After the family's total out-of-pocket expenses equal this amount, benefits for all family members will be reimbursed at 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for the remainder of the Calendar Year. The medical and prescription Coinsurance amounts will no longer apply.</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	90%* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Newborn	90% After Deductible	70% of Allowed Benefit After Deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90%* After Deductible	70%* of Allowed Benefit After Deductible
Rehabilitation Facility*	90%* After Deductible	70% of Allowed Benefit * After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% After Deductible	90% After Deductible
Emergency Room - for HIV screening	100%	100%
Emergency Room - Non-Medical Emergency	90% After Deductible	70% of Allowed Benefit After Deductible

Outpatient – includes all services billed by the Hospital	90% After Deductible	70% of Allowed Benefit After Deductible
Ambulatory Surgical Facility	90% After Deductible	70% of Allowed Benefit After Deductible
Professional Expenses		
Anesthesia (Inpatient and Outpatient)	90% After Deductible	70% of Allowed Benefit After Deductible
Emergency Room - Accidental Injury or Medical Emergency	90% After Deductible	90% After Deductible
Emergency Room - for HIV screening	100%	100%
Emergency Room - Non-Medical Emergency	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)	90% After Deductible	70% of Allowed Benefit After Deductible
Physician office visit - Specialist	90% After Deductible	70% of Allowed Benefit After Deductible
Second Surgical Opinion	90% After Deductible	70% of Allowed Benefit After Deductible
Surgery (Inpatient and Outpatient)	90% After Deductible	70% of Allowed Benefit After Deductible

* Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (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)	90% After Deductible	70% of Allowed Benefit After Deductible
Allergy shots/serum (if billed separately from office visit)	90% After Deductible	70% of Allowed Benefit After Deductible
Allergy Testing - Primary Care Physician - Specialist	90% After Deductible	70% of Allowed Benefit After Deductible
Ambulance	90% 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)	90% After Deductible	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)	90% After Deductible	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)	90% After Deductible	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% After Deductible	70% of Allowed Benefit After Deductible
Orthopedic Appliance	90% After Deductible	70% of Allowed Benefit After Deductible
Patient Education (includes diabetes management and ostomy care)	90% After Deductible	70% of Allowed Benefit After Deductible
Pre-Admission Testing	90% After Deductible	70% of Allowed Benefit After Deductible
Private Duty Nursing	Not Covered	Not Covered
Prosthetics	90% After Deductible	70% of Allowed Benefit After Deductible
Renal Dialysis	90% After Deductible	70% of Allowed Benefit After Deductible
Therapy – Chemotherapy, Radiation, Physical, Occupational, Speech	90% After Deductible	70% of Allowed Benefit After Deductible
Urgent Care Center	90% After Deductible	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 Services		
Inpatient Hospital*	90%* After Deductible	70% of Allowed Benefit* After Deductible
Birthing Center	90% After Deductible	70% of Allowed Benefit After Deductible
Anesthesia	90% After Deductible	70% of Allowed Benefit After Deductible

Physician's Charges for Delivery	90% After Deductible	70% of Allowed Benefit After Deductible
Pre or postnatal office visits (not billed with delivery)	90% After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90% After Deductible	70% of Allowed Benefit After Deductible
Organ Transplants		
Inpatient Hospital*	90%* After Deductible	70% of Allowed Benefit* After Deductible
Anesthesia	90% After Deductible	70% of Allowed Benefit After Deductible
Transplant Procedure	90% After Deductible	70% of Allowed Benefit After Deductible
Laboratory tests, x-rays, diagnostic tests	90% After Deductible	70% of Allowed Benefit After Deductible
Preventive Care		
Preventive and Wellness Services for eligible adults and children in compliance with PPACA**	100%	70% of Allowed Benefit After Deductible

** A description of these services can be found at:
<http://www.healthcare.gov/law/about/provisions/services/lists.html>

* Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.

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*	90%* After Deductible	70% of Allowed Benefit* After Deductible
Inpatient Physician Visits	90% After Deductible	70% of Allowed Benefit After Deductible
Outpatient	90% After Deductible	70% of Allowed Benefit After Deductible
* Pre-certification from the Managed Care Vendor is required. Contact them prior to admittance to a Network Hospital or other facility Provider, or a penalty of 50% up to a maximum of \$500 will apply. Please call the Managed Care Vendor (InforMed) at (866) 475-1256.		
TYPE OF EXPENSE	Retail (30-day supply)	Mail Order (90-day supply)
Prescription Drugs		
All prescription expenses are subject to the Deductible. After the Deductible has been satisfied, the following Coinsurance amounts will apply.		
Generic Drugs	90% After Deductible	90% After Deductible
Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Non-Formulary Brand Name Drugs	90% After Deductible	90% After Deductible
Over-the-Counter Drugs related to	No Charge	

Preventive and Wellness Services as specified by PPACA**	
**A description of these services can be found at: http://www.healthcare.gov/law/about/provisions/services/lists.html	
NOTE: A Brand Name drug that has a Generic alternative is a Multisource Brand drug. If you are prescribed a Multisource Brand drug, and you purchase a Brand Name drug when a Generic drug is available, you will pay the difference in price between the Brand Name drug and the Generic drug, after the Plan covers the cost of the Generic drug. You will be required to pay this difference, even if your Physician writes "Dispense as Written".	

Notes:

1. Benefits for services provided by a Network Provider are payable as shown in the Summary of Benefits. To obtain In-Network benefits, you must use a 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 Network Providers to Non-Network Providers will be considered as Out-of-Network services. In order to receive In-Network benefits, ask your Physician to refer you to a Network Provider.
3. Anesthesia, x-rays, laboratory, emergency room services, inpatient consultations and other diagnostic services received at a Network Hospital or other facility Provider and rendered and billed by a Non-Network Provider will be paid at the In-Network benefit level, based on the Allowed Benefit. This exception does not apply if you and/or your Physician selected or had the opportunity to select a Network Provider and chose to receive services from a Non-Network Provider.
4. If a Network Provider performs diagnostic testing, X-rays, and other laboratory testing and the Network Provider sends the tests to a Non-Network Provider (such as a laboratory) for analysis and results, the Plan will pay at the In-Network benefit level, based on the Allowed Benefit.
5. If a Participant is temporarily residing overseas, his/her claims will be paid at the Out-of-Network benefit level.
6. Prescription drugs purchased overseas are not covered.
7. The Allowed Benefit is based on Plan allowances for treatment, services or supplies, rendered by a Non-Network Provider, essential to the care of the individual as determined by the Claims Administrator. Charges by a 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 Summary of Benefits. A fee schedule, selected by the Claims Administrator, may be used by the Plan in determining the amount of the Allowed Benefit.

PLAN PROVISIONS FOR THE QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN:

Deductible – The Deductible is a specified dollar amount that must be paid for eligible expenses each calendar year, before the Plan will provide benefits. Under the Qualified High Deductible Health Plan, expenses for all covered medical and prescription drug services, except Preventive Care, apply to the Deductible.

Individual Deductible – The Deductible for a Participant with individual coverage is shown in the Summary of Benefits. This Deductible must be met once each calendar year and applies to Covered Services indicated in the Summary of Benefits.

Individual and 1 Dependent Deductible / Family Deductible (Aggregate) – The Individual and 1 Dependent Deductible and the Family Deductible are shown in the Summary of Benefits. With both the Individual and 1 Dependent Deductible and the Family Deductible, there is no Individual Deductible. The entire Deductible amount must be met before benefits begin for any covered family member. The Deductible can be met in full by one family member or a combination of family members.

Out-of-Pocket Maximum – The Out-of-Pocket Maximum is the amount you are responsible for paying for a Covered Service. The following do not count towards the Out-of-Pocket Maximum: Deductibles, pre-certification penalties, expenses for non-Covered Services, preventive care, expenses in excess of a benefit maximum, and charges in excess of the Allowed Benefit for Non-Network Providers.

Individual Out-of-Pocket Maximum – After a Participant with individual coverage meets the amount shown in the Summary of Benefits, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all eligible expenses for the remainder of that Calendar Year. The medical and prescription Coinsurance amounts will no longer apply.

Individual and 1 Dependent Out-of-Pocket Maximum / Family Out-of-Pocket Maximum – The Individual and 1 Dependent Out-of-Pocket Maximum and the Family Out-of-Pocket Maximum include Coinsurance expenses incurred by one or more family members. After the family's total out-of-pocket expenses reach the maximum amount shown in the Summary of Benefits, the Plan will pay 100% of the allowance amount for Network Providers or the Allowed Benefit for Non-Network Providers for all family members' eligible expenses for the remainder of that calendar year. The medical and prescription Coinsurance amounts will no longer apply.

Prescription Coinsurance - The amount (shown in the Summary of Benefits) that a Participant is required to pay for a covered prescription after the Deductible has been satisfied. Coinsurance is expressed as a percentage and continues to apply until the Out-of-Pocket Maximum is met.

SECTION III: Current Plan Information

1. Name of current health insurance carrier: _____

2. Name of current dental insurance carrier: _____

3. Current Plan Details

Health Insurance	Employee	Employee/Child	Employee/Spouse	Family
Plan I				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Plan II				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Plan III				
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$
Dental Insurance	Employee	Employee/Child	Employee/Spouse	Family
Monthly Premium	\$	\$	\$	\$
Employer Contribution	\$	\$	\$	\$

Number of COBRA Participants _____

Is coverage offered to retirees? (attach policy) ___ Yes ___ No

Number of Retirees: ___ Over 65 ___ Under 65 Expected

enrollment (5 employee minimum) _____

Number of disabled employees _____

4. What other forms of health and welfare plans are available to your employees?

5. Please complete the attached census for all eligible employees.

6. Please attach bill for each employee benefit offered.

SECTION IV: Underwriting

1. To the best of your information and belief, is there any eligible person who has been treated for:

- | | |
|--|---------------------------|
| ___ AIDS/HIV | ___ Existing Pregnancy |
| ___ Birth Defects or Disorders | ___ Psychiatric Disorders |
| ___ Cancer | ___ Substance Abuse |
| ___ Chronic Heart, Kidney or Liver Disease | |

2. To the best of your information and belief, is there any eligible person who has incurred \$10,000 or more in medical expenses in the last 12 months or expects to be hospitalized for a serious medical condition? ___ Yes ___ No

Association Mutual
Health Insurance Company

PPO
Health Benefit Plan

Certificate of Coverage

January 1, 2008

WELCOME

We are very pleased to welcome you as a Member of Association Mutual Health Insurance Company PPO Health Benefit Plan. This health plan is offered by Association Mutual Health Insurance Company (AMHIC). This Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, hospice care, and private-duty nursing.

Special cost containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-admission Certification, and Individual Case Management. These programs ensure that you receive the Medically Necessary care in the most cost-effective manner. These cost containment provisions, if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC contracted with several prominent PPO networks (One Net, National Capital PPO, CareFirst and PHCS) to provide services to our Members. When you receive care from a contracted Network Provider, your benefits would be paid at a higher level than services performed by non-Network Providers. Network Providers will file claim forms for you and we will make payments directly to them. In order to ensure the proper use of the medical care system, we suggest you establish an ongoing relationship with a Network Physician.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

TABLE OF CONTENTS

SECTION		PAGE
1	INTRODUCTION	1
2	SUMMARY OF BENEFITS	4
3	DEFINITIONS	9
4	MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION AND COBRA	16
5	COST CONTAINMENT FEATURES	28
6	YOUR BENEFITS	31
	- Accidental Injuries	31
	- Ambulance Services	32
	- Anesthesia Services	33
	- Blood Expenses	33
	- Chemotherapy and Radiation Therapy	33
	- Chiropractic Services	34
	- Cleft Palate and Cleft Lip	34
	- Second and Third Surgical Opinions	35
	- Dental Services	35
	- Hemodialysis	37
	- Home Health Care	37
	- Hospice Care	38
	- Laboratory, Pathology, X-ray and Radiology Services	40
	- Maternity and Newborn Care	41
	- Medical Care for General Conditions	42
	- Medical Emergencies	43
	- Mental Health, Alcohol and Drug Abuse Care	44
	- Organ Transplants	45
	- Preventive Care for Adults	46
	- Preventive Child Care Services	47
	- Private-Duty Nursing Services	47
	- Rehabilitation Therapies: Occupational, Physical and Speech	48
	- Room Expenses and Ancillary Services	49
	- Supplies, Equipment and Appliances	50
	- Surgery	51
	Prescription Drugs and Medicines	54
7	GENERAL LIMITATIONS AND EXCLUSIONS	60

8	GENERAL PROVISIONS	65
9	HOW TO FILE HEALTH CARE CLAIMS	68
	- Claim Appeal Procedures	69
10	WORKERS COMPENSATION	75
11	AUTOMOBILE NO-FAULT INSURANCE PROVISIONS	76
12	THIRD-PARTY LIABILITY – SUBROGATION	77
13	DUPLICATE COVERAGE AND COORDINATION OF BENEFITS	78
14	PRIVACY OF PROTECTED HEALTH INFORMATION	81
15	HIPAA SECURITY STANDARDS	83

SECTION 1

INTRODUCTION

This Plan is a preferred Provider plan offered by Association Mutual Health Insurance Company (AMHIC) based on benefits, limitations, exclusions, and payment as determined by Association Mutual Health Insurance Company.

Your AMHIC PPO Health Benefit Plan identification card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Certificate will be provided as long as: you are enrolled under this Certificate when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Association Mutual Health Insurance Company PPO Health Benefit benefits to you (the Member). As a Member, you are bound by all the terms of this Certificate.

Association Mutual Health Insurance Company shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. Association Mutual Health Insurance Company decision shall be final.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and Certificates, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC. Any such change or modification shall have been either requested or signed by your Employer. Further no course of action, usage or custom or internal policy of AMHIC may amend or become part of our agreement with you.

If the Plan is terminated, amended, or benefits are eliminated, the rights of a Covered Person are limited to covered charges incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility for participation, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform the AMHIC duties there under.

How to Read This Certificate This Certificate is designed to make it easy for you to determine your benefits. For instance if you need to know the benefit for a surgery, turn to *Section 5: Your Benefits*.

The **Surgery** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. (**NOTE:** Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for AMHIC payments only with respect to particular types of care.)

The last part of each **BENEFITS** subsection lists the most important limitations and exclusions to that particular service. *Section 7: General Limitations and Exclusions*, lists other limitations and exclusions, which apply to all benefits. **The items in Section 7 apply to all services and supplies, whether or not these items are listed separately within any BENEFITS subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022
(703) 934-6227 or 1-800-888-6227

Identification Cards - After you enroll in this plan, you and your Dependents, if any, will receive an Association Mutual Health Insurance Company PPO Health Benefit Plan identification card. This card is for identification purposes only. While you are a Member, you must show your identification card to the Provider before you receive Covered Services. If your identification card is lost or stolen, you should contact our Customer Service Department at (703) 934-6227. A new identification card will be sent to you.

Finding an In-Network Provider You are enrolled in one of four PPO Networks and the name of your PPO Network is included on your identification card. To find out if a health care Provider is an In-Network Provider, you may look at your Network's website. To access your Network's website, go to www.amhic.com or www.NCAS.com. Due to changing of Providers within the Network, it would be best to confirm the Provider participates by calling the Provider.

Pre-certification Requirements If your Physician recommends that you or a covered family Member be Hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require Pre-admission certification. All other Hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned Hospitalization or within 48 hours after an urgent or emergency admission. If you do not comply with the pre-certification requirement, Covered Services will be reduced by 50% up to a maximum of \$500. To obtain admission certification, call Hines & Associates at (800) 670-7718.

How We Calculate Deductible, Copays, and Coinsurance

The Association Mutual Health Insurance Company PPO Health Benefit Plan is a preferred Provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use In-Network Providers. When you obtain services from a Non-Network Provider, you will usually receive a lower level of benefits. If this is the case, your out-of-pocket costs will be more.

AMHIC has contracted with networks of participating Network Providers in an attempt to control the costs of health care. As part of this effort, many Providers agree to control costs by giving discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. AMHIC provides its Members and their covered Dependents the highest level of benefits when services are rendered by In-Network Providers. There is no guarantee that In-Network Providers can provide all services all the time and services performed by In-Network Providers could change from time to time. If a service is not available from an In-Network Provider, the Out-of-Network benefit will apply.

In their contracts, Network Providers agree to accept the Network's allowable amount as contracted between the participating Provider and the Network as payment in full for Covered Services. For example, your Physician may charge \$100 for a procedure, and the Network's allowable amount is \$85. Your Deductible, Copay and Coinsurance are based on the Network's allowable amount of \$85, and not the Physician's charge of \$100, so if you use a Network Provider, you save money.

You benefit from all Network discounts. Discounts allow AMHIC and your Employer to offer more extensive plans with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer. Without Network discounts, your Employer might have to choose either a less extensive plan offering fewer benefits or pass the additional costs on to Employees.

SECTION 2

SUMMARY OF BENEFITS FOR PPO PLAN

PPO PLAN		
<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 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.</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. Please refer to Section 5.</p>		
INDIVIDUAL LIFETIME MAXIMUMS		
Overall Medical Maximum	\$2,000,000	
Hospice Care	180 days	
INDIVIDUAL CALENDAR YEAR MAXIMUMS		
Mental Health/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	
	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 (No more than \$200 per Individual can be applied toward the Family Deductible)	\$900 (No more than \$300 per Individual can be applied toward the Family Deductible)
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, and in and outpatient treatment of mental health and substance abuse disorders</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 R&C After deductible
Inpatient Newborn	\$100 copay, then 100% up to \$5,000, then 90% per confinement	70% of R&C After deductible
Skilled Nursing/Extended Care Facility* (maximum of 100 days per calendar year)	90%	70% of R&C After deductible
Rehabilitation Facility*	90%	70% of R&C 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 - non-emergency	90% After deductible	70% of R&C After deductible
Outpatient	100%	70% of R&C After deductible
Ambulatory Surgical Facility	100%	70% of R&C After deductible
Physician Expenses		
Anesthesia (In and Outpatient)	90%	70% of R&C After deductible
Emergency care in Emergency Room	100%	100%
Non-emergency care in Emergency Room	90% After deductible	70% of R&C After deductible
Physician hospital visit	90% After deductible	70% of R&C After deductible
Physician office visit	\$15 copay per visit, then 100%	70% of R&C After deductible
Second Surgical Opinion	100%	100%
Surgery (In and Outpatient)	90%	70% of R&C After deductible

* Pre-certification from Hines 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 R&C After deductible
Allergy shots/serum (if billed separately from office visit)	100%	70% of R&C After deductible
Allergy Testing	\$15 copay per visit, then 100%	70% of R&C After deductible
Ambulance	Not available In-Network Seek Non-Network Provider	70% of R&C After deductible
Cardiac Rehabilitation	90% After deductible	70% of R&C After deductible
Chiropractic Care (maximum of \$2,000 per calendar year)	\$15 copay per visit, then 100%	70% of R&C After deductible
Durable Medical Equipment	90% After deductible	70% of R&C After deductible
Home Health Care (maximum of 100 visits per calendar year)	\$15 copay per visit, then 100%	70% of R&C After deductible
Home Infusion Therapy	90% After deductible	70% of R&C After deductible
Hospice Care (maximum of 180 days per Lifetime)	100%	70% of R&C After deductible
Infertility Testing (maximum of \$1,000 per calendar year)	90% After deductible	70% of R&C After deductible
Laboratory tests, x-rays and diagnostic tests, including specialty imaging	90%	70% of R&C After deductible
Orthotics	90% After deductible	70% of R&C After deductible
Patient Education – (includes diabetes management, ostomy care)	90% After deductible	70% of R&C After deductible
Pre-Admission Testing	100%	100%
Private Duty Nursing	Not available In-Network Seek Non-Network Provider	70% of R&C After deductible
Prosthetics	90% After deductible	70% of R&C After deductible
Renal Dialysis	90% After deductible	70% of R&C After deductible
Therapy – Physical	\$15 copay per visit, then 100%	70% of R&C After deductible
Therapy – Chemotherapy, Radiation, Occupational, Speech	90% After deductible	70% of R&C After deductible
Urgent Care	\$15 copay per visit, then 100%	70% of R&C After deductible
All Other Eligible Expenses	90% After deductible	70% of R&C 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 R&C After deductible
Birthing Center	100%	100%
Anesthesia	90%	70% of R&C After deductible
Physician's Charges for Delivery	90%	70% of R&C After deductible
Pre or post natal office visits (not billed with delivery)	\$15 copay per visit, then 100%	70% of R&C After deductible
Laboratory tests, x-rays, diagnostic tests, specialty imaging	90%	70% of R&C After deductible
Organ Transplants		
Inpatient Hospital*	\$100 copay, then 100% up to \$5,000, then 90% per confinement	70% of R&C After deductible
Anesthesia	90%	70% of R&C After deductible
Transplant Procedure (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow, peripheral stem cell)	90%	70% of R&C After deductible
Laboratory tests, x-rays, diagnostic tests	90%	70% of R&C 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 R&C 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 R&C After deductible
Routine tests, x-rays, immunizations (billed separately from visit) (applies to \$500 calendar year max)	100%	70% of R&C After deductible
Routine Mammogram (does not apply to \$500 calendar year max)	\$15 copay per visit, then 100%	70% of R&C After deductible
Pap Smear (applies to \$500 calendar year max)	100%	70% of R&C 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 R&C After deductible

* Pre-certification from Hines 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 * (maximum of 60 days per calendar year)	\$100 copay, then 100% up to \$5,000, then 90% per confinement	50% of R&C After deductible
Inpatient Physician Visits	90% of R&C After deductible	50% of R&C After deductible
Outpatient *	\$20 copay per visit, then 100%**	75% of R&C for visits 1-40 and 60% of R&C for visits 41+ After deductible
** Pre-certification from Hines 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 800-670-7718.		
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 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. 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.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee– Employees who report for work with the *Employer* at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, *full-time* basis. If your usual place of employment is in your home, you will be considered *actively at work* if, at any time on the date in question, you are neither:

1. Confined in a *Hospital*; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, *full-time* basis.

As an *Employee*, you will be deemed *actively at work* on each day of a regular paid vacation or on a regular non-working day on which you are not *totally disabled*, provided you were *actively at work* on the last preceding regular working day.

Ambulatory Surgical Center– Is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Alcoholism Treatment Center– A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Ancillary Services– See this heading under *Section 5: Your Benefits, Room Expenses and Ancillary Services*.

AMHIC– Association Mutual Health Insurance Company domiciled in the District of Columbia.

Birthing Center– Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Biologically Based Mental Illness– Schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder; and any biologically based mental illness appearing in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Certificate of Coverage – A written document that reflects certain details about an individual's creditable health coverage. It is intended to establish an individual's prior Creditable Coverage for purposes of reducing the extent to which a plan offering health coverage can apply a pre-existing exclusion. You should have received a Certificate of Creditable Coverage from your prior plan. You

may request a Certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the Certificate. You must present that Certificate to the Employer in order for your Creditable Coverage to reduce your Pre-Existing Condition Waiting Period under this Plan.

COBRA– The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate– This document which constitutes the agreement between us and the Employer regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Coinsurance– The percentage of the cost of Covered Services that a Member must pay after the Copay or Deductible has been met.

Copay– A flat dollar amount a Member must pay to receive a specific service or benefit. The *Summary of Benefits* show the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment– A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any covered person who does not follow the cost containment requirements established by the cost containment organization may not receive the maximum benefits provided by this plan.

Covered Services– Services and supplies provided to a Member for which we have an obligation to pay under the terms of this Certificate.

Creditable Coverage - Coverage under almost any other type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps Plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-Existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-Existing Condition Waiting Period.

Customer Service Department– AMHIC's Customer Service Department for Medical is *c/o NCAS, P.O. Box 10136, Fairfax, VA 22038-8022, 1-800-888-6227*. The Customer Service Department for Prescription Drugs is *Express Scripts, Inc., 1-800-235-4357*.

Deductible– A specified amount of expense for Covered Services that the Insured must pay within each Member's Calendar Year before AMHIC provides benefits. The *Summary of Benefits* show the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent– An individual who meets the eligibility requirements described in Section 4 under Dependents.

Disability (Disabled)– In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Effective Date– The date when you or your covered Dependent(s) become covered under the plan.

Employer– Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date– The first day of coverage or, if there is a Waiting Period, the first day of hire.

ERISA– The Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational– Services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

Association Mutual Health Insurance Company must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. Association Mutual Health Insurance Company shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of Association Mutual Health Insurance Company will be final and binding on the Plan. Association Mutual Health Insurance Company will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Membership– A Membership that covers three or more persons (the Employee and two or more Dependents).

Hazardous Pursuits– Involve or expose an individual to risk of a degree or nature not customarily undertaken in the course of the Employee's customary occupation with the Employer or in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

Home Health Aide– A person licensed or certified to provide home health care services.

Home Health Care Agency– An agency certified by the state as meeting the provisions of Title XVIII of the Federal “Social Security Act,” as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

Home Hospice– An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital–A health institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Illness– A bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Identification Card– The card we give you that shows such information as the Member name, Member number, Policy name and type of coverage.

Individual Membership– A Membership covering one person.

Injury– An accidental physical Injury to the body caused by unexpected external means.

Insured– You or any Dependent who is enrolled for coverage under this Certificate under the terms of the Certificate. NOTE: “You” and “Your” refer to the Insured.

Legal Guardian– A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime– A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Maximum Benefit Allowance– The amount determined by AMHIC to be Reasonable and Customary (R&C) Allowance for a Covered Service. Our determination of a Maximum Benefit Allowance is the maximum amount we approve for any particular service. Deductible, Copay, and Coinsurance or other cost-sharing amounts are based on this allowance and are the amounts the Insured pays to a Provider.

Medicaid– Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Emergency – The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. We cover emergency services necessary to screen and stabilize a Member without prior authorization if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that an emergency medical condition or life or limb threatening emergency existed.

Medically Necessary– A term used to describe technologies, services, or supplies provided by a Hospital, Physician, or Other Provider that we determine in conjunction with qualified Providers are:

- Medically appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease, or injury;
- Provided for the diagnosis, or the direct care and treatment of the Insured's condition, illness, disease or injury;
- In accordance with standards of sound medical practice and meet with our technology evaluation criteria;
- Not primarily for the convenience of the Insured, or the Insured's Provider; and
- The most appropriate supply or level of service that can be safely be provided to the Insured. When applied to Hospitalization, this further means the Insured requires acute care as an inpatient due to the nature of the services rendered or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

NOTE: The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, by itself, make it a Medically Necessary or covered expense, even though it is not specifically listed as an exclusion. Claims for services and supplies that are not Medically Necessary may be denied either before or after Payment.

Medicare— Health insurance for the aged and disabled as established by Title I of public Law 89-98 (79 Statutes 291) including parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member— The person in whose name the Membership is established and to whom the Identification Card is issued.

Member's Benefit Year— The Member's Benefit Year begins on the Member's Effective Date of Membership as established for the Member, and expires on the following December 31; a Member's new Benefit Year begins on each subsequent January 1.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Network Provider— A panel of Licensed Providers and/or a group of participating healthcare institutions which provide medical services to contracted groups of Members. Savings received because of the contracted rates are not the responsibility of the Member. Contact NCAS or access the Preferred Provider Organization's (PPO) website, to determine if a Provider participates.

No-Fault Auto Insurance— The basic reparations provision of a law providing for payment without determining fault in connection with automobiles accidents.

Non-Network Provider— A Facility Provider (such as a Hospital) or a Professional Provider (such as a Physician) that has not entered into an agreement with us or which the Member is not enrolled.

Palliative Treatment – Relief of symptoms for a time but does not cure or end the cause of symptoms.

Participant - Any eligible Employee or eligible Dependent who has elected coverage in this Plan and has fulfilled all requirements to continue participation.

Pay, Paid, or Payment— "Pay" means to satisfy a debt or obligation. After the R&C or Maximum Benefit Allowance is determined, AMHIC will satisfy its percentage of the bill by an actual dollar AMHIC PPO

Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Insured's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy– A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician - A properly Licensed Provider holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption - The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's Placement for Adoption with such person terminates upon the termination of such legal obligation.

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the Effective Date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Member or Dependent if the Employer fails to make Premium payments.

Protected Health Information (PHI) - Individually identifiable health information which is maintained or transmitted by a health plan.

Provider – A person or facility that is recognized by AMHIC as a health care Provider, and fits one or more of the following descriptions:

- Professional Provider – A Physician or Other Professional Provider who is recognized by AMHIC.
- Other Professional Provider – A Professional Provider (except a Physician) that is recognized by AMHIC and licensed, certified, or registered by the state or jurisdiction where services are provided to perform designated health care services. This includes certified nurse midwives. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority appointed by us. A professional supplier of medical supplies and equipment is considered an Other Professional Provider.
- Facility Provider – An Alcoholism Treatment Center, Home Health Care Agency, Hospice Agency, Hospital, or Other Facility which we recognize as a health care Provider. These Facility Providers may be referred to collectively as a Facility Provider or separately as an Alcoholism Treatment Center Provider, Home Health Agency Provider, Hospice Agency Provider, Hospital Provider, or Other Facility Provider.
- Other Facility – A Facility Provider (except a Hospital, Alcoholism Treatment Center, Home Health Agency, or Hospice Agency) that we recognize as a Provider and that is licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority appointed by us. Examples: ambulatory surgery center, dialysis center, Veteran's Administration, or Department of Defense Hospital.

Reasonable and Customary Allowance - Plan allowances for treatment, services or supplies essential to the care of the individual as determined by the Claims Administrator. Charges by the Licensed Provider must be the amount usually charged for similar services and supplies when there is no insurance. Charges for Covered Services that do not exceed the amount in the fee schedule

used by the Plan will be reimbursed as specified in the Schedule of Benefits. The fee schedule published by MDR is used by the Plan to determine the Reasonable and Customary Allowance.

Room Expenses – See this heading under *Section 5: Your Benefits, Room Expenses and Ancillary Services*.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Significant Break in Coverage - A break in coverage of 63 days or more. Waiting Periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the plan when evaluating whether to impose a pre-existing condition limitation period.

Waiting Period - A Waiting Period is the period that must pass before an Employee or Dependent is eligible to enroll under a group health plan. The Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee - All regular, full time Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of *20 hours per week*, and their Dependents are eligible for Membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement of at least six months shall be classified as eligible. The Employer must cover any such individuals as a Class providing the same level of Employer contributions as set forth in a written policy or manual to all Members of the class.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth in the Employer plan, and meeting AMHIC requirements, are eligible for Membership. To be considered a qualifying retiree you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file with AMHIC and include one of the following two minimum requirements:

- a) You must be age 55 or older with 10 or more years of active service with one of the participating organizations of AMHIC; or
- b) You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any Dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC qualifying retiree.

AMHIC eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from active status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage. If a Medicare eligible retiree does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the AMHIC plans will pay as if Medicare were Primary.

Check with your Human Resources Department to see if your employer has a post-retirement health policy.

Dependents - Eligible Dependents are your:

- a) A legal Spouse as defined by applicable state law.
- b) An unmarried child who is the natural or legally adopted child of the Member, through the end of the month in which the child becomes age 19.
- c) Your same or opposite-gender domestic partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy;
- d) An unmarried child who is the natural or legally adopted child of the Member, between the age of 19 thru 26 who is enrolled as a full-time student in a university, college, vocational

school, secondary school or institution for training of nurses and who is primarily Dependent on the Member for financial support. A Full-Time student's coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated on the (last day of the month) of the attended school term. A Student Certification form, indicating Full-Time Student status, must be updated by the Employee and sent to the Employer by August 31st of each school year. The Student Certification must be forwarded to AMHIC.

- e) An unmarried child age 19 and older who is incapable of self-support because of mental incompetence or severe physical handicap and is Dependent on the Member for financial support, as certified by a Physician and us. The condition must begin before or during the month in which the child reached age 19 (age 26 if full-time student). We require proof acceptable to us of the child's physical or mental Disability each Insured's Benefit Year.
- f) Any child of a Participant who does not qualify as a Dependent under subsections c, d or e above, solely because the child is not primarily Dependent upon the Participant for support so long as over half of the support of the child is received by the child from the Participant pursuant to a multiple support agreement.

A Spouse or child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse or Domestic Partner**" means the person recognized as the covered Employee's husband, wife, or same or opposite-gender domestic partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy; and under the laws of the state where the covered Employee lives. Association Mutual Health Insurance Company may require documentation proving a legal marital relationship. You must notify AMHIC if your Spouse, Domestic Partner, or Dependent child has access to health insurance coverage under another Plan, such as through coverage provided by your Spouse's Employer or as the result of a divorce decree.

The term "**Dependent children**" means any of a Participant's:

- a) Natural children;
- b) Legally adopted children or children placed in the Employee's home pending final adoption;
- c) Stepchildren who depend on you for support;
- d) Foster children (provided the foster child is not a ward of the state);
- e) Children who are under the Legal Guardianship of the Employee;
- f) Children of a domestic partner;
- g) Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
- h) Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation could include:

- a) A Birth Certificate;
- b) A Marriage License;
- c) Court documents, legal separation, guardianship or adoption
- d) AMHIC Affidavit of Domestic Partnership;
- e) Medicare Parts A & B card (if employer has a retiree policy);
- f) Proof of Loss of Coverage;
- g) Certificate of Prior Coverage (HIPAA);
- h) Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee - To become covered by the Plan, you must complete an enrollment application. During your new Employee orientation, you will be given an application to complete. You should return the completed form to your Employer within 31 days from your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing Individual, Individual Plus One or Family coverage. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) 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:

- a) The Employee was covered under a health plan (including COBRA coverage) at the time coverage was initially offered;
- b) If required by AMHIC, the Employee states in writing that the other coverage is the reason for declining enrollment;
- c) The other coverage that the Employee had was COBRA coverage and the COBRA coverage was exhausted;
- d) The coverage is other health plan coverage and it is terminated due to loss of eligibility:
 - 1) as a result 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), termination of employment, or reduction in the number of hours of employment or termination of employer contributions to the coverage and not due to failure to pay 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);
 - 2) The other coverage the Employee had was offered through an HMO, or other arrangement (in the group or individual market) that does not provide benefits to individuals who no longer reside, live, or work in a service area and (in the case of group coverage through an HMO) no other benefit package is available to the individual;
 - 3) An individual incurs a claim that would meet or exceed a lifetime limit on all benefits.
 - 4) A plan no longer offers any benefits to a class of similarly situated individuals.

NOTE: When a loss of eligibility occurs, the Employee must request enrollment in writing within 31 days of exhaustion, termination of coverage or (in the case of the lifetime limit) of the date a claim is denied due to the lifetime limit.

- e) 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:

- 1) In the case of a marriage, on a date specified by AMHIC 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;
 - 2) In the case of a Dependent's birth, the date of such birth;
 - 3) In the case of a Dependent's adoption or Placement for Adoption, the date of such adoption, or Placement for Adoption.
- f) 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 initially join the Plan during an Open or 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. In order to have the pre-existing condition limitation reduced or waived, you must provide your Employer with a Certificate of Creditable Coverage from your prior health plan or coverage. Please contact your prior Employer or health plan for this Certificate.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of eligibility.

New Dependents – A newborn, an adopted child, a child placed for adoption and a previously ineligible Dependent who meets the eligibility requirements (i.e. an over-age Dependent child is not a full-time student and then becomes a full-time student) are eligible to be added to the Plan.

Coverage for the new Dependent becomes effective on the date of eligibility provided that you request enrollment within 31 days.

See the section entitled Special Enrollment Period for further information.

Open Enrollment - Before the Plan Year begins, an open enrollment period shall be authorized to allow eligible Employees (including COBRA participants and retirees) to change their participation elections, to obtain new participation for the Employee and/or eligible Dependents, or to accept transfers of Employees covered under the Network Only Plan and the HMO. You may also change your network selection at this time. The Open Enrollment period shall be held before the Plan Year begins with an Effective Date of the following January 1st.

Re-Enrollment Provision - If an eligible Employee takes FMLA leave, as defined by the Family and Medical Leave Act (FMLA), due to one or more of the following:

- a. Because of the birth of a son or daughter of the Employee and in order to care for such son or daughter;
- b. Because of the placement of a son or daughter with the Employee for adoption or foster care;
- c. In order to care for the spouse, or a son, daughter, or parent, of the Employee, if such spouse, son, daughter, or parent has a serious health condition;
- d. Because of a serious health condition that makes the Employee unable to perform the functions of the position of such Employee;

and terminates his or her coverage in the Plan, he will be able to re-enroll in the Plan upon return to active employment at the conclusion of a period not to exceed that defined by the FMLA. This Employee will **not** be subject to Pre-existing Waiting Period provisions.

Enrollment forms are obtainable from your Employer's Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume

employment with your Employer within a period of time specified by the Employer, you will become eligible for Reinstatement of Coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Waiting Period or Pre-existing Waiting Period if prior to re-employment you worked long enough to satisfy these Waiting Periods. (A Certificate of Creditable Coverage will be required.)

Leave of Absence (other than Family and Medical Leave Act absence) – If you are on an approved Leave of Absence that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of Continuation Coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Waiting Period or Pre-existing Waiting Period if prior to the Leave of Absence you worked long enough to satisfy these Waiting Periods.

Changing Coverage -You may change your election during the Plan Year if you experience a Life Event. Your election is the type of coverage you selected when you enrolled (i.e. Individual, Individual Plus One or Family coverage). The following is a list of Life Events:

1. Legal Marital Status - Events that change your legal marital status, including marriage, death of Spouse, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including regaining eligibility status (e.g. returning to school full-time), birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change employment status of Employee or Dependent(s) such as termination or commencement of employment, a reduction or increase in hours of employment, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence and any change in employment status resulting in person becoming eligible or ceasing to be eligible under a Plan;
4. Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents;
5. Residence or Worksite - A change in the place of residence or work for you, your Spouse, or your Dependent; or
6. Other Events ;
 - a. Judgment, Decree or Order - If you or your Spouse are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your child, you may make a corresponding change in your election.
 - b. Medicare/Medicaid Coverage - If you, your Spouse, Domestic Partner or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
 - c. Eligibility for COBRA - If you, your Spouse, Domestic Partner or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
 - d. Family and Medical Leave Act - If you take leave under the Family and Medical Leave Act ("FMLA"), you may make other elections concerning group health coverage that are permitted by FMLA.
 - e. Significant Cost Increases. If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
 - f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.
 - g. Changes Under Another Employer's Plan - You may also change your elections to correspond to certain changes that your Spouse, Domestic Partner or a Dependent

makes to his or her benefit elections under a benefit Plan offered by his or her Employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee, Spouse, Domestic Partner or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Spouse's, Domestic Partner's or Dependent's Employer; and that the election change corresponds with that gain or loss of coverage.

You must contact the your Employer's Human Resource Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your Life Event change.

When Can I Change or Cancel Enrollment? – You may change or cancel coverage in the Plan if you have an eligible Life Event change or during Open Enrollment.

You must contact the your Employer's Human Resource office to verify eligibility to cancel coverage and fill out the appropriate paperwork within 31 days.

Uniformed Service under USERRA – A Participant who is absent from employment with the Employer on account of being in “uniformed service” as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period in which he is in “uniformed service.” The manner in which such payments are made shall be determined by AMHIC in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee unless such Pre-Existing Condition exclusion or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents - The Effective Date of the eligible Employee is on the later of the following dates:

- a. The Employer's Effective Date;
- b. The first of the month following an Employee's hire date, unless the Employee's hire date is on the first business day of the month, in which case coverage is effective on the Employee's date of hire.

If you are not *actively at work* for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to *active employment*.

New Employees: New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, are effective on the first day of the month following the date of eligibility.

New Dependents - If you acquire a new Dependent (birth, marriage or adoption) refer to the section entitled Special Enrollment Period. If a previously ineligible Dependent meets the eligibility requirements, refer to the section entitled How Do I Enroll.

If your current enrollment election already provides coverage for the Dependent without a change, coverage is in effect from the date of eligibility upon receipt of a new enrollment application.

Changing Coverage - If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new identification card.

Late Enrollee - An individual whose enrollment in a plan is due to a late enrollment. Participants who join the Plan during Open Enrollment are Late Enrollees. A late enrollment means enrollment in any AMHIC sponsored medical plan other than on:

- the earliest date on which coverage can become effective under the plan; or
- a special Enrollment Date.

Pre-existing Waiting Period - A pre-existing condition is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the Enrollment Date. Participants must satisfy a 10-month Waiting Period from the Enrollment Date before becoming eligible to receive benefits for pre-existing conditions.

This provision will not apply to newborns or children who are adopted or placed for adoption and enrolled in the plan within 31 days. Pregnancy is not considered a pre-existing condition.

If an Employee or Dependent has not satisfied the pre-existing condition Waiting Period of the Employer's plan in effect immediately prior to the Effective Date of this Plan, credit will be given for

the period of time which elapsed while the Participant was covered by the prior plan.

The period of pre-existing condition exclusion will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Coverage may be used for this purpose.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends If your group is covered by provisions requiring continuation of group coverage under District of Columbia or Federal Law (Consolidated Omnibus Budget Reconciliation Act of 1985 *COBRA*), you and your covered Dependents who lose eligibility under a group may be able to continue as group Members for a limited period of time. Contact your group for more information. AMHIC offers COBRA to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the deletion will be effective on the last day of the month.

If a Member does not elect or does not qualify for COBRA continuation, coverage under this Certificate ends on the last day of the month.

For any Insured, including Dependents:

- When the Member's Employer gives us Written Notice of termination or reduction of hours. If the Employer fails to timely remove an ineligible Insured, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date.
- Upon the Member's death. NOTE: If your benefits as an active Employee or qualifying retiree end due to your death, your Surviving Dependents' coverage may continue under this plan. Surviving Dependents are allowed to continue coverage offered by Association Mutual Health Insurance Company Employee Benefit Plan.
- When we do not receive the Premium payment on time.
- When there is fraud or intentional misrepresentation of material fact on the part of the Insured.
- When the Insured is no longer eligible for this group coverage under the terms of the Certificate.
- The date group coverage under this Certificate is discontinued for the entire group, or the Member's enrollment classification.
- A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to the Employer from whose employment a covered Employee retired at any time.

For a Dependent:

- When the Dependent child marries, such a Dependent has the right to select COBRA continuation.
- At the end of the last paid billing period for Dependent coverage.
- When the Dependent no longer qualifies as a Dependent by definition, such a Dependent has the right to select COBRA continuation.
- The date of a final divorce decree or legal separation for a Dependent Spouse, such a Dependent has the right to select COBRA continuation.
- When the Member notifies us in writing to end coverage for a Dependent.
- When a domestic partnership is terminated.

We will not refund Premiums paid on behalf of a Participant if:

- We do not receive Written Notice of termination/change within 31 days of the Effective Date of termination/change; or
- We have paid any claims on behalf of the deleted Participant.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the Certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A covered person may continue coverage for a period of 18, 29 or 36 months, at his/her own expense, pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" as follows:

1. Termination of Employment: A covered Employee, Spouse, Domestic Partner and Dependent child (qualified beneficiary) may elect to continue coverage under this Plan for up to 18 months, if their eligibility ends due to one of the following qualifying events:

- a. The covered Employee is terminated (for reasons other than Gross Misconduct*);
- b. The covered Employee's number of hours of employment is reduced.

* Gross Misconduct is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his or her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and nondisabled family Members who are entitled to COBRA continuation coverage, if he is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security Disability Income benefits.

The Qualified Beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's Disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

- a. The date of the Social Security Administration's Disability determination
- b. The date on which the qualifying event occurs
- c. The date on which the qualified beneficiary loses coverage; or
- d. The date on which the qualified beneficiary is informed of the obligation to provide the Disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days after it determines that he is no longer disabled. Please send the required documentation to the COBRA Plan Administrator at the address shown at the end of this Section.

2. Loss of Dependent Eligibility: A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his or her eligibility ends due to any of the following qualifying events:

- a. The covered Employee dies
- b. The covered Employee is divorced or legally separated
- c. The covered Employee becomes eligible for and elects Medicare benefits
- d. A Dependent child ceases to be a Dependent (as defined by the Plan).

The Employee or covered Dependent must notify the Employer as follows:

Notice Obligations

A covered Employee, Spouse or Dependent is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of domestic partnership or of the Employee's child losing Dependent status. The qualified beneficiary must notify the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later. Written notification must be provided to your Employer.

The qualified beneficiary may be required to complete a "COBRA Qualifying Event Notification Form" and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in COBRA coverage being forfeited.

Multiple Event Extension: If a covered Dependent elects the 18 month continuation following an event shown in Part 1 and later becomes entitled to a 36 month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18 month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage Effective Date, the Dependent must notify the COBRA Plan Administrator in writing, within 60 days of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

- 3. Retirees and Bankruptcy** – Covered retirees of an Employer that declares Chapter XI bankruptcy are eligible for continuation coverage if they lose coverage within one year before or after the bankruptcy proceedings begin. Retirees may continue their coverage until their death. The Spouse and Dependent children of the retiree are eligible for continuation coverage until the retiree's death plus an additional thirty-six months of coverage after the date of the retiree's death.

Election - A covered Employee can elect COBRA coverage for himself or herself and/or his or her covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for his or her Dependents, such coverage may be elected by the Dependents. No Spouse, domestic partner or child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before any of the above qualifying events except for the following: A Qualified Beneficiary includes a child born to or placed for adoption with a covered Employee during the period of COBRA coverage. An election on behalf of a minor child can be made by the child's parent or Legal Guardian.

To continue coverage, the Employee or Dependent, hereinafter called a continuee, affected by the qualifying event must make written election by the 60th day following: (a) the last day of coverage;

or (b) the date he is sent notice of the right to continue coverage; whichever is later.

Within 45 days of the election date, the continuee must pay the required monthly Premium for the COBRA coverage period prior to the election. The 18 or 36 month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium - The due date for the monthly Premium is the first day of each coverage month and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims - No claim will be payable under this COBRA provision, until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination - Coverage under the COBRA provision will terminate on the earliest of the following:

- a. The date on which the Employer ceases to provide a group health plan to Employees;
- b. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
- c. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
- d. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
- e. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
- f. The end of the applicable 18, 29 or 36 month period. In no case will coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period;
- g. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

NCAS
PO Box 3065
Fairfax, VA 22038
(703) 934-6227 or (800) 888-6227

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by Hines & Associates, the Managed Care Vendor (MCV). The staff at the Managed Care Vendor are Physicians and Registered Nurses who monitor the use of your health care benefits to ensure that you and your family:

- a. Receive the best medical care possible in the most appropriate health care setting;
- b. Avoid unnecessary surgery and excess Hospital days;
- c. Receive medical advice on questions you have regarding medical care;
- d. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the Managed Care program include:

- a. Pre-certification of all:
 - Hospital admissions, including inpatient psychiatric and obstetrical admissions;
 - Outpatient treatment for mental health and substance abuse conditions;
- b. Continued Stay Review of all Hospitalizations;
- c. Case management of potentially catastrophic cases;

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of MCV. This may include, but is not limited to the following reviews:

- a. Cosmetic
- b. Investigational/Experimental
- c. Outpatient services, e.g. speech therapy, physical therapy, chiropractic services

Otherwise, all medical necessity review will be performed at NCAS utilizing the CareFirst Medical Policy.

HOW THE MANAGED CARE PROGRAM WORKS

PRE CERTIFICATION:

- a. If your Physician recommends that you or a covered family Member be Hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require Pre-admission certification. All other Hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned Hospitalization or within 48 hours after an urgent or emergency admission. To obtain pre-certification, call:

Hines & Associates: (800) 670-7718

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

- b. Notification may be initiated by you, a family Member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 24 hours. At that time the Hospital will be advised of the number of approved days.

- c. Outpatient services for mental health and substance abuse require Hine's approval of a plan of treatment before benefits for covered in-network services are provided. Benefits are only available when a plan of treatment is provided to and approved by Hines.

CONTINUED STAY REVIEW:

- a. If necessary, you, a family Member, your Physician, or the Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review.
- b. If your admission or request for extension is denied; you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in Complaints and Appeals in *Section 8: How to File Claims and Appeals*.

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission (or out-patient mental health and substance abuse care), covered charges will be reduced by 50% to a maximum of \$500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay. If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse, midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic illness or accident, which usually results in a lengthy stay or multiple Hospital confinements. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

By fully exploring treatment alternatives and, when appropriate, using a flexible approach to benefit administration, the case manager, Physicians, patients and families are able to work together to provide the patient with quality care which promotes the fullest recovery possible, in the most effective manner.

"A flexible approach to benefit administration" means that the case manager can approve treatment alternatives which usually are not covered under the Plan but will provide quality care to the patient and generate a savings over other covered options.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Certificate, and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and meet the eligible for coverage criteria under the definition of Experimental/Investigational. Please see these definitions in *Section 2: Definitions*. All benefit items listed in this *Section 6*, are subject to the following provisions *Section 5: Cost Containment Features* and *Section 7: General Limitations and Exclusions*. *Sections 6 and 7* of this Certificate explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Out-of-Network Providers are based on the Reasonable and Customary allowance. In-Network payments are based on the allowable amount as contracted between the Provider and the PPO Network.

Association Mutual Health Insurance Company shall have the discretionary authority to determine your eligibility and all benefits and all terms contained in your Certificate. The Association Mutual Health Insurance Company's decision shall be final.

Hospital Benefits This portion of your coverage pays for the services and supplies described in this section when they are provided by the following Facility Providers:

- Alcoholism Treatment Centers
- Home Health Care Agencies
- Hospice Agencies Hospitals
- Other Facilities such as: Extended Care Facility, Ambulatory Surgical Facility, Birthing Center, Inpatient Nursery Services, Emergency Room Services

We require Hospital admission pre-certification (See *Section 5: Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by the following Professional Providers:

- Physicians
- Other Professional Providers

Accidental Injuries

Definition - Internal or external injuries caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions. (Examples: strains, animal bites, burns, contusions, and abrasions.)

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services. For a more detailed explanation, please refer to **Medical Care for General Conditions and Room Expenses and Ancillary Services**. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or Other Facility is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under **Medical Care for General Conditions**. Please refer to that section for further information.

Outpatient: Medical care provided by a Physician or Other Professional Provider is covered. Please refer to **Medical Care for General Conditions** for additional information.

Limitations and Exclusions

Surgical Services — When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the Surgery subsection of this Certificate.

Ambulance Services

Definition - a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Insured cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

- Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
- Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
- When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the limits shown above, under **Hospital Benefits**.

Limitations and Exclusions

- **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Insured's physical condition requires the services of an air ambulance. Our medical consultants determine, on a case-by-case basis, when transport by ambulance is a benefit. If our medical consultants decide that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.
- **Other Transportation Services** — We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
- **Patient Safety Requirement** — If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or Other Facility.

Medical-Surgical Benefits Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

- **Acupuncture** — We cover only if Medically Necessary. See the *Summary of Benefits* for amount of benefits and limitations.
- **Hypnosis** — See this heading under *General Limitations and Exclusions*.
- **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
- **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
- **Other** — **The Limitations and Exclusions** that apply to Surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition - Blood expenses include the following items:

- Charges for processing, transporting, handling, and administration.
- Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or Other Facility for processing, transporting, handling, and administration. We provide benefits as explained under **Medical Care for General Conditions**. Covered expenses include charges made by a Hospital or Other Facility for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

- **General** — **The Limitations and Exclusions** that apply to **Surgery** benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

- **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

- **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an **Inpatient** or **Outpatient** basis is covered.

Limitations and Exclusions

- **Chemotherapy and Radiation Therapy** — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition - Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an illness or accidental injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

- **Conditions and Treatment** — The health problem in the form of a neuromusculoskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
- **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
- **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. (See the Surgery section for covered benefits).

Cleft Palate and Cleft Lip

Definition

- **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
- **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under Room Expenses and Ancillary Services.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or Other Facility when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

- Speech therapy.
- Otolaryngology treatment.
- Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or Other Professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery. (See the Surgery subsection.)

Outpatient: We will allow benefits when provided by a Physician or Other Professional Provider for the following services: Speech therapy. Otolaryngology treatment. Audiological assessments. Orthodontic treatment. Prosthodontic treatment. Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

- **Benefit Eligibility** — Refer to *Section 3: Membership Eligibility, Enrollment, Changes, and Termination* under How and When You May Add Dependents for details on newborn coverage.
- **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. We must give written authorization for such dental benefits in advance of the date of service. For details, please refer to the heading Prior Benefit Authorization in *Section 4: Cost Containment Features*.
- **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary. (See *Section 2 Definitions*, under Medically Necessary.)
- **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. We must give written authorization for such surgical benefits in advance of the date of services.

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

- **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the **Surgery** subsection.

- Excision of exostosis of the jaw (removal of bony growth).
- Surgical correction of accidental injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
- Treatment of fractures of facial bones.
- Incision and drainage of cellulitis (inflammation of soft tissue).
- Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five categories listed above under **Inpatient** benefits, as well as for related services provided by a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five categories of procedures referenced above under **Inpatient Hospital Benefits** when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your doctor or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical Benefits when you meet **all** of the following criteria:

- You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily injuries **outside** the mouth or oral cavity
- Your Injury occurred on or after your Effective Date of Membership. NOTE: This criteria applies regardless of any pre-existing conditions clause or waiver thereof.
- Treatment must be for injuries to your sound natural teeth.
- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.
- The first services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident.
- All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of injuries from biting or chewing.

Limitations and Exclusions

- **Facility Charges** — Inpatient and outpatient services at a Facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
- **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-authorization certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to the paragraph entitled **Pre-Authorization Certification** in *Section 5: Cost Containment Features*.
- **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
- **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or “spare” dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
- **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.

- **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *General Limitations and Exclusions*.

Hemodialysis

Definition - the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or Other Facility. We allow benefits as explained in **Medical Care for General Conditions**.

Outpatient: Services are covered if you are treated in a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or Other Facility. We allow benefits as explained in **Medical Care for General Conditions**.

Outpatient: Services are covered for treatment in a Hospital, Other Facility, or in your home.

Home Health Care

Definition - the following services provided by a certified Home Health Care Agency under a plan of care to eligible Insured in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary, and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency.

We allow benefits for up to 100 visits by a Member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a Member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

- Professional nursing services performed by a registered nurse (RN) and licensed practical nurse (LPN).
- Physical therapy performed by a registered physical therapist.
- Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
- Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.
- Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly

accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.

- Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
- Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
- Medical supplies furnished to the Insured by the Home Health Care Agency during visits for services.
- Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

- Prostheses and orthopedic appliances.
- Rental or purchase of durable medical equipment (except hemodialysis equipment).
- Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
- Homemaker services for the patient only.

Limitations and Exclusions

- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient Hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
- **Non-Covered Services** — The following list of services are not home health care benefits:
 - Blood, blood plasma, or blood derivatives.
 - Services provided by a Hospital.
 - Services provided by a Physician.
 - Services related to non-covered conditions and surgeries, as excluded in this Certificate.
 - Services or supplies for personal comfort or convenience, including "homemaker" services.
 - Services related to well-baby care.
 - Food or housing.
- **Prior Authorization** — The Physician treating your condition must submit a prior benefit authorization request for any prescribed home health care services.
- **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as **Outpatient** benefits as described under **Mental Health, Alcohol or Drug Abuse Care**.
- **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition - an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice

care addresses physical, social, psychological, and spiritual needs of the patient and his or her family.

Benefits - Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Insured's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Insured with a life expectancy of six months or less, who alone or in conjunction with a family Insured or Insured, has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Insured's illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

- Hospice day care services provided on a regularly scheduled basis in a Hospital, skilled nursing facility or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations
- Hospice home care services provided in the Insured's home to meet the Insured's physical requirements and/or to accommodate a Insured's maintenance or supportive needs
- Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN)
- Intermittent and 24-hour on-call social/counseling services Certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons
- Therapies, including physical, occupational, and speech
- Nutritional counseling by a nutritionist or dietitian
- Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Insured or family in dealing with a specified medical condition, and family counseling related to the Insured's terminal condition
- Homemaker services for the patient only Medically Necessary surgical and medical supplies
- Drugs and biologics billed by the hospice Provider
- Oxygen and respiratory supplies
- Radiation therapy and chemotherapy
- Rental of durable medical equipment when billed by the hospice Provider
- Bereavement support services up to six visits for the family within 90 days following the death of the Participant

Limitations and Exclusions

- **Non-covered Services** — The following items and services are not covered expenses under this Hospice Care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:
 - Blood, blood plasma, or blood derivatives
 - Services provided by a Hospital
 - Services related to non-covered conditions and surgeries, as excluded in this Certificate

- Food services or meals other than dietary counseling
- Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care
- Private duty nursing
- Services by volunteers or people who do not regularly charge for their services
- Services by licensed pastoral counselor to a insured of his congregation
- **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
- **Prior Benefit Authorization** — We must give written authorization for hospice care benefits in advance of the date of service.

Laboratory, Pathology, X-ray, and Radiology Services

Definition

- **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs).
- **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or Other Facility. Benefits are allowed as set forth under **Medical Care for General Conditions** and **Mental Health, Alcohol, or Drug Abuse Care**. **Outpatient:** Services are covered when provided by a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

- **Mammogram Services** — For benefits see *Preventive Care for Adults* and X-ray and radiology services.
- **Mental Illness, Alcohol and Drug Abuse** — Outpatient laboratory and X-ray services for the diagnosis or treatment of these conditions are subject to the outpatient benefit limits described in Mental Health, Alcoholism, or Drug Abuse Care.
- **Non-covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-benefit service.
- **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or Other Facility are allowed only when our records show that the Physician has one of the following agreements with the facility:
 - The Hospital or Other Facility will bill only for technical services such as charges for use of equipment; or
 - The Hospital or Other Facility will not submit any charges for laboratory or X-ray services.
- **Prostate Screening** — For benefits see *Preventive Care for Adults*.
- **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs. For details, see *General Limitations and Exclusions*, under **Obesity and Weight Loss**.

Maternity and Newborn Care

Definition:

Maternity services - services required by a Member for the diagnosis and care of a pregnancy (excluding over the counter products) and for delivery services. Delivery services include:

- All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Insured receives from her obstetrician or nurse midwife.
- Normal delivery.
- Caesarean section.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic or elective termination of pregnancy prior to full term.
- Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions Association with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.

Newborn services include —

- Routine Hospital nursery charges for a newborn well baby.
- Routine Physician care of a newborn well baby in the Hospital after delivery.
- Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
- All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under **Medical Care for General Conditions**. Routine Hospital nursery charges are also covered.

We may not, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, AMHIC provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not, require the Provider obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered charges include: Pre-natal medical care. A Hospital or Other Facility's charges for use of labor, delivery, recovery, and nursery rooms. Laboratory and X-ray services related to pre-natal or post-natal care. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

- Delivery services (post-natal medical care is included in the allowance for delivery services).
- Professional component for interpretation of laboratory and X-ray results.
- Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section. (See Newborn Child Benefits below.)

Outpatient: The following services are covered when billed by a Physician:

- Pre-natal medical care.
- Delivery services (post-natal medical care is included in the allowance for delivery services).
- Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

- **Artificial Conception** — See this heading under *General Limitations and Exclusions*.
- **Genetic Counseling** — See this heading under *General Limitations and Exclusions*.
- **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one Facility Provider to another, or effective the date the mother is discharged from the Facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, provided the baby is enrolled as a Participant within 31 days of birth. Please refer to *Section 3: Insuredhip Eligibility, Enrollment, Changes, and Termination* under **Effective Date of Coverage – New Dependents**.

Medical Care for General Conditions

Definition:

Inpatient medical care — non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient medical care — non-surgical services provided in the Physician's office, the outpatient department of a Hospital or Other Facility, or your home.

General conditions — conditions **not** related to Mental Health, Alcohol, or Drug Abuse.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under **Room Expenses and Ancillary Services**.

Outpatient: We will allow benefits for medical care provided by a Hospital or Other Facility when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

- A condition requiring **only** medical care; or
- A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an Illness, disease, or Injury. We will allow benefits for education, including medical

nutrition therapy, for Insureds who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or Other Facility are also covered.

Limitations and Exclusions

- **Biofeedback** — We will not Pay for biofeedback or related services.
- **Birth Control** — Benefits are available for FDA approved contraceptive drugs and contraceptive devices which require a physician's prescription and administration. The associated office visit is also covered. We will also allow benefits for surgical sterilization. See this heading under *General Limitations and Exclusion*.
- **Convalescent Care** — See this heading under *General Limitations and Exclusions*.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*.
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*.
- **Domiciliary Care** — See this heading under *General Limitations and Exclusions*.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*.
- **Growth Hormones** — We allow benefits for growth hormones if appropriate based on medical necessity.
- **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when medically necessary and prescribed by the patient's physician.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.
- **Temporomandibular Joint Surgery or Therapy** — See this heading under *General Limitations and Exclusions*.
- **Therapies** — See this heading under *General Limitations and Exclusions*.
- **Transfers** — See this heading under *General Limitations and Exclusions*.
- **Vision** — See this heading under *General Limitations and Exclusions*.
- **Weight Loss Programs** — Services and supplies related to weight loss are not covered. For details, see *General Limitations and Exclusions*, **Obesity and Weight Loss**.

Medical Emergencies

Definition - The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. We cover emergency services necessary to screen and stabilize a Insured without prior authorization from us if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed. To be eligible for this benefit, the Insured must seek emergency care within 48 hours after the Injury or onset of Illness.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under **Medical Care for General Conditions**. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or Other Facility (See **Medical Care for General Conditions**).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under **Medical Care for General Conditions**.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician. (See **Medical Care for General Conditions**.) Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

- **Mental health conditions** — are those that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). Anorexia Nervosa and Bulimia Nervosa, eating disorders, are classified as manifest mental disorders. Biologically Based Mental Illness conditions are considered medical conditions, not mental health conditions, and are covered as any other physical illness.
- **Alcoholism or drug abuse conditions** — are those requiring rehabilitation treatment from alcohol or drug abuse.
- **Inpatient care charges** — charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for Mental health or alcoholism is also considered to be inpatient care. Partial Hospitalization is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
- **Outpatient care charges** — charges billed by a Physician, Hospital, Alcoholism Treatment Center, Other Professional Provider, or Other Facility for services provided in the Physician's or Other Professional Provider's office, the outpatient department of a Hospital, Alcoholism Treatment Center, Other Facility, or your home.
- **Pre-certification** - You must contact Hines prior to In-Network, inpatient or outpatient treatment for a mental health or substance abuse condition. Please call Hines at (800) 670-7718.

Benefits

Inpatient: Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services. (See **Room Expenses and Ancillary Services**.) Partial Hospitalization benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

- **Biofeedback** — See this heading under *General Limitations and Exclusions*.
- **Charges** made for any non-emergency Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Diagnosis** — Benefits for Mental Health are provided only for the diagnoses of manifest mental disorders. These disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*.
- **Domiciliary Care** — See this heading under *General Limitations and Exclusions*.

- **Duration of Care** — We will only Pay for services that can be expected to improve your Mental Health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or our medical consultants.
- **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *General Limitations and Exclusions*.
- **Private Room Expenses** — Under no circumstances will private room benefits be allowed for treatment of Mental Health, Alcohol, or Drug Abuse. See this heading under *General Limitations and Exclusion*.
- **Professional Services — Mental Health** — Professional services for Mental Health must be performed by a Physician, licensed clinical psychologist, or Other Professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other Professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
- **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or Other Professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried Employee of the Alcoholism Treatment Center.
- **Therapies** — See this heading under *General Limitations and Exclusions*.
- **Transfers** — See this heading under *General Limitations and Exclusions*.

Organ Transplants

Definition - A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

The following transplant procedures are covered under this provision:

- bone marrow transplant for a Insured with aplastic anemia, leukemia, severe combined immunodeficiency disease, or Wiskott-Aldrich syndrome
- corneal transplant
- kidney
- liver transplant for a child under age 18 with congenital biliary atresia
- peripheral stem cell

Inpatient or Outpatient Benefits: When the transplant recipient or donor is a Member, the surgical procedure, storage, and transportation costs directly related to the donation of an organ or bone marrow to be used in a covered transplant are considered Covered Services.

Major Organ Transplants Coverage is available for services and supplies related to a major organ transplant, limited to one or more of the following:

- heart
- heart-lung
- liver
- lung
- pancreas-kidney

To be considered Covered Services, services must be related to a covered major organ transplant.

Prior authorization —The Provider is responsible for ensuring prior authorization is received from Hines before scheduling a pre-transplant evaluation. A case manager will be assigned to the Insured and must be contacted with the results of the evaluation.

Inpatient: Coverage is available only when the transplant is performed at a facility with a transplant program approved by AMHIC. The case manager will work with the Insured's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by an AMHIC approved Hospital or Other Facility.

Outpatient: Services provided by an AMHIC approved Hospital or Other Facility are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when authorized.

Organ Procurement: Organ acquisition/procurement costs for the surgical removal, storage, and transportation of a heart, liver, lung, pancreas, or kidney acquired from a cadaver are covered.

Limitations and Exclusions

- **Convalescent Care** — See this heading under *General Limitations and Exclusions*.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Donor Specification** — We will only cover an organ transplant from a human donor. (For example: transplant of a non-human animal organ or artificial organ is not covered.)
- **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*.
- **Medicare Eligibility Insured** — Who are now eligible for, or who are anticipating receiving eligibility for Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
- **Other Organ Transplants** — Organ transplant other than those listed under Bone Marrow, Cornea, Kidney, Specified Liver, and Peripheral Stem Cell Transplants or Major Organ Transplants will be subject to medical policy and criteria.
- **Prior Benefit Authorization** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-authorized by our medical director.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.

Preventive Care for Adults

Definition Routine Physicals — Services provided by a Physician for the prevention of disease. A comprehensive "check up" for the purpose of monitoring health.

Medical-Surgical Benefits

Outpatient: Services and supplies are covered for routine physicals for Insured over the age of 19, including blood tests, cholesterol tests, stress tests, prostate screening, pap smears, baseline mammogram, annual mammograms, pelvic exams, related laboratory and X-ray services for routine and non-diagnostic purposes, and immunizations. Preventive services are limited to a maximum payment of \$500, with the exception of charges for an annual mammogram and colonoscopy, which do not have a maximum. Any expenses for services that exceed these maximum limits are your financial responsibility and are not covered under this Certificate.

Limitations and Exclusions

- **Child Care Services** — Benefits for children to age 19 are available under the subsection entitled **Preventive Child Care Services**

- **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
- **Inpatient or Emergency Room Care** — We will not Pay for preventive care services received while you are an inpatient, or in the emergency room of a Hospital or Other Facility
- **Routine Exams** — We will not Pay for routine exams related to insurance, licensing, employment, school, sports or camp

Preventive Child Care Services

Definition:

- **Preventive Care** — services provided by a Physician for the prevention of disease. This includes well-child visits for the purpose of monitoring health.
- **Well-child visit** — a visit that includes the following components: age-appropriate physical exam (but not a complete physical exam unless this is age-appropriate), immunizations, vaccinations and routine blood tests.

Medical-Surgical Benefits

Outpatient: Benefits are provided for well-child visits (as defined above) for children under age 19. Refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Limitations and Exclusions

- **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
- **Inpatient or Emergency Room Care** — We will not pay for preventive care services received while you are an inpatient or in the emergency room of a Hospital or Other Facility
- **Routine Exams** — We will not pay for routine exams related to insurance, licensing, employment, school, sports or camp **See *General Limitations and Exclusions***

Private-Duty Nursing Services

Definition - services that require the training, judgment, and **technical** skills of an actively practicing registered nurse (RN) or licensed practical nurse (LPN). Such services must be prescribed by your attending Physician for the **continuous** medical treatment of your condition.

Medical-Surgical Benefits

Outpatient: We will allow benefits for private-duty nursing services in your home or other outpatient location.

Limitations and Exclusions

- **Alternative Care** — We will not allow benefits for nursing services ordinarily provided by a Hospital staff or its intensive care or coronary care units
- **Claims Review** — All claims are subject to review to ensure that private-duty nursing services are **absolutely** required. The fact that private-duty nursing services are a benefit under this Certificate does not guarantee that any or all services will be covered
- **Custodial Care** — See this heading under *General Limitations and Exclusions*
- **Family Members** — We will not allow benefits for services provided by a family Member, regardless of the circumstances
- **Maximum Payment Limits** — Private-duty nursing benefits are limited to one 8 hour shift per day.

- **Physician's Certification** — All claims for private-duty nursing services must include a Physician's certification that such services are Medically Necessary. The billing must also indicate the nurse's degree and license number

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definition:

- **Occupational therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury to live independently.
- **Physical therapy** — The use of physical agents to treat Disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
- **Speech therapy (also called speech pathology)** — services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits Inpatient and Outpatient: When provided by a Hospital or other facility the following types of therapy are covered as set forth under **Medical Care for General Conditions:**

- Occupational therapy
- Physical therapy
- Speech therapy

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

- Cardiac Rehabilitation programs, excluding cardiac classes
- Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy
- Physical therapy performed by a Physician or registered physical therapist
- Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an Accidental Injury.
- Benefits for Insured over the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and AMHIC will result in significant improvement with treatment and would not normally be expected to improve without intervention.
- Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of dependent children under age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

- **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
- **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:
 - Learning disorders
 - Stuttering, at any age
 - Behavioral disorders

- Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Insured's Provider, neurologist, or other related specialist
- Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions)
- Deafness
- Disorders of cognitive etology
- Sensory integration therapy
- **Habilitative Therapy** — We will not Pay for Habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions:

- **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and Other Facilities bill for and regularly make available for the treatment of the Insured's condition. Such services include, but are not limited to:
 - Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
 - Intensive and coronary care units.
 - Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
 - Dressings and supplies, sterile trays, casts, and splints.
 - Diagnostic and therapeutic services.
 - Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).
- **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
- **Skilled nursing facility** — a state-licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under **Medical Care for General Conditions and Mental Health, Alcohol, or Drug Abuse Care**. An inpatient Hospital admission requires the recommendation of a Physician and Pre-certification by us.

Skilled Nursing Facility Admissions: For Covered Services, you must be admitted to a skilled nursing facility within 14 days of a Hospital stay that lasted 3 or more days. Coverage is available to each Insured for up to 100 days per Member's Benefit Year in a skilled nursing facility. Covered services include semiprivate Room Expenses and Ancillary Services.

Outpatient: Ancillary services billed by a Hospital or Other Facility are covered. For additional outpatient Hospital Benefits, see the following sections:

- Hemodialysis
- Laboratory, Pathology, X-ray, and Radiology Services
- Rehabilitation Therapies: Occupational, Physical, and Speech

Limitations and Exclusions:

- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*

- **Isolation Charges** — See this heading under *General Limitations and Exclusions* •
- **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for Room Expenses and Ancillary Services related to these special conditions are Paid, see Mental Health, Alcoholism, or Drug Abuse Care
- **Personal or Convenience Items** — See this heading under *General Limitations and Exclusions*
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*

Supplies, Equipment, and Appliances

Definitions:

- **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
- **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an illness or injury.
- **Prosthesis** — any device that replaces all or part of a missing body organ or body Insured.
- **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under **Medical Care for General Conditions:**

- Medical supplies used while you are in the Hospital
- Use of durable medical equipment owned by the Hospital while you are Hospitalized

Outpatient: Covered expenses include medical supplies used during covered outpatient visits. (See **Medical Care for General Conditions**).

Medical-Surgical Benefits The following medical supplies are covered not subject to the annual maximum payment:

- Medical supplies not available from a Pharmacy, including but not limited to:
 - Colostomy bags and other supplies required for their use.
 - Catheters.
 - Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

NOTE: Some diabetic supplies are covered under the *Prescription Drugs and Medicines* of this Certificate. Coverage is not provided for such diabetic supplies under both sections of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the participating Pharmacy.

- We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
- The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:
 - Artificial arms, legs, or eyes.
 - Leg braces, including attached shoes.
 - Arm and back braces.
 - Maxillofacial prostheses.
 - Cervical collars.
 - Surgical implants.
 - Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.

- Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription
- We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient)

Limitations and Exclusions

- **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Network or Reasonable and Customary Benefit Allowance for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and “fashion” eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
- **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
- **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury
- **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain
- **Medical Supplies** — Items that do not serve a useful medical purpose, or that are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).
- **Physician’s Certification** — With all supplies, equipment, and appliances, we require a Physician’s certification that such items are a necessary expense and are medically required for the Insured’s condition
- **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items
- **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of medical necessity

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under **Medical Care for General Conditions**.

Outpatient: Services provided by a Hospital or Other Facility are covered.

Medical-Surgical Benefits

Inpatient and Outpatient: The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a “multiple surgery.” Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

The following guidelines apply to surgical procedures:

Assistant Surgeon Fees – The amount eligible will be based on 20% of the Network or Reasonable and Customary allowance for the covered surgical procedure.

Co-Surgery Fees – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Network or Reasonable and Customary allowance for that procedure.

Multiple Surgical Procedures – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Network or Reasonable and Customary allowance and all other eligible procedures will be based on 50% of the Network or Reasonable and Customary allowance.

Limitations and Exclusions

- **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician’s office or in the outpatient department of a Hospital or Other Facility
- **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:
 - When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
 - When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered
- **Convalescent Care** — See this heading under General Limitations and Exclusions
- **Cosmetic Surgery** — See this heading under General Limitations and Exclusions
- **Custodial Care** — See this heading under General Limitations and Exclusions
- **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see **Dental Services**
- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*
- **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or Other Facility requires such services, assistant surgery benefits are not allowed.
- **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried Employee or person paid by the Hospital, we will not allow Medical-Surgical Benefits for the assistant surgery.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*
- **Obesity and Weight Loss** — We will Pay for surgery required as the result of obesity **only when we give prior benefit authorization**. Such surgery is limited to once per Insured, per Lifetime. For details, please see this heading under *General Limitations and Exclusions*
- **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Member’s Membership Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. NOTE: This limitation

applies regardless of any pre-existing conditions clause or waiver thereof, we must give written authorization for such surgery benefits in advance of the date of services. This benefit requires prior benefit authorization.

- **Other** — The **Limitations and Exclusions** that apply to **Surgery** benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.
- **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
- **Restorative or Reconstructive Surgery** — See this heading under *General Limitations and Exclusions*
- **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
- **Sex-Change Operations** — See this heading under *General Limitations and Exclusions*
- **Sterilization Reversals** — Reversals of sterilization procedures are not covered
- **Temporomandibular Joint Surgery or Therapy** — See this heading under *General Limitations and Exclusion*.
- **Vision** — See this heading under *General Limitations and Exclusions*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for generic, formulary brand and non-formulary brand prescription drugs under a 3-tier Prescription Drug Plan. Co-payment amounts are as follows.

Prescription Drug Card	Co-payment per Prescription	
	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	\$7.00	\$ 14.00
Formulary Brand Drugs	\$25.00	\$50.00
Non-formulary Brand Drugs	\$ 40.00	\$ 80.00

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".

Generic versions of brand name drugs are reviewed and approved by the FDA (Food & Drug Administration). Generic drugs have the same active ingredients and come in the same strength and dosage form as the brand name drug. If you choose the generic drug, you will always pay the lowest Copay.

A formulary is a list of FDA-approved prescription drugs and supplies developed by Express Scripts' Pharmacy and Therapeutics Committee which represents the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your Pharmacy benefit plan, the formulary drug list is used as a guide for determining the amount that you pay as a Copayment for each prescription, with drugs listed on the formulary typically available at a lower Copayment to you. To access the formulary list, your Physician can log on to www.express-scripts.com.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher Copay.

Express Scripts

The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide and they display a decal in their window or near the Pharmacy department. You may access Express Scripts on the web at www.express-scripts.com or by calling their Customer Service Department at (800) 235-4357 for a list of participating pharmacies.

When you present your prescription drug card to a participating Pharmacy, your cost for a prescription or a refill will be the prescription drug co-payment as indicated in the Schedule of Benefits. For maintenance prescription drugs you can obtain a larger quantity (90-day supply), saving you trips to the Pharmacy and prescription co-payment expenses by using the Mail Service Prescription Drug Program.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not experimental/investigative, in order to be a covered service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before AMHIC can determine medical necessity. AMHIC may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits established by AMHIC, or utilization guidelines. Prior authorization may be required for certain drugs.

Covered Services include:

- Prescription legend drugs, including self-administered injectable drugs.
- Injectable insulin and syringes used for administration of insulin.
- Anorexiant.
- Prescribed oral contraceptive and contraceptive devices.
- Prescribed pre-natal vitamins.
- Prescribed nicorette gum or patches.
- Tretinoin (sold under such brand names as Retin-A®) – For Insureds up to the age of 30. “Prior authorization” is required for patients age 30 or older and must be prescribed for “Acne Treatment” only.
- Certain supplies, equipment or appliances obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma). Call Express-Scripts at (800) 235-4357 to determine approved covered supplies.
- Prescription Drugs approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction like Viagra) are limited to 6 pills per month. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or mail service they may be covered as medical supplies, durable medical equipment and appliances instead of under prescription drug benefits under other sections of this Certificate. (“Prior authorization” is required.)

Limitations and Exclusions

- **Appetite suppressants** — drugs prescribed for weight control or appetite suppressants are not covered
- **Cosmetic services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered
- **FDA Approval** — Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. AMHIC may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology
- **Fertility drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered
- **Formulas/Vitamins** — Benefits are not allowed for special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders, see Covered Services in this subsection for benefits), vitamins, folic acid or minerals, except for legend prenatal vitamins

- **Growth Hormones** — We must give written authorization for such therapy in advance of the date of service. Please contact Express-Scripts' Customer Service Department at (800) 235-4357 for additional information
- **Tretinoin (sold under such brand names as Retin-A®) for Insureds over age 30** — Prescription drugs for Insured over age 30 must be accompanied by a "prior authorization" and be for "Acne Treatment"
- **Other non-covered items** — Benefits are not allowed for:
 - Delivery charges
 - Charges for the administration of any drug
 - Drugs consumed at the time and place where dispensed or where the prescription order is issued, including but not limited to samples provided by a Physician
 - Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse
 - Hypodermic needle, syringe, or similar device, except when used for administration of a Covered Drug when prescribed in accordance with the terms of this section
 - Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use)
 - Drugs and supplies unless specifically included as a covered drug
 - Medication or supplies when benefits are available under a personal Injury protection contract or no-fault motor vehicle insurance
 - Medication or supplies where cost is recoverable under any Workers Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Insured
- **Prescriptions** — Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have over-the-counter bio-equivalents are not covered even if written as a prescription. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin. Some prescription drugs may not be covered even if you receive a Prescription Order from your Physician
- **Prior Authorization** — Prescription drugs which are not prior authorized by Express Scripts are not considered covered drugs eligible for reimbursement under this section, unless otherwise specified in this section
- **Quantity** — Prescription Drugs which are dispensed in quantities which exceed the applicable limits established by AMHIC, at its sole discretion are not covered
- **Refills** — Refills in excess of the number the prescription drug or maintenance prescription drug order calls for or refilled after one year from the date of such order
- **Smoking cessation** — Non prescribed Nicorette, nicotine patches, or any other drug containing nicotine or other smoking deterrent medications are not covered
- **Travel** — Prescription Drugs and/or immunizations required or recommended solely for the purpose of international travel are not covered.
- **Overseas** — Prescription drugs purchased overseas are not covered.

HOW TO FILE A CLAIM FOR PRESCRIPTIONS

Member Pharmacies - Many pharmacies participate in the Prescription Plan program. When you go to a participating Pharmacy, show your Prescription Plan identification card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your co-payment and fill your prescription(s).

Non-Member Pharmacies or Member Pharmacies When the Participant Does Not Use the Prescription Plan Card - You must submit a claim directly to the Prescription Plan when you purchase a prescription from a non-Member Pharmacy or do not use your card at a Member Pharmacy. The Prescription Plan will only pay the maximum contracted price for each prescription, less your co-payment. The maximum contracted price used for reimbursement will probably be less than the amount you are charged. Reimbursement will be sent directly to you. To submit a claim, obtain, please call Express Scripts' Customer Service at: (800) 235-4357 or visit their website at: www.express-scripts.com and login your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for maintenance drugs which require a prescription by law to purchase, and insulin. The maximum quantity which can be claimed is a 90-day supply which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription co-payments. Please visit www.express-scripts.com to order these drugs on-line or call Express Scripts' Customer Service at: (800) 235-4357 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Participants Who are Temporarily Residing Overseas – Prescription drugs purchased while you temporarily reside overseas are not be eligible for benefits under the Express Scripts Prescription Drug Program.

Definitions:

- **Brand Name Prescription Drug** — the initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).
- **Copay** — the predetermined fixed-dollar or percentage amount which the Insured must pay for each separate prescription drug order, maintenance prescription drug order or refill of a covered drug.
- **Formulary Prescription Drug** - A formulary is a list of FDA-approved prescription drugs and supplies developed by Express Scripts' Pharmacy and Therapeutics Committee which represents the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your Pharmacy benefit plan, the formulary drug list is used as a guide for determining the amount that you pay as a Copayment for each prescription, with drugs listed on the formulary typically available at a lower Copayment to you. To access Express-Scripts' formulary list, your Physician can log on to www.express-scripts.com.
- **Generic Prescription Drug** — drugs which have been determined by the FDA to be bioequivalent to brand name drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a brand name drug and is its bioequivalent, generic drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage

form (tablet, capsule, cream) as the counterpart brand name drug. On average, generic drugs cost about half as much as the counterpart brand name drug.

- **Mail Service** — a prescription drug program which offers a convenient means of obtaining maintenance prescription drugs by mail if the Insured takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy mail service which has entered into a reimbursement agreement with us, and sent directly to the Insured's home.
- **Maintenance Prescription Drug** — prescription drugs that are used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.
- **Multisource Brand** — a Brand drug that has a Generic alternative.
- **Network Pharmacy** — means a Pharmacy acceptable as a participating Pharmacy by AMHIC to provide covered drugs to Insured under the terms and conditions of this subsection.
- **Non-Network Pharmacy** — a Pharmacy which does not participate in this program. Charges incurred at Non-Network Pharmacies will be paid based on the Network Pharmacy reimbursed charges.
- **New FDA Approved Drug Product or Technology** — the first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use. New FDA Approved Drug Product or Technology does not include:
 - New formulations;
 - A new dosage form or new formulation of an active ingredient already on the market;
 - Already marketed drug product but new manufacturer;
 - A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
 - Already marketed drug product, but new use;
 - A new use for a drug product already marketed by the same or a different firm; or
 - A newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications)
- **Pharmacy** — an establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a network Provider or a non-network Provider.
- **Pharmacy and Therapeutics Committee** — a committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
- **Prescription Legend Drug** — a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a Prescription Legend Drug under this Certificate.
- **Prescription Order** — a written request by a Physician for a drug or medication and each authorized refill for same.
- **Prior Authorization** — the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain prior authorization, please request that your doctor contact Express Scripts before prescribing a drug that requires prior authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable copay. If the drug is not approved, you will be

responsible for the full cost. To call Express Scripts, please use the Express Scripts phone number shown on your identification card .

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These General Limitations and Exclusions apply to **all** benefits described in this Certificate. **We will not allow benefits for any of the following services, supplies, situations, or related expenses:**

Alcohol-related— Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, "test tube" fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable No-Fault insurance laws. (See *Section 11: Automobile No-Fault Insurance Provisions* for further information.)

Autologous hematopoietic— Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Charges— For any non-emergency Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning.

Charges— For services received as a result of Injury or Sickness caused by or contributed to by engaging in an Illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by our medical consultants. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. We must give written authorization for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Insured in activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in the Facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Member's own home arrangements are not appropriate, and consisting chiefly of room and board, is **not** covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health coverage Membership, then total benefit Payments will not be more than 100 percent of total covered expenses. (See *Section 13: Duplicate Coverage and Coordination of Benefits* for further information.)

Experimental or Investigative Procedures — Any treatment, procedure, drug or device that has been found by AMHIC not to meet the eligible-for-coverage criteria, which are listed and defined in *Section 2: Definitions* under Experimental/Investigational. The determination that a service is not considered eligible-for-coverage or is Experimental/Investigational can be made by AMHIC either before or after the service is rendered. We do not cover treatment or procedures which are Experimental/Investigational, or which are not proven to be effective, as determined by our medical director and/or appropriate medical/surgical authorities selected by us.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to; discussion of family history or tests results to determine the sex or physical characteristics of an unborn child, or testing for inherited susceptibility. Genetic tests to evaluate risks for certain types of conditions may be covered based on medical policy, review and criteria and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected Disability are not covered.

Hair Loss — Wigs, or artificial hairpieces except for the treatment of a serious medical condition and this benefit is limited to one per Insured per calendar year. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or homeopathic medicine including services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Isolation Charges — We will only Pay private Room Expenses under your Hospital Benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Insured has received a professional or courtesy discount, or for services provided by the Insured upon him/herself, or by a family Insured.

Massage Therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary (as defined in *Section 2: Definitions*). Our decision as to whether a service or supply is Medically Necessary is based upon the opinions of our medical or surgical consultants as to what is “approved and generally accepted medical or surgical practice.” **The fact that a Physician may prescribe, order, recommend, or approve a service does not, of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Non-covered Services— Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (such as non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother’s milk or diets, even if the substance is prescription and the sole source of nutrition.

Obesity and Weight Loss — Obesity in itself is not considered an Illness or disease, and benefits are not allowed solely for its evaluation and treatment. Benefits will only be allowed for obesity when a surgical procedure is required due to Morbid Obesity. Morbid obesity is defined as a condition in which persistent and uncontrollable weight gain causes a threat to life based on current guidelines used by AMHIC. Surgery benefits will not be allowed unless written authorization is given by us in advance of the date of surgery, regardless of the medical necessity for the surgery. You are limited to one surgical treatment per Lifetime. Surgery benefits will not be provided for subsequent procedures to correct further Injury or Illness resulting from the Insured’s noncompliance with prescribed medical treatment.

Personal Comfort or Convenience — Services and supplies used primarily for your personal comfort or convenience that are not related to the treatment of your condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the Hospitalization, services, or supplies were made necessary by an accident, illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — A pre-existing condition is any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the date of enrollment of the individual in this plan. Pregnancy or Genetic information in the absence of any diagnosis of a condition related to the information are not considered pre-existing conditions. The Plan will **not** pay more than \$500 per Insured for Covered Services or supplies related to a pre-existing condition for ten consecutive months after the date of enrollment. If you had prior coverage within 63 days of your Effective Date, the pre-existing Waiting Period will be applied for the portion which is not covered by Health Insurance Portability and Accountability Act of 1996 (HIPAA) Creditable Coverage. NOTE: Newly adopted child, newborn child, or children placed for adoption are not subject to the pre-existing condition exclusion above if enrolled within 31 days of eligibility.

Prior Benefit Authorization— The Plan must give written authorization for certain services in advance of the date of services.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered charges are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of Mental Health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. A congenital defect or anomaly is defined as existing at or dating from birth, disorders due to inappropriate growth are not considered congenital. Such surgery may have a coincidental cosmetic effect.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical illness, subject to the same Deductible, Copay and Coinsurance. If a Member chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Plan must give written authorization for such benefits in advance of the date of services.

Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Services, supplies, or prescription drugs for the treatment of sexual dysfunction, except for Viagra under the Prescription Drug Program and limited to [6] pills a month.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Therapies and self-help programs not specifically covered under this Certificate include, but are not limited to:

- Recreational, sex, primal scream, and sleep therapies.
- Self-help, stress management, smoking cessation, and weight loss programs.
- Transactional analysis, encounter groups, and transcendental meditation (TM).
- Sensitivity or assertiveness training and rolfing.
- Religious or marital counseling.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification, or arthritis class.
- Myotherapy or massage therapy.
- Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. (See *Section 12: Third-Party Liability— Subrogation* for further information.)

Transfers — The transfer of a patient from one Physician to another for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Travel expenses for you or your Physician.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Insured from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Workers' Compensation Services or supplies resulting from a work-related illness or injury. (See *Section 10: Workers' Compensation* for further information.)

SECTION 8

GENERAL PROVISIONS

Advance Benefit Confirmation If you wish to know what benefits will be Paid before receiving a service or sending a claim to us, we may require you to submit a written request for such information. In some cases, we may require a written statement from your Physician identifying the circumstances of your case and the specific services that will be provided.

Assignment of Benefits All Network benefits in this Plan will be paid directly to Network Providers. These Payments fulfill our obligation to the Insured for these services.

Catastrophic Events In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan We may amend this Plan when authorized by AMHIC. We will give your Employer any amendments within 60 days following the Effective Date of the amendment. If your Employer requests a change which reduces or eliminates coverage, such change shall have been either requested in writing or signed by the Employer.

No Employee of your Employer, NCAS, or any contracted vendor may change this Plan by giving incomplete or incorrect information, or by contradicting the terms of this Plan . Any such situation will not prevent us from administering this Plan in strict accordance with its terms.

Contracting Entity The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a contract solely between the Employer and AMHIC, is a mutual association insurer under District of Columbia captive law. The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Member by any Facility or Professional Provider, and is not liable for any loss or Injury caused by any health care Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

- Requested in connection with utilization summaries or review provided to a third party, such as your Employer, if that third party funds all or a part of the cost of your claims.
- Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
- We receive a judicial or administrative subpoena for such information.
- The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
- The information is required for:
 - Workers' Compensation proceedings;
 - No-Fault auto insurance cases;
 - Third-party liability (subrogation) proceedings; and

- Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Insured We reserve the right and opportunity to request a medical examination of a Member when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance & Securities Regulation (DISR) within the department of regulatory agencies.

Member's Legal Expense Obligations You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, we will be entitled to receive and you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Insured shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Insured's Lifetime, unless such statement is contained in written instrument signed by the Insured making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Paragraph Headings The paragraph and section headings used throughout this Plan are for reference only. They are not to be used by themselves for interpreting the provisions of the Plan.

Payment in Error If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments made in error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments made in error.

Payment of Premium by Your Employer Since your Employer has contracted with us to pay claims under a special financial arrangement, claims administration may be handled in one of the following ways:

- Funds for payment of your claims are held by your Employer, and are used to pay submitted claims. If the claims funds agreed upon by your Employer and us are not maintained by your Employer, payments for submitted claims will not be made.
- Funds for payment of your claims are paid to us by your Employer. If the claims funds agreed upon by your Employer and us are not remitted by your Employer, payments for submitted claims will not be made.

Claims not paid because of insufficient claims funds should be submitted for payment to and are the liability of your Employer.

Provider Contracts Network Providers and Non-Network Providers may have agreed to an additional discount, which is calculated after the Maximum Network Allowance or Reasonable and Customary Allowance, Deductible, Copay and Coinsurance. For example, we may receive an additional Network discount of 10 percent. AMHIC would reimburse the Network Provider or Non-Network Provider the balance of the benefit allowance minus your Deductible, Copay and Coinsurance, and minus the additional 10 percent. The amount of the additional discounts, if any, varies by Provider and by the type of health care plan you have with AMHIC. Certain discounts are not passed directly on to you for purposes of calculating your Deductible, Copay and Coinsurance.

Release of Medically-Related Information You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are Hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Research Fees We reserve the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms.

Reserve Funds No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

Sending Notices All notices to the Member are considered to be sent to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either: The Member at the latest address appearing on our Membership records; or The Member's Employer.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

In-Network Providers

Before you use a Provider listed in the Network directory, call the Provider or the Network to verify that the Provider is still a Member. Simply present your NCAS Identification Card at the time you receive services. The Provider will file a claim with the Network and will be directly reimbursed for the services you receive.

Out-of-Network Providers

MEDICAL SERVICES - Reimbursement of medical expenses provided by Out-of-Network Providers is handled by NCAS. Claims for benefits may be filed by a Hospital, Physician's office, or by the Participant. Payment will be made by NCAS either to the Provider or the Participant.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and be sure to include the following information on the bill:

- | | |
|-------------------------------------|-----------------------------|
| a. Employee Name | f. Procedure Code |
| b. Employee's Identification Number | g. Diagnosis Code |
| c. Patient Name | h. Date of Service |
| d. Employer Name or Group Number | i. Charge for Each Service. |
| e. Provider's Tax ID Number (TIN) | |

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022
(703) 934-6227 or 1-800-888-6227

NOTE ON HOSPITAL CHARGES - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Participant is responsible for balances. When you are unsure, ask the Hospital or NCAS for guidance.

Remember - Authorization is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and the next business day following an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (Refer to *Section 5*).

Call Hines at: (800) 670-7718

When Claims Should Be Filed All claims must be submitted within 12 months after the expenses are incurred; otherwise, they are not eligible for reimbursement. After claims are received, each claim will be granted or denied by NCAS within the number of days specified in this section of the booklet for the specific type of claim. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time. The Claims Processor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Processor will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

- the specific reason or reasons for the denial;
- specific reference to those Plan provisions on which the denial is based;
- a description of any additional information or material necessary to correct the claim and
- an explanation of why such material or information is necessary; and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIM APPEAL PROCEDURES

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claim with the Claims Administrator. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Claims Administrator shall review the claim itself or appoint an individual or an entity to review the claim.

The Claim Appeal Procedures divides claims into several categories, with different time frames and requirements as described below. If you have any questions, contact the Claims Administrator.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims - A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

For urgent care claims, the Claims Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, AMHIC PPO

but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Pre-Service Claims - A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

For a pre-service claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims - A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

For a post-service claim, the Claims Administrator shall notify the Claimant of the Plan's adverse benefit determination no later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims - If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an adverse initial benefit determination. These determinations shall be known as concurrent care decisions.

In such a case, the Claims Administrator shall notify the Claimant of the adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Calculation of Time Period - For purposes of the time periods specified, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to

make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Denial of Initial Claims - If the Claims Administrator denies a claim, it must provide to the Claimant, in writing or by electronic communication:

- (a) The specific reasons for the adverse determination;
- (b) A reference to the specific plan provisions on which the determination is based;
- (c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502 (a) following an adverse benefits determination on review;
- (e) In the case of an adverse benefit determination by the Plan, the following must be provided:
 - (i) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that the same will be provided upon request by the Claimant and without charge; or
 - (ii) If the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances or a statement that the same will be provided upon request by the Claimant and without charge.

In the case of an adverse benefit determination concerning an urgent care claim, the information described in this section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

II. APPEAL PROCEDURES

First Appeal - In addition to having the right to review documents and submit comments as described above, a Claimant has a right to file an appeal to the Plan within 180 days from the date of the initial notice. The Claimant's appeal request should include the patient's name, identification number, and any additional documentation to be reviewed. When reviewing the appeal, the Plan must meet the following requirements:

- (a) The Plan provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- (b) The Plan provides that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental,

investigational or not Medically Necessary or appropriate, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- (c) The Plan provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit review determination;
- (d) The Plan provides that the health care professional engaged for purposes of consultation be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- (e) The Plan provides in the case of a claim involving urgent care, for an expedited review process pursuant to which:
 - (i) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - (ii) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Second Appeal - If the claim is denied on appeal, under the procedures described above, the Claimant may request that the claim be reviewed a second time. The request for this second level of review must be received by the Claims Administrator within 30 days of the date of the second adverse benefit determination notice.

The appeal should state in detail the reasons that you believe your claim should be granted, and should identify specifically any facts or reasons that you believe support your claim; you should refer specifically to provisions of the Plan upon which you rely. You should attach to the appeal copies of any documents that support your claim and send all information to the Claims Administrator.

Decision on your appeal will, in the absence of extraordinary circumstances, be made within 60 days after its receipt. The decision will be in writing and will be sent to you at the address indicated on your Appeal, or to any legal counsel or other representative that you specify. The Claims Administrator's decision on your Appeal will explain the specific reasons for the decision. An interpretation of the terms of the Plan adopted by the Claims Administrator in deciding your Appeal shall be at the Claims Administrator's discretion and shall not be subject to further review or dispute by the Plan.

Extra-Contractual Appeals Policy, Second Level Appeal Process – The Director of Program Support of Select Benefit Plan Administrator (SPBA) may direct NCAS the plan claim administrator, to pay benefits outside the terms of the Plan document if the Employee has filed a written first level appeal that explains the basis of his/her appeal and NCAS has first declined that appeal if one of the following criteria is met:

- (a) To the extent necessary to restore equity where the claimant was misadvised by SBPA, Wachovia Insurance Services or NCAS staff as to the availability of a benefit or benefit payments for a particular procedure or course of treatment. The claimant must provide documentation that a "prudent layperson" would have relied on. A prudent layperson refers to a clear-thinking adult with an average knowledge of health and medicine.

- (b) To the extent the approval of payment will result in savings (current or future) for the plan.

Process – This second level appeal process requires the claimant to file a written second level of appeal within fifteen (15) working days of the date of the denial letter from NCAS. The claimant must state why they want to appeal the first level of denial and the reasons why they disagree with the first level appeal denial.

Second level of appeal letters should be sent to NCAS. If the claimant does not file the second level appeal request within fifteen (15) working days of the date of the denial letter, the second level of appeal will be denied unless it is determined that a good cause prevented the timely submission such as serious illness, hospitalization, other serious family matters, etc.

Approval – Approval by the Executive Committee of AMHIC is required for an appeal which will result in a payment over \$1,000, or if payment is for a second payment to the same claimant. The Director of Program Support for SBPA may approve payments for under \$1,000.

Denial – If the second level of appeal is denied, the claimant will receive a written denial letter within 15 (fifteen) days of receipt of the second appeal letter. The decision at the second level of appeal is final. There is no further appeal available.

III. DEADLINE FOR APPEAL DECISIONS

Urgent Health Benefit Claims - In case of urgent care health claims, the Claims Administrator shall notify the Claimant of the Plan's determination on review as soon as possible, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

Pre-Service Health Benefit Claims - In the case of a pre-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review not later than 15 days after receipt of the Claimant's request for review of the adverse determination.

Post-Service Health Benefit Claims - In the case of a post-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review, not later than 30 days after receipt of the Claimant's request for review of the adverse determination.

Calculation of Time Periods - For purposes of the time periods specified in this Section, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the benefit determination on review shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds.

Manner and Content of Notice of Appeal Decision- Upon completion of its review of an adverse initial claim determination, the Claims Administrator will provide the Claimant with written or electronic notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall contain:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is based;

- (c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
- (d) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to the Claimant upon request;
- (e) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

IV. MISCELLANEOUS

Summary of Appeal Procedures – The appeal procedures described above are intended to reflect, in detail, the Claims Procedures Regulations issued by the Department of Labor. The following summarizes the steps involved:

1. Initial Claim Determination – Regulations require that the claim be identified as urgent, concurrent, pre-service and post-service. After a claim is filed, the Claims Administrator is required to notify the claimant of its decision within a specified period of time, contingent on the type of claim. If the claim is denied, the Claims Administrator is required to provide specific information regarding its decision.
2. Claims Administrator (1st Level of Appeal) – If the claimant disagrees with the claim denial, he can file an appeal with the Claims Administrator. When submitting the request for appeal and reviewing the appeal, the Claimant and the Claims Administrator must follow the guidelines specified in Section II. The Claims Administrator must respond to the Claimant's request for appeal according to the guidelines explained in Section III above.
3. Claims Administrator (2nd Level of Appeal) – If the claimant's first request for appeal is denied, the claimant can request a second review. This request can be made to the Claims Administrator. The claimant must follow the guidelines explained above.
4. Claims appeals should be sent to:

AMHIC c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022

Failure of Plan to Follow Procedures - If the Plan fails to follow the claims procedures required by this Article, a Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedy under ERISA section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Preemption of State Law - With respect to any Insured benefit under this Plan, nothing in this Section shall be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this Section.

Statute of Limitations - Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Claims Administrator has been rendered (or deemed rendered).

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan . This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

- Occupational disease laws.
- Employer's liability.
- Municipal, state, or federal law.
- Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Industrial Commission.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury even **if other benefits are not Paid because:**

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care which is not authorized by Workers' Compensation insurance.
- Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
- You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile No-Fault insurance policy.

A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or No-Fault statute.

How We Coordinate Benefits With Complying Policies Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

- The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.
- After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the No-Fault statute. If there is more than one complying policy, each will have to pay its maximum No-Fault statutory coverages before we will become liable for any further Payments.
- If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.
- The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the No-Fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens if You Do Not Have a Complying Policy The Plan will not pay benefits for injuries received by the Member, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile No-Fault complying policy as required by law. Benefits will be provided under the terms of the Plan for injuries sustained by a Member who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Member is not covered by a complying policy. In that event, we may exercise our rights under *Section 12: Third-Party Liability — Subrogation*.

SECTION 12

THIRD-PARTY LIABILITY — SUBROGATION

Third-party liability exists when someone else is legally responsible for your condition or Injury. AMHIC will not pay for any services or supplies under this Plan for which a third party is liable.

We may, however, provide benefits under these conditions:

- When it is established that a third-party liability does not exist; or
- When you guarantee in writing to reimburse us if the third party later settles with you for any amount, or if you recover any damages in court.

Our Rights When Third-Party Liability Exists When a third party is or may be liable for the costs of any covered expenses payable to you or on your behalf under this Plan, we have subrogation rights. This means that we have the right, either as co-plaintiffs or by direct suit, to enforce your claim against a third party for the benefits paid to you or on your behalf.

When you fail to cooperate in satisfying our subrogation interest, and we must file a lawsuit against you or the third party in order to enforce our rights under this provision, you or any Dependent receiving benefits under this Plan shall be responsible for attorneys' fees and costs incurred by us.

Your Obligations When Third-Party Liability Exists If a third party is or may be liable for the costs of any expenses payable to you or on your behalf under this Plan, then you must do the following:

- Promptly notify us of your claim against the third party.
- You and your attorney must provide for the amount of benefits Paid by us in any settlement with the third party or the third party's insurance carrier.
- If you receive money for the claim by suit, settlement, or otherwise, you must fully reimburse us for the amount of benefits provided you under this Plan. You may not exclude recovery for our health care benefits from any type of damages or settlement recovered by you.
- Cooperate in every way necessary to help us enforce our subrogation rights.
- You may not take any action that might prejudice our subrogation rights.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage Duplicate (Double) Coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage. The total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered charges.

Definition For this section the following terms are used:

- **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:
 - Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. "Plan" also includes coverage provided by exclusive or preferred Provider organizations, but excludes school accident-type coverage.
 - Coverage under labor management trustee plans, union welfare plans, and Employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

We consider each policy, contract, or other arrangement for benefits a separate "plan." That part of any such Contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate "plan."

- **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
- **Secondary Plan** refers to the plan (or plans) which has second responsibility (liability) for a claim.

Conditions of Coordination of Benefits The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the Primary Plan.

How We Determine Which Plan is Primary and Which is Secondary We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

- A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
- A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a Dependent under that coverage.
- If both plans cover the Member as a Dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and Dependent(s) longest is primary over the plan which has covered the **other parent** and Dependent(s) for a shorter period of time.
- When the parents are separated or divorced, and the parent with custody of the child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
- When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
- The benefits of a plan which covers a person as an Employee who is neither laid-off nor retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired Employee (or as that Employee's Dependent).
- When the above rules do not establish the order of benefit determination, the plan which has covered the Member for the longest period of time is primary.

Right to Receive and Release Necessary Information We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees and Spouses Age 65 and Over - When an Employee in Active Service who is age 65 or over and when the covered Dependent Spouse of any such Employee who is age 65 or over becomes eligible for Medicare, the individual must choose either of the following options:

- a. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
- b. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees and Spouses Age 65 and Over – AMHIC eligible retirees and Spouses who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the plan will be secondary for the participant if the individual is age 65 and over and retired. Medicare is primary and the plan will be secondary for the Dependent Spouse if both the participant and their covered Dependent Spouse are 65 and retired.

If the Medicare eligible retiree (or Spouse) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the AMHIC plans will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of Disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of Disability, in addition to the 3 month Waiting Period or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare - Medicare is the primary payer for individuals entitled to Medicare due to Disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a family Member then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare due to ESRD at the time of COBRA election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare due to Age at the time of COBRA election – Medicare is the primary payer and the COBRA plan the secondary payer. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a Spouse of any age then Medicare is the secondary payer.

Medicare due to Disability at the time of COBRA election - Medicare is the primary payer for individuals entitled to Medicare due to Disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a family Member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan agrees to the following:

1. The Plan will not disclose PHI to Association Mutual Health Insurance Company (AMHIC), in its capacity as The Plan, unless it receives a certification by The Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed from the Group Health Plan to Members of AMHIC's designated administrator, as necessary, for AMHIC to carry out the Plan Administration functions as The Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and the Standards for Employee Welfare Benefit Plan documents: Privacy of Protected Information policy. The following disclosures are NOT permitted without the individual's authorization:
 - 2.1 Disclosures by a health insurance company or health maintenance organization that provides benefits to AMHIC associations through its Group Health Plan, if the disclosures do not comply with the provisions of the plan documents;
 - 2.2 Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or Employee benefit plan offered by AMHIC.
3. The Plan agrees it will not use or further disclose PHI received from the Group Health Plan other than as permitted or required by the plan documents or as required by law.
4. The Plan agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI received from the Group Health Plan will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law, and it agrees to the same restrictions and conditions within this amendment that apply to The Plan with respect to such information.
5. The Plan will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.
6. The Plan will agree to report to the Group Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
7. The Plan will agree to permit individuals to have access to any PHI, which it has received from the Group Health Plan, in accordance with AMHIC's Rights of Access to Protected Health Information policy.
8. The Plan will agree to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's Individual Requests to Amend Health Information policy.
9. The Plan will agree to make available the information required to provide an accounting of disclosures in accordance with AMHIC's Accounting of Disclosures of

Health Information policy.

10. The Plan will agree to make its internal practices books, and records relating to the use and disclosure of protected health information received from the Group Health Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Group Health Plan with Federal privacy regulations regarding PHI.
11. The Plan will agree, if feasible, to return or destroy all PHI received from the Group Health Plan that The Plan still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
12. In order to provide adequate separation between The Plan and the Group Health Plan, those Employees or classes of Employees described below, under the control of The Plan may be given access to PHI for disclosure. Any Employee or person who receives PHI relating to Payment, Health Care Operations, or other matters pertaining to the Group Health Plan in the ordinary course of business are included in this description.
 - 12.1 Those who are assigned to the administration of the Group Health Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Group Health Plan.
 - 12.2 Others who are authorized to have access to PHI on behalf of AMHIC in its role as The Plan, for purposes permitted by the plan documents.
13. The Plan will agree to restrict the access to and use of PHI received from the Group Health Plan by staff (as described in item 12 above) to the Plan Administration functions that The Plan performs for the Group Health Plan.
14. The Plan agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any Member of the staff who is authorized to have access to the Group Health Plan's PHI violates any of the provisions of the plan documents as set forth in this policy and will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

Plan Sponsor Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the AMHIC in its capacity as the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

SIGNATURE PAGE

APPROVED AND ACCEPTED

IN WITNESS, Whereof, this document is executed at:

Silver Spring MD
City State

By: Rhona N Byer
Signature

Rhona N Byer, Executive
Name and Title

10/08/08
Date

ON BEHALF OF:

Association Mutual Health Insurance Company PPO Health Benefit Plan

S. Sells
Witness Signature

10/8/08
Date

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

Amendment 1

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

1. **Section 2, Summary of Benefits** – This section is AMENDED to ADD that HIV screening is covered when performed in a hospital emergency room as follows:

TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Emergency Room – for HIV screening	100%	100%
Professional Expenses		
Emergency Care in Emergency Room - for HIV screening	100%	100%

The foregoing amendment is effective April 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
PPO Health Benefit Plan

7/20/09
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
Birthing 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.

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

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

PPO HEALTH BENEFIT PLAN

Amendment 3

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

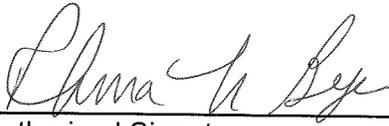
1. **Section 4, Membership Eligibility, Enrollment, Effective Date, Termination, and COBRA, Who is Eligible? - Dependents** – This section is AMENDED to reflect an INCREASE to the age limit for a child and REMOVAL of the full-time student requirement as follows:
- a) A legal Spouse as defined by applicable state law.
 - b) A child who is the natural or legally adopted child of the Participant, through the end of the year in which the child becomes age 26.
 - c) Your same or opposite-gender Domestic Partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy;
 - d) A child age 26 and older who is incapable of self-support because of mental incompetence or severe physical handicap and is Dependent on the Participant for financial support, as certified by a Physician and us. The condition must begin before or during the month in which the child reached age 26. We require proof acceptable to us of the child's physical or mental Disability each Insured's Benefit Year.
 - e) Any child of a Participant who does not qualify as a Dependent under subsections b or d above, solely because the child is not primarily Dependent upon the Participant for support so long as over half of the support of the child is received by the child from the Participant pursuant to a multiple support agreement.

The foregoing amendment is effective May 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 Health Insurance Company
PPO Health Benefit Plan

6/30/10
Date

By: 
Authorized Signature

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:

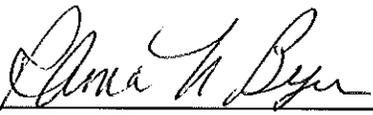
NOTE: Participants under age 19, who are enrolled in the Plan, are not subject to the Pre-existing Condition Exclusion.

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
Birthing 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.

Association Mutual
Health Insurance Company

Network Only
Health Benefit Plan

Certificate of Coverage

January 1, 2008

WELCOME

We are very pleased to welcome you as a Member of Association Mutual Health Insurance Company Network Only Health Benefit Plan. This health plan is offered by Association Mutual Health Insurance Company (AMHIC). This Member Certificate is a guide to your coverage and provides a comprehensive description of your benefits, so it includes some technical language.

This coverage pays benefits for the majority of your health care expenses. Most of your Hospital inpatient care, care received at the doctor's office, emergency care, and prescription drugs are covered. Your coverage also pays benefits for ambulance service, home health care, hospice care, and private-duty nursing.

Special Cost Containment features are provided to help you use your benefits to your advantage. It is important that you become familiar with these provisions: Pre-admission Certification and Individual Case Management. These programs ensure that you receive the Medically Necessary care in the most cost-effective manner. These Cost Containment provisions if used properly, can hold down the cost of your medical bills, and consequently keep your Premium from escalating.

AMHIC has contracted with the CareFirst Provider Network to provide services to our Members. When you receive care from a contracted Network Provider, your benefits would be paid at a higher level. Network Providers will file claim forms for you and we will make payments directly to them. In order to ensure the proper use of the medical care system, we suggest you establish an ongoing relationship with a Network physician.

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

**NETWORK ONLY
HEALTH BENEFIT PLAN**

TABLE OF CONTENTS

SECTION		PAGE
1	INTRODUCTION	1
2	SUMMARY OF BENEFITS	4
3	DEFINITIONS	10
4	MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION AND COBRA	17
5	COST CONTAINMENT FEATURES	29
6	YOUR BENEFITS	32
	- Accidental Injuries	32
	- Ambulance Services	33
	- Anesthesia Services	34
	- Blood Expenses	34
	- Chemotherapy and Radiation Therapy	34
	- Chiropractic Services	35
	- Cleft Palate and Cleft Lip	35
	- Second and Third Surgical Opinions	36
	- Dental Services	36
	- Hemodialysis	38
	- Home Health Care	38
	- Hospice Care	39
	- Laboratory, Pathology, X-ray and Radiology Services	41
	- Maternity and Newborn Care	42
	- Medical Care for General Conditions	43
	- Medical Emergencies	44
	- Mental Health, Alcohol and Drug Abuse Care	45
	- Organ Transplants	46
	- Preventive Care for Adults	47
	- Preventive Child Care Services	48
	- Rehabilitation Therapies: Occupational, Physical and Speech	48
	- Room Expenses and Ancillary Services	49
	- Supplies, Equipment and Appliances	50
	- Surgery	52
	Prescription Drugs and Medicines	54
7	GENERAL LIMITATIONS AND EXCLUSIONS	59

8	GENERAL PROVISIONS	64
9	HOW TO FILE HEALTH CARE CLAIMS	67
	- Claim Appeal Procedures	68
10	WORKERS COMPENSATION	74
11	AUTOMOBILE NO-FAULT INSURANCE PROVISIONS	75
12	THIRD-PARTY LIABILITY – SUBROGATION	76
13	DUPLICATE COVERAGE AND COORDINATION OF BENEFITS	77
14	PRIVACY OF PROTECTED HEALTH INFORMATION	80
15	HIPAA SECURITY STANDARDS	82

SECTION 1

INTRODUCTION

This Plan is a preferred Provider plan offered by Association Mutual Health Insurance Company (AMHIC) based on benefits, limitations, exclusions, and payment as determined by Association Mutual Health Insurance Company.

Your Association Mutual Health Insurance Company Network Only Health Benefit Plan Identification Card will identify you to a Provider as a person who has the right to these benefits. The benefits that are described in this Member Certificate will be provided as long as: you are enrolled under this Certificate when you receive Covered Services; and your Premium has been paid to AMHIC.

This Certificate is part of the legal agreement between the Member's Employer and AMHIC to provide Association Mutual Health Insurance Company Network Only Plan benefits to you (the Member). As a Member, you are bound by all the terms of this Certificate.

Association Mutual Health Insurance Company shall have discretionary authority to determine your eligibility for benefits and all terms contained in your Certificate. Association Mutual Health Insurance Company decision shall be final.

This Certificate contains all the terms of the legal agreement between you and AMHIC, and supersedes all other statements and contracts, oral or in writing, with respect to the subject matter of this Certificate. No change or modification to your agreement with AMHIC will be valid unless it is in writing and signed by an authorized representative of AMHIC. Any such change or modification shall have been either requested or signed by your Employer. Further no course of action, usage or custom or internal policy of AMHIC may amend or become part of our agreement with you.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Person are limited to covered charges incurred before termination, amendment, or elimination. AMHIC and anyone acting on its behalf, has full and final discretionary authority over the administration of the Certificate, including but not limited to, the power to:

- Construe, interpret, and apply the provisions of the Certificate;
- Determine questions concerning eligibility for participation, benefit coverage, or the amount of any benefits payable;
- Take all other actions necessary to carry out the provisions of the Certificate; and
- Perform the AMHIC duties there under.

How to Read This Certificate This Certificate is designed to make it easy for you to determine your benefits. For instance if you need to know the benefit for a surgery, turn to *Section 6: Your Benefits*.

The **Surgery** subsection explains what we consider to be a surgery service. This subsection also describes your benefits and eligible Providers. (**NOTE:** Many Providers are limited in the types of care or services they are licensed or certified to perform. Often, we recognize a Provider as eligible for AMHIC payments only with respect to particular types of care.)

The last part of each **BENEFITS** subsection lists the most important limitations and exclusions to that particular service. *Section 7: General Limitations and Exclusions*, lists other limitations and exclusions, which apply to all benefits. **The items in Section 7 apply to all services and supplies, whether or not these items are listed separately within any BENEFITS subsection.**

If you have any questions about your coverage, please call or write to our Customer Service Department:

AMHIC
c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022
(703) 934-6227 or 1-800-888-6227

Identification Cards After you enroll in this plan, you and your Dependents, if any, will receive an Association Mutual Health Insurance Company Network Only Health Benefit Plan Identification Card. This card is for identification purposes only. While you are a Member, you must show your Identification Card to the Provider before you receive Covered Services. If your Identification Card is lost or stolen, you should contact our Customer Service Department at (703) 934-6227. A new Identification Card will be sent to you.

Finding an In-Network Provider There are different ways for you to find out if a health care Provider is a preferred Provider. To find out if a health care Provider is a preferred Provider, you may look at the Network's website. To access your Network's website, go to www.amhic.com or www.NCAS.com. Due to the changing of Providers within the Network, it would be best to confirm that the Provider participates by calling the Provider.

Pre-certification Requirements If your Physician recommends that you or a covered family Member be Hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations when this Plan is the secondary payer do not require Pre-admission certification. All other Hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned Hospitalization or within 48 hours after an urgent or emergency admission. If you do not comply with the pre-certification requirement, Covered Services will be reduced by 50% up to a maximum of \$500. To obtain admission certification, call Hines & Associates at (800) 670-7718.

How We Calculate Deductible, Copays, and Coinsurance

The Association Mutual Health Insurance Company Network Only Health Benefit Plan is a Network Provider plan. This means that **you** determine the level of your benefits. You do this each time you obtain a health care service. You will receive the highest level of benefits provided under this Certificate when you use In-Network Providers. Benefits are not provided for services rendered by Non-Network Providers (with a few exceptions).

AMHIC has contracted with networks of participating Network Providers in an attempt to control the costs of health care. As part of this effort, many Providers agree to control costs by giving discounts to AMHIC. Most other insurers maintain similar arrangements with Providers. There is no guarantee that In-Network Providers can provide all services all the time and services performed by In-Network Providers could change from time to time.

In their contracts, Network Providers agree to accept the allowable amount as contracted between the participating Provider and the Network as payment in full for Covered Services. For example, your Physician may charge \$100 for a procedure, and the Network's allowable amount is \$85. Your Deductible, Copay and Coinsurance are based on the Network's allowable amount of \$85, and not the Physician's charge of \$100, so if you use a Network Provider, you save money.

You benefit from all Network discounts. Discounts allow AMHIC and your Employer to offer a more extensive plan with lower Deductibles, Copay and Coinsurance amounts and make it possible to offer a lower-cost benefit plan to you and your Employer. Without Network discounts, your Employer might have to choose either a less extensive plan offering fewer benefits or passes the additional costs on to Employees.

SECTION 2

SUMMARY OF BENEFITS FOR NETWORK ONLY PLAN

Network Only 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 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.</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. Please refer to Section 5.</p>	
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	\$100
Individual and 1 Dependent	\$200
Family (Employee and 2 or more Dependents)	\$300 (No more than \$100 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
<p>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</p>	

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	\$100 copay, then 100%	Not Covered
Inpatient Newborn	\$100 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	\$50 copay, then 100% Copay waived if admitted	\$50 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)	\$10 copay per visit, then 100%	Not Covered
Physician office visit - Specialist	\$20 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)	\$20 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	\$10 copay, then 100% \$20 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*	\$100 copay, then 100%	Not Covered
Birthing 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)	\$10 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	\$10 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)	\$10 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)	\$10 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)	\$10 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.

SECTION 3

DEFINITIONS

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of this Certificate. You may want to refer back to this section to find out exactly how – for the purposes of this Certificate – a word is used.

Actively at Work/Active Employee– Employees who report for work with the *Employer* at their usual place of employment and are able to perform all of the usual and customary duties of their occupation on a regular, *full-time* basis. If your usual place of employment is in your home, you will be considered *Actively at Work* if, at any time on the date in question, you are neither:

1. Confined in a *Hospital*; nor
2. Disabled to a degree that you could not have performed your usual and customary duties on a regular, *full-time* basis.

As an *Employee*, you will be deemed *Actively at Work* on each day of a regular paid vacation or on a regular non-working day on which you are not *totally disabled*, provided you were *Actively at Work* on the last preceding regular working day.

Ambulatory Surgical Center– Is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Alcoholism Treatment Center– A detoxification and/or rehabilitation facility licensed by a state to treat alcoholism/drug abuse.

Ancillary Services– See this heading under *Section 5: Your Benefits, Room Expenses and Ancillary Services*.

AMHIC– Association Mutual Health Insurance Company domiciled in the District of Columbia.

Birthing Center– Any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located. The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Biologically Based Mental Illness– Schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder; and any biologically based mental illness appearing in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

Certificate of Coverage – A written document that reflects certain details about an individual's creditable health coverage. It is intended to establish an individual's prior Creditable Coverage for purposes of reducing the extent to which a plan offering health coverage can apply a pre-existing

exclusion. You should have received a Certificate of Creditable Coverage from your prior plan. You may request a Certificate from your prior plan if you did not receive one. If necessary, your Human Resources Department will assist you in obtaining the certificate. You must present that Certificate to the Employer in order for your Creditable Coverage to reduce your Pre-Existing Condition Waiting Period under this Plan.

COBRA– The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Certificate– This document which constitutes the agreement between us and the Employer regarding the benefits, limitations, exclusions, terms, and other conditions of coverage. A copy of the Certificate is provided to each Member.

Coinsurance– The percentage of the cost of Covered Services that a Member must pay after the Copay or Deductible has been met.

Copay– A flat dollar amount a Member must pay to receive a specific service or benefit. The *Summary of Benefits* show the amount of your Copay and which Covered Services are subject to a Copay.

Cost Containment– A system to evaluate and monitor the way medical services are delivered and resources are allocated without compromising the quality of care. Any covered person who does not follow the Cost Containment requirements established by the Cost Containment organization may not receive the maximum benefits provided by this plan.

Covered Services– Services and supplies provided to a Member for which we have an obligation to pay under the terms of this Certificate.

Creditable Coverage - Coverage under almost any other type of medical plan, including group health plans, individual insurance, Medicare, Medicaid, Tricare, Indian Health Service medical care or care through a tribal organization, state health benefits risk pools, the Federal Employees Health Benefits Program, a public plan, the State Children's Health Insurance Program and a Peace Corps Plan. A public plan includes plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan. Creditable coverage is measured in days. Each day of Creditable Coverage reduces by one day any Pre-Existing Condition Waiting Period under this Plan. However, if the break in coverage between your old plan and this Plan is 63 days or longer, you will not receive any Creditable Coverage, and you will be subject to the full Pre-Existing Condition Waiting Period.

Customer Service Department– AMHIC's Customer Service Department for Medical is *c/o NCAS, P.O. Box 10136, Fairfax, VA 22038-8022, 1-800-888-6227*. The Customer Service Department for Prescription Drugs is *Express Scripts, Inc., 1-800-235-4357*.

Deductible– A specified amount of expense for Covered Services that the Insured must pay within each Member's Calendar Year before AMHIC provides benefits. The *Summary of Benefits* show the amount of the Deductibles. It also shows which Covered Services are subject to a Deductible.

Dependent– An individual who meets the eligibility requirements described in Section 4 under Dependents.

Disability (Disabled)– In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Effective Date– The date when you or your covered Dependent(s) become covered under the plan.

Employer– Any organization that has an agreement with AMHIC to provide health care benefits for a group of Members. The Employer will collect Premiums on behalf of the Members, deliver to the Members all notices from AMHIC, and comply with all provisions of the Certificate.

Enrollment Date– The first day of coverage or, if there is a Waiting Period, the first day of hire.

ERISA– The Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational– Services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

Association Mutual Health Insurance Company must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. Association Mutual Health Insurance Company shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of Association Mutual Health Insurance Company will be final and binding on the Plan. Association Mutual Health Insurance Company will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Membership– A Membership that covers three or more persons (the Employee and two or more Dependents).

Hazardous Pursuits– Involve or expose an individual to risk of a degree or nature not customarily undertaken in the course of the Employee's customary occupation with the Employer or in the course of the class of leisure time activities commonly considered as not involving unusual or excessive risk. For purposes of this Plan only, such Hazardous Pursuits are limited to hang gliding, sky diving, use of all terrain vehicles, outdoor rock climbing, motorcycle, automobile or speedboat racing, bungee jumping, ice climbing, ultra-light flying and river running.

Home Health Aide– A person licensed or certified to provide home health care services.

Home Health Care Agency– An agency certified by the state as meeting the provisions of Title XVIII of the Federal “Social Security Act,” as amended, for Home Health Care Agencies. A Home Health Care Agency is primarily engaged in arranging and providing nursing services, Home Health Aide services, and other therapeutic and related services.

Home Hospice– An agency certified by the state to provide hospice care. Hospice care is a centrally administered program of palliative, supportive, and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, home health care, and follow-up bereavement services available 24 hours, 7 days a week.

Hospital–A health institution offering facilities, beds, and continuous services 24 hours a day. The Hospital must meet all licensing and certification requirements of local and state regulatory agencies.

Illness– A bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Identification Card– The card we give you that shows such information as the Member name, Member number, Policy name and type of coverage.

Individual Membership– A Membership covering one person.

Injury– An accidental physical Injury to the body caused by unexpected external means.

Insured– You or any Dependent who is enrolled for coverage under this Certificate under the terms of the Certificate. NOTE: “You” and “Your” refer to the Insured.

Legal Guardian– A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime– A word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Maximum Benefit Allowance– The amount determined by AMHIC to be Reasonable and Customary (R&C) Allowance for a Covered Service. Our determination of a Maximum Benefit Allowance is the maximum amount we approve for any particular service. Deductible, Copay, and Coinsurance or other cost-sharing amounts are based on this allowance and are the amounts the Insured pays to a Provider.

Medicaid– Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Emergency – The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. We cover emergency services necessary to screen and stabilize a Member without prior authorization if a prudent lay person, having average knowledge of health services and medicine and acting reasonably, would have believed that an emergency medical condition or life or limb threatening emergency existed.

Medically Necessary– A term used to describe technologies, services, or supplies provided by a Hospital, Physician, or Other Provider that we determine in conjunction with qualified Providers are: AMHIC Network Only

- Medically appropriate for the symptoms and diagnosis or treatment of the condition, illness, disease, or injury;
- Provided for the diagnosis, or the direct care and treatment of the Insured's condition, illness, disease or injury;
- In accordance with standards of sound medical practice and meet with our technology evaluation criteria;
- Not primarily for the convenience of the Insured, or the Insured's Provider; and
- The most appropriate supply or level of service that can be safely be provided to the Insured. When applied to Hospitalization, this further means the Insured requires acute care as an inpatient due to the nature of the services rendered or the Insured's condition, and the Insured cannot receive safe or adequate care as an outpatient.

NOTE: The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, by itself, make it a Medically Necessary or covered expense, even though it is not specifically listed as an exclusion. Claims for services and supplies that are not Medically Necessary may be denied either before or after Payment.

Medicare— Health insurance for the aged and disabled as established by Title I of public Law 89-98 (79 Statutes 291) including parts A & B and Title XVIII of the Social Security Act, as amended from time to time. This also refers to prescription drug insurance for the aged and disabled as established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Member— The person in whose name the Membership is established and to whom the Identification Card is issued.

Member's Benefit Year— The Member's Benefit Year begins on the Member's Effective Date of Membership as established for the Member, and expires on the following December 31; a Member's new Benefit Year begins on each subsequent January 1.

Morbid Obesity – A diagnosed condition in which an individual's body weight exceeds the normal weight by 100 pounds or has a body mass index (BMI) of 40 or more (35 with certain co-morbid conditions). The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

Network Provider— A panel of Licensed Providers and/or a group of participating healthcare institutions which provide medical services to contracted groups of Members. Savings received because of the contracted rates are not the responsibility of the Member. Contact NCAS or access the Preferred Provider Organization's (PPO) website, to determine if a Provider participates.

No-Fault Auto Insurance— The basic reparations provision of a law providing for payment without determining fault in connection with automobiles accidents.

Non-Network Provider— A Facility Provider (such as a Hospital) or a Professional Provider (such as a Physician) that has not entered into an agreement with us or which the Member is not enrolled.

Palliative Treatment – Relief of symptoms for a time but does not cure or end the cause of symptoms.

Participant - Any eligible Employee or eligible Dependent who has elected coverage in this Plan and has fulfilled all requirements to continue participation.

Pay, Paid, or Payment— "Pay" means to satisfy a debt or obligation. After the R&C or Maximum Benefit Allowance is determined, AMHIC will satisfy its percentage of the bill by an actual dollar AMHIC Network Only

Payment, by a negotiated Provider discount, or by combining these two methods of Payment. The Insured's portion of the payment includes Deductible, Copay, and Coinsurance or other cost-sharing amounts.

Pharmacy– A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician - A properly Licensed Provider holding a degree of Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Psychologist (PhD), Dentist (DDS or DMD), or Chiropractor (DC).

Placement for Adoption - The assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Premium – Amount that must be paid monthly to AMHIC for each Member's health insurance coverage. Your Employer may require you to pay all or a portion of this Premium. AMHIC may change your Premium amount. AMHIC will notify your Employer prior to the Effective Date of a Premium change. It is up to the Employer to notify its Members of any Premium changes. In all cases, the Employer must pay the total Premiums owed for your health benefits under this Certificate to AMHIC. AMHIC is not responsible for providing benefits for an Employer's Member or Dependent if the Employer fails to make Premium payments.

Protected Health Information (PHI) - Individually identifiable health information which is maintained or transmitted by a health plan.

Provider – A person or facility that is recognized by AMHIC as a health care Provider, and fits one or more of the following descriptions:

- Professional Provider – A Physician or Other Professional Provider who is recognized by AMHIC.
- Other Professional Provider – A Professional Provider (except a Physician) that is recognized by AMHIC and licensed, certified, or registered by the state or jurisdiction where services are provided to perform designated health care services. This includes certified nurse midwives. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority appointed by us. A professional supplier of medical supplies and equipment is considered an Other Professional Provider.
- Facility Provider – An Alcoholism Treatment Center, Home Health Care Agency, Hospice Agency, Hospital, or Other Facility which we recognize as a health care Provider. These Facility Providers may be referred to collectively as a Facility Provider or separately as an Alcoholism Treatment Center Provider, Home Health Agency Provider, Hospice Agency Provider, Hospital Provider, or Other Facility Provider.
- Other Facility – A Facility Provider (except a Hospital, Alcoholism Treatment Center, Home Health Agency, or Hospice Agency) that we recognize as a Provider and that is licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority appointed by us. Examples: ambulatory surgery center, dialysis center, Veteran's Administration, or Department of Defense Hospital.

Reasonable and Customary Allowance - Plan allowances for treatment, services or supplies essential to the care of the individual as determined by the Claims Administrator. Charges by the Licensed Provider must be the amount usually charged for similar services and supplies when there is no insurance. Charges for Covered Services that do not exceed the amount in the fee schedule

used by the Plan will be reimbursed as specified in the Schedule of Benefits. The fee schedule published by MDR is used by the Plan to determine the Reasonable and Customary Allowance.

Room Expenses – See this heading under *Section 5: Your Benefits, Room Expenses and Ancillary Services*.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Significant Break in Coverage - A break in coverage of 63 days or more. Waiting Periods are not considered breaks in coverage. Under HIPAA, if an individual has a break in coverage of at least 63 days, any Creditable Coverage before that break will be disregarded by the plan when evaluating whether to impose a pre-existing condition limitation period.

Waiting Period - A Waiting Period is the period that must pass before an Employee or Dependent is eligible to enroll under a group health plan. The Waiting Period does not count as prior Creditable Coverage or as days in a break in coverage.

Written Notice – Notice, in writing, in a form supplied by or satisfactory to AMHIC.

SECTION 4

MEMBERSHIP ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE, TERMINATION, AND COBRA

WHO IS ELIGIBLE?

Employee - All regular, full time Employees, as determined by the Employer's policy, regularly scheduled to work a minimum of *20 hours per week*, and their Dependents are eligible for Membership. An Employee on an authorized leave of absence, as determined by the Employer's policy, shall be classified as eligible.

Fellows or Special colleagues, as defined by the Employer, who are in a formal written agreement or fellowship arrangement of at least six months. The Employer must cover any such individuals as a Class providing the same level of Employer contributions as set forth in a written policy or manual to all Members of the class.

If an Employee qualifies as both an Employee and a Dependent, such person may be covered as an Employee or Dependent, but not as both. If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

Retirees – Retirees meeting the requirements set forth in the Employer plan, and meeting AMHIC requirements, are eligible for Membership. To be considered a qualifying retiree you must have participated in the AMHIC plan at the time of retirement and your association's written retiree policy must be on file and include one of the following two minimum requirements:

- a) you must be age 55 or older with 10 or more years of active service with one of the participating organizations of AMHIC; or
- b) You must have at least two years of service with a participating organization and your age plus length of service equals 65 or more.

The Employee and any dependents must have participated in one of the AMHIC medical plans at the time of retirement to be considered an AMHIC qualifying retiree.

AMHIC eligible retirees who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare Part B is available at the retiree's own expense. Copies of the retiree's Medicare card showing enrollment in Medicare Parts A & B must be forwarded to AMHIC in order for AMHIC to change the Employee's premium from active status to retiree/Medicare status. Once this information is received, Medicare will provide primary coverage and AMHIC will provide secondary coverage. If a Medicare eligible retiree does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the AMHIC plans will pay as if Medicare were Primary.

Check with your Human Resources Department to see if your employer has a post-retirement health policy.

Dependents - Eligible Dependents are your:

- a) A legal Spouse as defined by applicable state law.
- b) An unmarried child who is the natural or legally adopted child of the Member, through the end of the month in which the child becomes age 19.
- c) Your same or opposite-gender Domestic Partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy;
- d) An unmarried child who is the natural or legally adopted child of the Member, between the age of 19 thru 26 who is enrolled as a full-time student in a university, college, vocational

school, secondary school or institution for training of nurses and who is primarily Dependent on the Member for financial support. A Full-Time student's coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated on the (last day of the month) of the attended school term. A Student Certification form indicating, Full-Time Student status, must be updated by the Employee and sent to the Employer by August 31st of each school year. The Student Certification must be forwarded to AMHIC.

- e) An unmarried child age 19 and older who is incapable of self-support because of mental incompetence or severe physical handicap and is Dependent on the Member for financial support, as certified by a Physician and us. The condition must begin before or during the month in which the child reached age 19 (age 26 if full-time student). We require proof acceptable to us of the child's physical or mental Disability each Insured's Benefit Year.
- f) Any child of a Participant who does not qualify as a Dependent under subsections c, d or e above, solely because the child is not primarily Dependent upon the Participant for support so long as over half of the support of the child is received by the child from the Participant pursuant to a multiple support agreement.

A Spouse or child in the armed forces of any country is not eligible for coverage.

The terms "**Spouse or Domestic Partner**" means the person recognized as the covered Employee's husband, wife, or same or opposite-gender Domestic Partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy; and under the laws of the state where the covered Employee lives. Association Mutual Health Insurance Company may require documentation proving a legal marital relationship. You must notify AMHIC if your Spouse, Domestic Partner or Dependent child has access to health insurance coverage under another Plan, such as through coverage provided by your Spouse's Employer or as the result of a divorce decree.

The term "**Dependent children**" means any of a Participant's:

- a) Natural children;
- b) Legally adopted children or children placed in the Employee's home pending final adoption;
- c) Stepchildren who depend on you for support;
- d) Foster children (provided the foster child is not a ward of the state);
- e) Children who are under the Legal Guardianship of the Employee;
- f) Children of a Domestic Partner;
- g) Children for whom the Employee is required to provide health care coverage under a recognized Qualified Medical Child Support Order;
- h) Grandchild, niece, or nephew, if the child is under the primary care of the Employee, and if the Legal Guardian of the child, if other than the Employee, is not covered by a health care policy. The term "primary care" means that the Employee provides food, clothing, and shelter on a regular and continuous basis during the time that the District of Columbia public schools are in regular session.

Certain enrollments or terminations will require documentation. This documentation could include:

- a) A Birth Certificate;
- b) A Marriage License;
- c) Court documents, legal separation, guardianship or adoption;
- d) AMHIC Affidavit of Domestic Partnership;
- e) Medicare Parts A & B card (if Employee has a retiree policy);
- f) Proof of Loss of Coverage;
- g) Certificate of Prior Coverage (HIPAA);
- h) Declaration of Termination of Domestic Partnership.

ENROLLMENT

HOW DO I ENROLL?

Employee - To become covered by the Plan, you must complete an enrollment application. During your new employee orientation, you will be given an application to complete. You should return the completed form to your Employer within 31 days from your eligibility date.

When you enroll, you may select coverage for yourself and/or your Dependents. You have a choice of electing Individual, Individual Plus One or Family. If you have eligible Dependents whom you want to enroll, you must select one of the Employee and Dependent options when you complete your enrollment application.

Special Enrollment Period: If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) 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:

- a) The Employee was covered under a health plan (including COBRA coverage) at the time coverage was initially offered;
- b) If required by the Plan Administrator, the Employee states in writing that the other coverage is the reason for declining enrollment;
- c) The other coverage that the Employee had was COBRA coverage and the COBRA coverage was exhausted;
- d) The coverage is other health plan coverage and it is terminated due to loss of eligibility:
 - 1) as a result 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), termination of employment, or reduction in the number of hours of employment or termination of employer contributions to the coverage and not due to failure to pay 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);
 - 2) The other coverage the Employee had was offered through an HMO, or other arrangement (in the group or individual market) that does not provide benefits to individuals who no longer reside, live, or work in a service area and (in the case of group coverage through an HMO) no other benefit package is available to the individual;
 - 3) An individual incurs a claim that would meet or exceed a lifetime limit on all benefits.
 - 4) A plan no longer offers any benefits to a class of similarly situated individuals.

NOTE: When a loss of eligibility occurs, the Employee must request enrollment in writing within 31 days of exhaustion, termination of coverage or (in the case of the lifetime limit) of the date a claim is denied due to the lifetime limit.

- e) 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.

- f) 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 initially join the Plan during an Open or 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. In order to have the pre-existing condition limitation reduced or waived, you must provide your Employer with a Certificate of Creditable Coverage from your prior health plan or coverage. Please contact your prior Employer or health plan for this certificate.

Changing Status - If your employment status changes so that you are eligible to participate in the Plan, you must complete an enrollment form within 31 days of the date of eligibility.

New Dependents – A newborn, an adopted child, a child placed for adoption and a previously ineligible Dependent who meets the eligibility requirements (i.e. an over-age Dependent child is not a full-time student and then becomes a full-time student) are eligible to be added to the Plan.

Coverage for the new Dependent becomes effective on the date of eligibility provided that you request enrollment within 31 days.

See the section entitled Special Enrollment Period for further information.

Open Enrollment - Before the Plan Year begins, an Open Enrollment period shall be authorized to allow eligible Employees (including COBRA participants and retirees) to change their participation elections, to obtain new participation for the Employee and/or eligible Dependents, or to accept transfers of Employees covered under the PPO Plan and the HMO. You may also change your network selection at this time. The Open Enrollment period shall be held before the Plan Year begins with an Effective Date of the following January 1st.

Re-Enrollment Provision - If an eligible Employee takes FMLA leave, as defined by the Family and Medical Leave Act (FMLA), due to one or more of the following:

- a. Because of the birth of a son or daughter of the Employee and in order to care for such son or daughter;
- b. Because of the placement of a son or daughter with the Employee for adoption or foster care;
- c. In order to care for the Spouse, or a son, daughter, or parent, of the Employee, if such Spouse, son, daughter, or parent has a serious health condition;
- d. Because of a serious health condition that makes the Employee unable to perform the functions of the position of such Employee;

and terminates his or her coverage in the Plan, he will be able to re-enroll in the Plan upon return to active employment at the conclusion of a period not to exceed that defined by the FMLA. This Employee will **not** be subject to Pre-existing Waiting Period provisions.

Enrollment forms are obtainable from your Employer's Human Resource office.

Reinstatement – If your coverage terminates due to termination of employment and you resume

employment with your Employer within a period of time specified by the Employer, you will become eligible for Reinstatement of Coverage. Eligibility will begin on the date you resume employment and you shall not be subject to the Waiting Period or Pre-existing Waiting Period if prior to re-employment you worked long enough to satisfy these Waiting Periods. A Certificate of Creditable will be required.

Leave of Absence (other than Family and Medical Leave Act absence) – If you are on an approved Leave of Absence that is not covered under FMLA, your coverage will be continued for the period of time approved by your Employer, provided you pay the required Premium equivalent. If you do not resume employment at the end of this period, your coverage will be deemed to have terminated for purposes of Continuation Coverage under COBRA. You will become eligible for reinstatement of coverage on the date you resume employment and shall not be subject to the Waiting Period or Pre-existing Waiting Period if prior to the Leave of Absence you worked long enough to satisfy these Waiting Periods.

Changing Coverage -You may change your election during the Plan Year if you experience a Life Event. Your election is the type of coverage you selected when you initially enrolled (i.e. Individual, Individual Plus One or Family). The following is a list of Life Events:

1. Legal Marital Status - Events that change your legal marital status, including marriage, death of Spouse, divorce, legal separation or annulment;
2. Number of Dependents - Events that change the number of eligible Dependents, including regaining eligibility status (e.g. returning to school full-time), birth, adoption, Placement for Adoption, or death of a Dependent;
3. Employment Status - Events that change employment status of Employee or Dependent(s) such as termination or commencement of employment, a reduction or increase in hours of employment, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence and any change in employment status resulting in person becoming eligible or ceasing to be eligible under a Plan;
4. Dependent satisfies or ceases to satisfy the requirements for unmarried Dependents;
5. Residence or Worksite - A change in the place of residence or work for you, your Spouse, or your Dependent; or
6. Other Events ;
 - a. Judgment, Decree or Order - If you or your Spouse are subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for you to provide medical coverage for your child, you may make a corresponding change in your election.
 - b. Medicare/Medicaid Coverage - If you, your Spouse, Domestic Partner or your Dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.
 - c. Eligibility for COBRA - If you, your Spouse, Domestic Partner or your Dependent becomes eligible for and elects COBRA under the Plan, you may make a corresponding election to pay for the continuation coverage.
 - d. Family and Medical Leave Act - If you take leave under the Family and Medical Leave Act ("FMLA"), you may make other elections concerning group health coverage that are permitted by FMLA.
 - e. Significant Cost Increases - If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.
 - f. Coverage Changes - If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, you may elect the new benefit option.

- g. **Changes Under Another Employer's Plan** - You may also change your elections to correspond to certain changes that your Spouse, Domestic Partner or a Dependent makes to his or her benefit elections under a benefit Plan offered by his or her Employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

The consistency rule requires that the change in status results in the Employee, Spouse, Domestic Partner or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Spouse's, Domestic Partner's or Dependent's Employer; and that the election change corresponds with that gain or loss of coverage.

You must contact the your Employer's Human Resource Office to verify eligibility to change coverage and complete an enrollment form within 31 days of your Life Event change.

When Can I Change or Cancel Enrollment? – You may change or cancel coverage in the Plan if you have an eligible Life Event change or during Open Enrollment.

You must contact the your Employer's Human Resource office to verify eligibility to cancel coverage and fill out the appropriate paperwork within 31 days.

Uniformed Service under USERRA – A Participant who is absent from employment with the Employer on account of being in "uniformed service" as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") may elect to continue participation in the Plan. The coverage period shall extend for the lesser of 24 months or until the Participant fails to apply for reinstatement or to return to employment with the Employer. The Participant shall be responsible for making the required contributions during the period in which he is in "uniformed service." The manner in which such payments are made shall be determined by the Plan Administrator in a manner similar to that of FMLA leave.

Notwithstanding anything in this Plan to the contrary, with respect to any Employee or Dependent who loses coverage under this Plan during the Employee's absence from employment by reason of military service, no Pre-Existing Condition exclusion or Waiting Period may be imposed upon the reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee unless such Pre-Existing Condition exclusion or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

EFFECTIVE DATE OF COVERAGE

WHEN DOES COVERAGE BECOME EFFECTIVE?

Employees and Their Eligible Dependents - The Effective Date of the eligible Employee is on the later of the following dates:

- a. The Employer's Effective Date;
- b. The first of the month following an Employee's hire date, unless the Employee's hire date is on the first business day of the month, in which case coverage is effective on the Employee's date of hire.

If you are not *Actively at Work* for reasons other than your health or a medical condition on the date your coverage would otherwise become effective, your benefits will not begin until the date you return to *active employment*.

New Employees: New full-time Employees who enroll in the Plan are eligible for coverage as indicated above. If you elect coverage for your Dependents when you enroll, their Effective Date will be the same as your Effective Date. Employees who, because of an employment status change, are now eligible for coverage and who enroll in the Plan, are effective on the first day of the month following the date of eligibility.

New Dependents - If you acquire a new Dependent (birth, marriage or adoption) refer to the section entitled Special Enrollment Period. If a previously ineligible Dependent meets the eligibility requirements, refer to the section entitled How Do I Enroll.

If your current enrollment election already provides coverage for the Dependent without a change, coverage is in effect from the date of eligibility upon receipt of a new enrollment application.

Changing Coverage - If you qualify to add or drop a Dependent, you must complete a new enrollment application. Please contact your Employer's Human Resource office for the form. Coverage will become effective as explained above.

After your new enrollment application is received, processed and approved, you will receive a new Identification Card.

Late Enrollee - An individual whose enrollment in a plan is due to a late enrollment. Participants who join the Plan during Open Enrollment are Late Enrollees. A late enrollment means enrollment in any AMHIC sponsored medical plan other than on:

- the earliest date on which coverage can become effective under the plan; or
- a special Enrollment Date.

Pre-existing Waiting Period - A pre-existing condition is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the Enrollment Date. Participants must satisfy a 10-month Waiting Period from the Enrollment Date before becoming eligible to receive benefits for pre-existing conditions.

This provision will not apply to newborns or children who are adopted or placed for adoption and enrolled in the plan within 31 days. Pregnancy is not considered a pre-existing condition.

If an Employee or Dependent has not satisfied the pre-existing condition Waiting Period of the Employer's plan in effect immediately prior to the Effective Date of this Plan, credit will be given for

the period of time which elapsed while the Participant was covered by the prior plan.

The period of pre-existing condition exclusion will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage. The Participant must show proof of prior Creditable Coverage. A Certificate of Coverage may be used for this purpose.

TERMINATION

WHEN DOES MY COVERAGE TERMINATE?

When Coverage Under This Certificate Ends If your group is covered by provisions requiring continuation of group coverage under District of Columbia or Federal Law (Consolidated Omnibus Budget Reconciliation Act of 1985 *COBRA*), you and your covered Dependents who lose eligibility under a group may be able to continue as group Members for a limited period of time. Contact your group for more information. AMHIC offers COBRA to all eligible Employees and their Dependents who terminate coverage.

If you are removing a Dependent, or if the Dependent is no longer eligible, the deletion will be effective on the last day of the month.

If a Member does not elect or does not qualify for COBRA continuation, coverage under this Certificate ends on the last day of the month.

For any Insured, including Dependents:

- When the Member's Employer gives us Written Notice of termination or reduction of hours. If the Employer fails to timely remove an ineligible Insured, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date.
- Upon the Member's death. NOTE: If your benefits as an active Employee or qualifying retiree end due to your death, your Surviving Dependents' coverage may continue under this plan. Surviving Dependents are allowed to continue coverage offered by Association Mutual Health Insurance Company Employee Benefit Plan.
- When we do not receive the Premium payment on time.
- When there is fraud or intentional misrepresentation of material fact on the part of the Insured.
- When the Insured is no longer eligible for this group coverage under the terms of the Certificate.
- The date group coverage under this Certificate is discontinued for the entire group, or the Member's enrollment classification.
- A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to the Employer from whose employment a covered Employee retired at any time.

For a Dependent:

- When the Dependent child marries, such a Dependent has the right to select COBRA continuation.
- At the end of the last paid billing period for Dependent coverage.
- When the Dependent no longer qualifies as a Dependent by definition, such a Dependent has the right to select COBRA continuation.
- The date of a final divorce decree or legal separation for a Dependent Spouse, such a Dependent has the right to select COBRA continuation.
- When the Member notifies us in writing to end coverage for a Dependent.
- When a Domestic Partnership is terminated.

We will not refund Premiums paid on behalf of a Participant if:

- We do not receive Written Notice of termination/change within 31 days of the Effective Date of termination/change; or
- We have paid any claims on behalf of the deleted Participant.

Certificate of Creditable Coverage – Each terminating Participant will receive a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this Plan. For Employees with Dependent coverage, the Certificate provided may include information on all covered Dependents. If you have any questions or need to request a Certificate of Creditable Coverage, please contact your Human Resources office.

COBRA CONTINUATION OPTION

A covered person may continue coverage for a period of 18, 29 or 36 months, at his/her own expense, pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, if coverage under the Plan would otherwise terminate because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary" as follows:

1. Termination of Employment: A covered Employee, Domestic Partner, Spouse and Dependent child (qualified beneficiary) may elect to continue coverage under this Plan for up to 18 months, if their eligibility ends due to one of the following qualifying events:

- a. The covered Employee is terminated (for reasons other than Gross Misconduct*);
- b. The covered Employee's number of hours of employment is reduced.

* Gross Misconduct is defined as the deliberate and willful violation of a reasonable rule or policy of the Employer, governing the Employee's behavior in performance of his or her work, provided such violation has harmed the Employer or other Employees or has been repeated by the Employee despite warning or other explicit instruction from the Employer. Employees may also be terminated for cause, such as fraudulent claims submission.

Disability Extension: A qualified beneficiary may elect to extend coverage an additional 11 months, up to a maximum of 29 months, for himself/herself and nondisabled family members who are entitled to COBRA continuation coverage, if he is disabled (as defined by Title II or XVI of the Social Security Act) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage and is covered for Social Security Disability Income benefits.

The Qualified Beneficiary must send the COBRA Plan Administrator a copy of the Social Security office's Disability determination letter within 60 days after the latest of (and in no event later than the end of the 18th month of COBRA coverage):

- a. The date of the Social Security Administration's Disability determination
- b. The date on which the qualifying event occurs
- c. The date on which the qualified beneficiary loses coverage; or
- d. The date on which the qualified beneficiary is informed of the obligation to provide the Disability notice.

If the Social Security office determines that the qualified beneficiary is no longer disabled, the COBRA Plan Administrator must receive a copy of the Social Security office's letter within 30 days after it determines that he is no longer disabled. Please send the required documentation to the Plan Administrator at the address shown at the end of this Section.

2. Loss of Dependent Eligibility: A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if his or her eligibility ends due to any of the following qualifying events:

- a. The covered Employee dies
- b. The covered Employee is divorced or legally separated
- c. The covered Employee becomes eligible for and elects Medicare benefits
- d. A Dependent child ceases to be a Dependent (as defined by the Plan).

The Employee or covered Dependent must notify the Employer/Plan Administrator as follows:

Notice Obligations

A covered Employee, Spouse or Dependent is responsible for notifying the Employer of the Employee's divorce or legal separation, termination of Domestic Partnership, or of the Employee's child losing Dependent status. The qualified beneficiary must notify the Employer within 60 days of the date of the event or the date on which coverage would terminate, whichever is later. Written notification must be provided to your Employer.

The qualified beneficiary may be required to complete a "COBRA Qualifying Event Notification Form" and attach official documentation which substantiates the event. If you do not have access to a form, please provide the Employer with the following information in writing and attach a copy of official documentation: Employee name, identification number, beneficiary name, address, telephone number, date of event, and description of event.

Failure to give notice within 60 days of the event can result in COBRA coverage being forfeited.

Multiple Event Extension: If a covered Dependent elects the 18 month continuation following an event shown in Part 1 and later becomes entitled to a 36 month continuation due to an event shown in Part 2, then that covered Dependent may continue coverage for up to 36 continuous months from the date of the first qualifying event.

For example, because the Employee is terminated, an 18-month continuation is elected for a covered Dependent. Before the 18 month period has ended, the covered Dependent reaches the maximum age to be covered under the Plan. This is a second qualifying event. In order to extend continuation of coverage up to 36 months from the original continuation of coverage Effective Date, the Dependent must notify the COBRA Plan Administrator in writing, within 60 days of the second event or the date coverage ends (whichever is later). Written notification must include: beneficiary's name, identification number, address, telephone number, date of event, description of event and a copy of official documentation substantiating the event (if divorce or legal separation.) The COBRA Plan Administrator contact and address can be found at the end of this section.

- 3. Retirees and Bankruptcy** – Covered retirees of an Employer that declares Chapter XI bankruptcy are eligible for continuation coverage if they lose coverage within one year before or after the bankruptcy proceedings begin. Retirees may continue their coverage until their death. The Spouse and Dependent children of the retiree are eligible for continuation coverage until the retiree's death plus an additional thirty-six months of coverage after the date of the retiree's death.

Election - A covered Employee can elect COBRA coverage for himself or herself and/or his or her covered Dependents. In the event that an Employee with family coverage does not elect COBRA coverage for his or her Dependents, such coverage may be elected by the Dependents. No Spouse, Domestic Partner or child is entitled to continuation coverage unless that individual was a covered Dependent under the Plan on the date before any of the above qualifying events except for the following: A Qualified Beneficiary includes a child born to or placed for adoption with a covered Employee during the period of COBRA coverage. An election on behalf of a minor child can be made by the child's parent or Legal Guardian.

To continue coverage, the Employee or Dependent, hereinafter called a continuee, affected by the qualifying event must make written election by the 60th day following: (a) the last day of coverage; or (b) the date he is sent notice of the right to continue coverage; whichever is later.

Within 45 days of the election date, the continuee must pay the required monthly Premium for the COBRA coverage period prior to the election. The 18 or 36 month continuation period will begin on the earliest of the above qualifying events.

Monthly Premium - The due date for the monthly Premium is the first day of each coverage month and COBRA allows 30 days from the due date to send the Premium to the COBRA Plan Administrator. The monthly Premium will not exceed 102% of the total monthly cost (determined by the Plan on an actuarial basis) for coverage of a similarly situated active Employee. However, when a disabled continuee extends coverage beyond 18 months, the monthly Premium will increase to 150% of that total average monthly Premium. The monthly Premium is subject to change at the beginning of each Plan Year.

Payment of Claims - No claim will be payable under this COBRA provision, until the COBRA Plan Administrator receives the applicable monthly Premium for the continuee's coverage.

Termination - Coverage under the COBRA provision will terminate on the earliest of the following:

- a. The date on which the Employer ceases to provide a group health plan to Employees;
- b. The date the continuee first becomes, after the date of the election, covered under any other group health plan (unless the plan contains pre-existing condition exclusions or limitations that are not reduced by Creditable Coverage);
- c. The date the continuee first becomes, after the date of the election, covered for Medicare benefits;
- d. The date the continuee fails to make timely payment of the monthly Premium under the Plan;
- e. For a disabled continuee who extends coverage beyond 18 months, the first of the month which begins 30 days after the continuee is no longer considered disabled as defined by Social Security regulations;
- f. The end of the applicable 18, 29 or 36 month period. In no case will coverage continue beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the COBRA coverage period;
- g. For cause, such as fraudulent claims submission, on the same basis that coverage could be terminated for similarly situated active Employees.

COBRA Plan Administrator – If you have any questions about the law or your obligations, you may contact the COBRA Plan Administrator:

NCAS
PO Box 3065
Fairfax, VA 22038
(703) 934-6227 or (800) 888-6227

SECTION 5

COST CONTAINMENT FEATURES

The Cost Containment provisions of this Plan are administered by Hines & Associates, the Managed Care Vendor (MCV). The staff at the Managed Care Vendor are Physicians and Registered Nurses who monitor the use of your health care benefits to ensure that you and your family:

- a. Receive the best medical care possible in the most appropriate health care setting;
- b. Avoid unnecessary surgery and excess Hospital days;
- c. Receive medical advice on questions you have regarding medical care;
- d. Receive the maximum benefits from your health care treatment and benefit plan.

Components of the Managed Care program include:

- a. Pre-certification of all:
 - Hospital admissions, including inpatient psychiatric and obstetrical admissions;
 - Outpatient treatment for mental health and substance abuse conditions;
- b. Continued Stay Review of all Hospitalizations;
- d. Case management of potentially catastrophic cases;

Pre-admission, admission, and continued stay review decisions are based on the medical policy guidelines of MCV. This may include, but is not limited to the following reviews:

- a. Cosmetic
- b. Investigational/Experimental
- c. Outpatient services, e.g. speech therapy, physical therapy, chiropractic services

Otherwise, all medical necessity review will be performed at NCAS utilizing the CareFirst Medical Policy.

HOW THE MANAGED CARE PROGRAM WORKS

PRE CERTIFICATION:

- a. If your Physician recommends that you or a covered family Member be Hospitalized, you must contact the Managed Care Vendor for assistance with the certification process. Hospitalizations out of the country or when this Plan is the secondary payer do not require Pre-admission certification. All other Hospitalizations require pre-certification. Admission certification must occur prior to an elective or planned Hospitalization or the next business day after an urgent or emergency admission. To obtain pre-certification, call:

Hines & Associates: (800) 670-7718

When you call, have your Member number, policy name, patient name, home phone number, Physician's name and Physician's phone number ready.

- b. Notification may be initiated by you, a family Member, Physician, or representative from the Hospital. The Managed Care Vendor will review your Physician's recommendations based on the medical information supplied and accepted standards and criteria for Hospital admission. In most cases, the Managed Care Vendor will notify you, your Physician, and the Hospital of your certification approval within 24 hours. At that time the Hospital will be advised of the number of

approved days.

- c. Outpatient services for mental health and substance abuse require Hine's approval of a plan of treatment before benefits for covered in-network services are provided. Benefits are only available when a plan of treatment is provided to and approved by Hines.

CONTINUED STAY REVIEW:

- a. If necessary, you, a family Member, your Physician, or the Hospital representative must call the Managed Care Vendor to request an extension of inpatient days beyond those originally assigned. The Managed Care Vendor will review your admission to determine if additional inpatient Hospital days are Medically Necessary. This type of review is known as Continued Stay Review.
- b. If your admission or request for extension is denied; you may appeal the decision to the Managed Care Vendor and they will review your case and render a decision. You or your representative may appeal the benefit determination by following the procedure outlined in Complaints and Appeals in *Section 8: How to File Claims and Appeals*.

NOTE: In order to receive full benefits for a Hospital admission, the admission must be certified by the Managed Care Vendor. **If the Managed Care Vendor is not notified of the Hospital admission (or out-patient mental health and substance abuse care), covered charges will be reduced by 50% to a maximum of \$500, even if the admission or services are determined to be Medically Necessary.** If the admission is not Medically Necessary, no benefits are payable for the entire Hospital stay. If the Participant stays in the Hospital longer than originally certified, and the extended stay is not certified through the Managed Care Vendor, no benefits are payable for the remainder of the Hospital stay.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., your Physician, nurse, midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

LARGE CASE MANAGEMENT (CARE MANAGEMENT):

A "Large Case" is one resulting from a catastrophic illness or accident, which usually results in a lengthy stay or multiple Hospital confinements. Large Case Management is the development of alternative treatment plans for Participants which meet the medical needs of the Participant, and achieve the most efficient use of medical resources.

By fully exploring treatment alternatives and, when appropriate, using a flexible approach to benefit administration, the case manager, Physicians, patients and families are able to work together to provide the patient with quality care which promotes the fullest recovery possible, in the most

effective manner.

"A flexible approach to benefit administration" means that the case manager can approve treatment alternatives which usually are not covered under the Plan but will provide quality care to the patient and generate a savings over other covered options.

SECTION 6

YOUR BENEFITS

This section describes the services and supplies covered by this Contract, and the benefits allowed on each of them. A Participant is entitled to the following benefits that are Medically Necessary and meet the eligible for coverage criteria under the definition of Experimental/Investigational. Please see these definitions in *Section 2: Definitions*. All benefit items listed in this *Section 6*, are subject to the following provisions *Section 5: Cost Containment Features* and *Section 7: General Limitations and Exclusions*. *Sections 6 and 7* of this Contract explain the services, supplies, situations, or related expenses for which we cannot allow Payment.

Payments to Out-of-Network Providers for Ambulance Services are based on the Reasonable and Customary allowance. In-Network payments are based on the allowable amount as contracted between the Provider and the PPO Network.

Association Mutual Health Insurance Company shall have the discretionary authority to determine your eligibility and all benefits and all terms contained in your Certificate. The Association Mutual Health Insurance Company's decision shall be final.

Hospital Benefits This portion of your coverage pays for the services and supplies described in this section when they are provided by the following Facility Providers:

- Alcoholism Treatment Centers
- Home Health Care Agencies
- Hospice Agencies Hospitals
- Other Facilities such as: Extended Care Facility, Ambulatory Surgical Facility, Birthing Center, Inpatient Nursery Services, Emergency Room Services

We require Hospital admission pre-certification (See *Section 5: Cost Containment Features*).

Medical-Surgical Benefits This portion of your coverage pays for the Medically Necessary services and supplies described in this section when they are provided by the following Professional Providers:

- Physicians
- Other Professional Providers

Accidental Injuries

Definition - Internal or external injuries caused by a source outside the body, requiring treatment for trauma rather than for illness-related conditions. (Examples: strains, animal bites, burns, contusions, and abrasions.)

Hospital Benefits

Inpatient: Benefits include the charges for a semiprivate room and covered Ancillary Services.

For a more detailed explanation, please refer to **Medical Care for General Conditions and Room Expenses and Ancillary Services**. NOTE: If you receive outpatient medical care as the result of an accident and are admitted to the Hospital as an inpatient on the same day, then your outpatient (emergency room) charges will be included in the Hospital bill with the inpatient services you also received.

Outpatient: Medical care provided by a Hospital or Other Facility is covered.

Medical-Surgical Benefits

Inpatient: Benefits are allowed according to the guidelines established under **Medical Care for General Conditions**. Please refer to that section for further information.

Outpatient: Medical care provided by a Physician or Other Professional Provider is covered. Please refer to **Medical Care for General Conditions** for additional information.

Limitations and Exclusions

Surgical Services — When an accident results in the need for surgery or fracture care, benefits for covered surgical services will be Paid according to the benefits and guidelines established in the Surgery subsection of this Certificate.

Ambulance Services

Definition - a specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an ambulance.

Hospital Benefits When the Insured cannot be safely transported by any other means, we will cover reasonable charges for the following Hospital ambulance services:

- Transportation to the closest Hospital with appropriate facilities, or from one Hospital to another for Medically Necessary inpatient care.
- Transportation to the closest Hospital with appropriate facilities, for Medically Necessary outpatient care for an Injury or Illness resulting from an accident or a Medical Emergency.
- When there is no Hospital in the local area that can provide Covered Services, we will cover ambulance transportation (ground or air) to the closest Hospital outside the local area, which can provide Medically Necessary Covered Services. We will only pay benefits when evidence clearly shows that the Hospital to which a patient is transported is the closest one having the appropriate specialized treatment facilities, equipment, or staff Physicians.

Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Medical-Surgical Benefits We allow benefits for Medically Necessary ambulance services, paid according to the limits shown above, under **Hospital Benefits**.

Limitations and Exclusions

- **Air Ambulance** — Ground ambulance is usually the approved method of transportation. Air ambulance is a benefit only when terrain, distance, or the Insured's physical condition requires the services of an air ambulance. Our medical consultants determine, on a case-by-case basis, when transport by ambulance is a benefit. If our medical consultants decide that ground ambulance services could have been used, then Payment will be limited to ground ambulance benefits to the closest Hospital with appropriate facilities, equipment, and staff. Commercial transport, private aviation, or air taxi services are not covered, regardless of the circumstances or their Federal Aviation Authority Certification.
- **Other Transportation Services** — We will not pay for other transportation services not specifically covered, such as private automobile, commercial or public transportation, or wheelchair ambulance.
- **Patient Safety Requirement** — If you could have been transported by automobile, commercial, or public transportation without endangering your health or safety, an ambulance trip will not be covered. We will not pay for such ambulance services even if other means of transportation were not available.

Anesthesia Services

Definition - General anesthesia produces unconsciousness in varying degrees with muscular relaxation and a reduction or absence of pain. Regional or local anesthesia produces similar effects to a limited region of the body without causing loss of consciousness. Anesthesia is administered by a Physician or certified registered nurse anesthetist (CRNA).

Hospital Benefits Inpatient and Outpatient: Anesthesia services are a benefit when administered for covered surgery and provided by a Hospital or Other Facility.

Medical-Surgical Benefits Inpatient and Outpatient: Anesthesia services are covered when administered by a Physician or CRNA, if necessary for a covered surgery. Benefit allowances are based on the complexity of the surgical procedure, the amount of time needed to administer the anesthetic, and the patient's physical condition at the time the service is provided.

Limitations and Exclusions

- **Acupuncture** — We cover only if Medically Necessary. See the *Summary of Benefits* for amount of benefits and limitations.
- **Hypnosis** — See this heading under *General Limitations and Exclusions*.
- **Local Anesthesia** — Our surgical benefit allowances include Payment for local anesthesia because it is considered a routine part of the surgical procedure. Thus, no additional benefits are provided for such incidental anesthesia services.
- **Standby Anesthesia** — Standby anesthesia is a benefit when anesthesia services may potentially be required. These benefits depend upon the procedure and the circumstances of the case.
- **Other** — **The Limitations and Exclusions** that apply to Surgery benefits also apply to anesthesia services. Anesthesia services received for a non-covered surgical procedure are not a benefit.

Blood Expenses

Definition - Blood expenses include the following items:

- Charges for processing, transporting, handling, and administration.
- Cost of blood, blood plasma, and blood derivatives.

Hospital Benefits

Inpatient and Outpatient: Covered expenses include charges made by a Hospital or Other Facility for processing, transporting, handling, and administration. We provide benefits as explained under **Medical Care for General Conditions**. Covered expenses include charges made by a Hospital or Other Facility for the cost of blood, blood plasma, and blood derivatives. Any donor credit will be deducted from covered blood expenses.

Limitations and Exclusions

- **General** — **The Limitations and Exclusions** that apply to **Surgery** benefits also apply to blood expenses. If you receive blood for a non-covered surgical procedure, such blood expenses will not be allowed.

Chemotherapy and Radiation Therapy

Definition

- **Chemotherapy** — drug therapy administered as treatment for malignant conditions and diseases of certain body systems.
- **Radiation therapy** — X-ray, radon, cobalt, betatron, telocobalt, and radioactive isotope treatment for malignant diseases and other medical conditions.

Hospital Benefits Chemotherapy and/or radiation therapy provided on an **Inpatient** or **Outpatient** basis is covered.

Limitations and Exclusions

- **Chemotherapy and Radiation Therapy** — Benefits are allowed only for therapeutic services necessary for treatment of malignant diseases and other conditions for which such therapy is standard treatment.

Chiropractic Services

Definition - Any service or supply administered by a licensed doctor of chiropractic medicine (D.C.).

Medical-Surgical Benefits Outpatient: Services or supplies administered by a chiropractor who acts within the scope of licensure and according to the standards of chiropractic medicine for the treatment of an illness or accidental injury. Covered Services include limited office visits with manual manipulation of the spine, X-ray of the spine, and certain physical therapy modalities and procedures. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

- **Conditions and Treatment** — The health problem in the form of a neuromuscularskeletal condition must be documented and diagnostic treatment services rendered must have a direct relationship to that condition.
- **Physical Therapy** — We will not allow benefits for physical therapy services given solely to maintain functioning at the level to which it has been restored, or when no further significant practical improvement can be expected.
- **Surgical Services** — We will not allow benefits for surgical services provided by a Doctor of Chiropractic. (See the Surgery section for covered benefits).

Cleft Palate and Cleft Lip

Definition

- **Cleft palate** — a birth deformity in which the palate (the roof of the mouth) fails to close.
- **Cleft lip** — a birth deformity in which the lip fails to close.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under Room Expenses and Ancillary Services.

Outpatient: We will allow benefits for medical and therapeutic services provided by a Hospital or Other Facility when they are necessary for the treatment of cleft palate and/or cleft lip. Covered Services include:

- Speech therapy.
- Otolaryngology treatment.
- Audiological assessments.

Medical-Surgical Benefits

Inpatient: We will allow benefits when provided by a Physician or Other Professional Provider for oral and facial surgery and follow-up oral and reconstructive surgery. (See the Surgery subsection.)

Outpatient: We will allow benefits when provided by a Physician or Other Professional Provider for the following services: Speech therapy. Otolaryngology treatment. Audiological assessments. Orthodontic treatment. Prosthodontic treatment. Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

Limitations and Exclusions

- **Benefit Eligibility** — Refer to *Section 3: Membership Eligibility, Enrollment, Changes, and Termination* under How and When You May Add Dependents for details on newborn coverage.
- **Dental Procedures** — Benefits for orthodontic, prosthodontic or prosthetic treatment are allowed when required as the result of cleft palate or cleft lip. We must give written authorization for such dental benefits in advance of the date of service. For details, please refer to the heading Prior Benefit Authorization in *Section 4: Cost Containment Features*.
- **Medically Necessary** — All benefits for treatment to cleft palate and/or cleft lip are limited to those which are Medically Necessary. (See *Section 2 Definitions*, under Medically Necessary.)
- **Reconstructive Surgery** — Benefits for surgical procedures and related expenses are allowed when oral, facial, or reconstructive surgery is required as the result of cleft palate or cleft lip. We must give written authorization for such surgical benefits in advance of the date of services.

Second and Third Surgical Opinions

Definition - a service provided by another Physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. We will allow a third surgical opinion if the second surgical opinion does not agree with your Physician's opinion.

Medical-Surgical Benefits

Inpatient: For each covered surgical treatment, we will allow benefits for Second and Third Surgical opinions.

Outpatient: For each covered surgical treatment, we will allow benefits for Second and/or Third Surgical opinions.

Limitations and Exclusions

- **Second and Third Surgical Opinion** — The second and/or third surgical opinion program is designed to help you decide if certain elective surgeries are Medically Necessary, or if other acceptable treatment methods are available for your condition.

Dental Services

Definition - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Hospital Benefits

Inpatient: Dental services are covered only if you are in a Hospital for one of the following reasons. We base our benefits on the guidelines in the **Surgery** subsection.

- Excision of exostosis of the jaw (removal of bony growth).
- Surgical correction of accidental injuries to the jaws, cheeks, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
- Treatment of fractures of facial bones.

- Incision and drainage of cellulitis (inflammation of soft tissue).
- Incision of accessory sinuses, salivary glands, or ducts.

We will allow benefits for the charges for a semiprivate room and covered Ancillary Services in a Hospital if you have a hazardous medical condition (such as heart disease, which requires that you have an otherwise non-covered dental procedure performed in the Hospital).

Outpatient: We will allow benefits for services included in the five categories listed above under **Inpatient** benefits, as well as for related services provided by a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient and Outpatient: We will allow benefits for the five categories of procedures referenced above under **Inpatient Hospital Benefits** when services are provided by a Physician, dentist, or oral surgeon. Our benefit allowances for surgery include Payment for visits to your doctor or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

Accidental Injury Benefits — We will allow benefits for accident-related dental expenses not otherwise covered under your Hospital and Medical-Surgical Benefits when you meet **all** of the following criteria:

- You are in need of dental services, supplies, and appliances because of an accident in which you sustained other bodily injuries **outside** the mouth or oral cavity
- Your Injury occurred on or after your Effective Date of Membership. NOTE: This criteria applies regardless of any pre-existing conditions clause or waiver thereof.
- Treatment must be for injuries to your sound natural teeth.
- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.
- The first services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident.
- All services must be performed while your coverage is in effect.

We will not Pay for restoring the mouth, teeth, or jaws because of injuries from biting or chewing.

Limitations and Exclusions

- **Facility Charges** — Inpatient and outpatient services at a Facility Provider due to the age of the patient and/or the nature of the dental services are not covered.
- **Hazardous Medical Conditions** — If you are admitted to a Hospital for a non-covered dental procedure because you have a hazardous medical condition that makes your Hospital stay Medically Necessary, we will not Pay for the services of the Physician, dentist, or oral surgeon in relation to that non-covered dental procedure even if the Hospital charges are Paid. The Physician treating your hazardous medical condition must submit a written pre-authorization certification request explaining why you must receive dental treatment in an inpatient setting. For details, please refer to the paragraph entitled **Pre-Authorization Certification** in *Section 5: Cost Containment Features*.
- **Orthognathic Surgery/Oral Surgery** — We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic.
- **Restorations** — Benefits for restorations are limited to those services, supplies, and appliances we determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident. We will not allow benefits for restorations, supplies, or appliances, which are not covered. Examples of such non-covered items include: duplicate or “spare” dental appliances, personalized restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.

- **Surgical Preparations for Dentures** — Artificial implanted devices and bone grafts for denture wear are not covered.
- **Temporomandibular Joint Surgery or Therapy** — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder. See this heading under *General Limitations and Exclusions*.

Hemodialysis

Definition - the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Hospital Benefits

Inpatient: Hemodialysis is covered if you are an inpatient in a Hospital or Other Facility. We allow benefits as explained in **Medical Care for General Conditions**.

Outpatient: Services are covered if you are treated in a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient: Services are covered if you are an inpatient in a Hospital or Other Facility. We allow benefits as explained in **Medical Care for General Conditions**.

Outpatient: Services are covered for treatment in a Hospital, Other Facility, or in your home.

Home Health Care

Definition - the following services provided by a certified Home Health Care Agency under a plan of care to eligible Insured in their place of residence: professional nursing services; certified nurse aide services; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupational therapy, and speech pathology and audiology services.

Benefits We allow benefits for home health services provided under active Physician and nursing management through a certified Home Health Care Agency. Registered nurses must coordinate the services on behalf of the Home Health Care Agency and the patient's Physician. We allow benefits only when we determine that this care is Medically Necessary and will replace an otherwise necessary Hospital inpatient admission.

All claims must be accompanied by the Physician's written certification that home health services are Medically Necessary, and a copy of the treatment plan established by your Physician in collaboration with the Home Health Care Agency.

We allow benefits for up to 100 visits by a Member of the home health team each calendar year for the following services and supplies when they are prescribed by your attending Physician.

NOTE: Services of up to four hours by a Member of the home health care team are counted as one visit. If a session lasts longer than four hours, then each four-hour period or part of a four-hour period is treated as one visit. We allow benefits for the following services:

- Professional nursing services performed by a registered nurse (RN) and licensed practical nurse (LPN).
- Physical therapy performed by a registered physical therapist.
- Occupational therapy performed by a properly accredited registered occupational therapist (OTR) or a certified occupational therapy assistant (COTA).
- Respiratory and inhalation therapy performed by a therapist trained or licensed to provide these services.

- Speech therapy and audiology given for speech disorders caused by a primary or secondary muscular or structural abnormality. Services must be provided by a properly accredited speech therapist who has received a Clinical Competence Certification or Equivalency Statement from the American Speech and Hearing Association.
- Medical social services ordered by the attending Physician and provided by a qualified medical or psychiatric social worker to assist you or your family in dealing with a specific medical condition. The individual providing such services must possess at least a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience.
- Certified nurse aide services required and supervised by a registered nurse or a physical, speech, or occupational therapist.
- Medical supplies furnished to the Insured by the Home Health Care Agency during visits for services.
- Nutrition counseling by a nutritionist or dietitian.

The following additional items and services are Covered Services under a home health care program. However, some of these expenses may also be covered under benefits otherwise provided by this Certificate:

- Prostheses and orthopedic appliances.
- Rental or purchase of durable medical equipment (except hemodialysis equipment).
- Expenses for prescription drugs, medicines, oxygen or insulin prescribed by the Physician and Provider and billed for by the Home Health Care Agency.
- Homemaker services for the patient only.

Limitations and Exclusions

- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Maintenance Care** — Benefits are allowed only for a home health care program that we determine is Medically Necessary in place of an inpatient Hospitalization. Maintenance care is not a benefit. Maintenance care is provided solely to keep the patient's condition at the level to which it has been restored, when no significant practical improvement can be expected.
- **Non-Covered Services** — The following list of services are not home health care benefits:
 - Blood, blood plasma, or blood derivatives.
 - Services provided by a Hospital.
 - Services provided by a Physician.
 - Services related to non-covered conditions and surgeries, as excluded in this Certificate.
 - Services or supplies for personal comfort or convenience, including "homemaker" services.
 - Services related to well-baby care.
 - Food or housing.
- **Prior Authorization** — The Physician treating your condition must submit a prior benefit authorization request for any prescribed home health care services.
- **Psychiatric Social Worker Services** — The services of a psychiatric social worker which are not related to a home health program prescribed by a Physician may be covered and Paid as **Outpatient** benefits as described under **Mental Health, Alcohol or Drug Abuse Care**.
- **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.

Hospice Care

Definition - an alternative way of caring for terminally ill individuals which stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care addresses physical, social, psychological, and spiritual needs of the patient and his or her family.

Benefits - Benefits are allowed for hospice care provided under active Physician and nursing management through a licensed Hospice Agency which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Hospice care is provided in the Insured's home or on an inpatient basis in a licensed hospice and/or other licensed health care facility. Benefits are allowed only for a terminally ill Insured with a life expectancy of six months or less, who alone or in conjunction with a family Insured or Insured, has voluntarily requested admission and been accepted into a hospice program. Hospice services include but shall not necessarily be limited to: nursing services, Physician services, certified nurse aide services, nursing services delegated to other assistants, homemaker, physical therapy, clergy/counselors, trained volunteers, and social services. All claims must include a Physician's certification of the Insured's Illness, including a prognosis for life expectancy and a statement that hospice care is Medically Necessary and a copy of the Hospice Agency's treatment plan. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Maximum Payment Limits

Inpatient and Outpatient: The Lifetime maximum benefit per Participant is 180 days. The following services are covered:

- Hospice day care services provided on a regularly scheduled basis in a Hospital, skilled nursing facility or any other facility licensed as a hospice care facility or approved by the Joint Commission on Accreditation of Health Organizations
- Hospice home care services provided in the Insured's home to meet the Insured's physical requirements and/or to accommodate a Insured's maintenance or supportive needs
- Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse (RN) or licensed practical nurse (LPN)
- Intermittent and 24-hour on-call social/counseling services Certified nurse aide services under the supervision of a registered nurse or nursing services delegated to other persons
- Therapies, including physical, occupational, and speech
- Nutritional counseling by a nutritionist or dietitian
- Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a Physician for the purpose of assisting the Insured or family in dealing with a specified medical condition, and family counseling related to the Insured's terminal condition
- Homemaker services for the patient only Medically Necessary surgical and medical supplies
- Drugs and biologicals billed by the hospice Provider
- Oxygen and respiratory supplies
- Radiation therapy and chemotherapy
- Rental of durable medical equipment when billed by the hospice Provider
- Bereavement support services up to six visits for the family within 90 days following the death of the Participant

Limitations and Exclusions

- **Non-covered Services** — The following items and services are not covered expenses under this Hospice Care program. However, some of these expenses may be covered under benefits otherwise provided by this Certificate:

- Blood, blood plasma, or blood derivatives
- Services provided by a Hospital
- Services related to non-covered conditions and surgeries, as excluded in this Certificate
- Food services or meals other than dietary counseling
- Services or supplies for personal comfort or convenience including homemaker services, except in crisis periods or in association with respite care
- Private duty nursing
- Services by volunteers or people who do not regularly charge for their services
- Services by licensed pastoral counselor to a Insured of his congregation
- **Review of Treatment** — We reserve the right to review treatment plans at periodic intervals.
- **Prior Benefit Authorization** — We must give written authorization for hospice care benefits in advance of the date of service.

Laboratory, Pathology, X-ray, and Radiology Services

Definition

- **Laboratory and pathology services** — testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material, which has been removed from the body. Diagnostic medical procedures requiring the use of technical equipment for evaluation of body systems are also considered laboratory services. Examples: electrocardiograms (EKGs) and electroencephalograms (EEGs).
- **X-ray and radiology services** — services including the use of radiology, nuclear medicine, and ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Hospital Benefits

Inpatient: Services are covered when provided by a Hospital or Other Facility. Benefits are allowed as set forth under **Medical Care for General Conditions** and **Mental Health, Alcohol, or Drug Abuse Care**. **Outpatient:** Services are covered when provided by a Hospital or Other Facility.

Medical-Surgical Benefits

Inpatient and Outpatient: Services are covered when provided by a Physician, independent pathology laboratory, or independent radiology laboratory.

Limitations and Exclusions

- **Mammogram Services** — For benefits see *Preventive Care for Adults* and X-ray and radiology services.
- **Mental Illness, Alcohol and Drug Abuse** — Outpatient laboratory and X-ray services for the diagnosis or treatment of these conditions are subject to the outpatient benefit limits described in Mental Health, Alcoholism, or Drug Abuse Care.
- **Non-covered Services** — If a service is not covered or is not a benefit, we will not Pay for laboratory, pathology, X-ray, and radiology services related to the non-benefit service.
- **Physician Charges** — Benefits for laboratory and X-ray services provided by a Physician while you are an inpatient or outpatient in a Hospital or Other Facility are allowed only when our records show that the Physician has one of the following agreements with the facility:
 - The Hospital or Other Facility will bill only for technical services such as charges for use of equipment; or
 - The Hospital or Other Facility will not submit any charges for laboratory or X-ray services.
- **Prostate Screening** — For benefits see *Preventive Care for Adults*.

- **Weight Loss Programs** — We will not Pay for laboratory or X-ray services related to weight loss programs. For details, see *General Limitations and Exclusions*, under **Obesity and Weight Loss**.

Maternity and Newborn Care

Definition:

Maternity services - services required by a Member for the diagnosis and care of a pregnancy (excluding over the counter products) and for delivery services. Delivery services include:

- All expectant mothers enrolled under this Certificate may take part in a program that provides support and education for expectant mothers. Through this program, expectant mothers receive outreach and education that add to the care that the Insured receives from her obstetrician or nurse midwife.
- Normal delivery.
- Caesarean section.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic or elective termination of pregnancy prior to full term.
- Complications of pregnancy: Conditions (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions Association with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period gestation in which a viable birth is not possible.

Newborn services include —

- Routine Hospital nursery charges for a newborn well baby.
- Routine Physician care of a newborn well baby in the Hospital after delivery.
- Newborn hearing screening tests performed by a covered health care Provider before the newborn child (an infant under three months of age) is discharged from the Hospital to the care of the parent or guardian.
- All Medically Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are allowed as set forth under **Medical Care for General Conditions**. Routine Hospital nursery charges are also covered.

We may not, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother's or newborn's attending Provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable). If the mother chooses to be discharged earlier, AMHIC provides benefits for one home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education; assistance and training in breast or bottle feeding; and any Medically Necessary and clinically appropriate tests.

In any case, we may not, require the Provider obtain authorization from us for prescribing a length of stay not in excess of 48 hours (or 96 hours). If 48 hours (or 96 hours if applicable) falls after 8:00 p.m., coverage shall continue until 8:00 a.m. the following morning.

Outpatient: Covered charges include: Pre-natal medical care. A Hospital or Other Facility's charges for use of labor, delivery, recovery, and nursery rooms. Laboratory and X-ray services related to pre-natal or post-natal care. Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Medical-Surgical Benefits

Inpatient: The following services are covered when billed by a Physician:

- Delivery services (post-natal medical care is included in the allowance for delivery services).
- Professional component for interpretation of laboratory and X-ray results.
- Routine inpatient care of the newborn child and pediatrician standby care at a Caesarean section. (See Newborn Child Benefits below.)

Outpatient: The following services are covered when billed by a Physician:

- Pre-natal medical care.
- Delivery services (post-natal medical care is included in the allowance for delivery services).
- Laboratory and X-ray services related to pre- or post-natal care.

Limitations and Exclusions

- **Artificial Conception** — See this heading under *General Limitations and Exclusions*.
- **Genetic Counseling** — See this heading under *General Limitations and Exclusions*.
- **Inpatient Hospital Benefits** — A separate inpatient Hospital benefit will be allowed for the newborn child only when the child is transferred from one Facility Provider to another, or effective the date the mother is discharged from the Facility Provider and the child remains as an inpatient.

Newborn Child Benefits — Benefits are provided for inpatient newborn care, including expenses related to circumcision of the newborn, on the same basis as for any other eligible expense, provided the baby is enrolled as a Participant within 31 days of birth. Please refer to *Section 3: Insuredhip Eligibility, Enrollment, Changes, and Termination* under **Effective Date of Coverage – New Dependents**.

Medical Care for General Conditions

Definition:

Inpatient medical care — non-surgical services provided by a Physician to a patient occupying a Hospital bed.

Outpatient medical care — non-surgical services provided in the Physician's office, the outpatient department of a Hospital or Other Facility, or your home.

General conditions — conditions **not** related to Mental Health, Alcohol, or Drug Abuse.

Hospital Benefits

Inpatient: We will allow benefits for inpatient care in a Hospital. Benefits include charges for a semi-private room and covered Ancillary Services, and are allowed as set forth under **Room Expenses and Ancillary Services**.

Outpatient: We will allow benefits for medical care provided by a Hospital or Other Facility when it is necessary for the treatment of an Illness, disease, or Injury.

Medical-Surgical Benefits

Inpatient: We will allow benefits for inpatient care provided by a Physician in a Hospital for:

- A condition requiring **only** medical care; or

- A condition that, during an admission for surgery, requires medical care not normally related to the surgery performed.

Outpatient: We will allow benefits for medical care provided by a Physician when necessary for the treatment of an illness, disease, or injury. We will allow benefits for education, including medical nutrition therapy, for Insured who have been diagnosed with diabetes. Covered injectable drugs administered by a Physician or in the outpatient department of a Hospital or Other Facility are also covered.

Limitations and Exclusions

- **Biofeedback** — We will not pay for biofeedback or related services.
- **Birth Control** — Benefits are available for FDA approved contraceptive drugs and contraceptive devices which require a physician's prescription and administration. The associated office visit is also covered. We will also allow benefits for surgical sterilization. See this heading under *General Limitations and Exclusion*.
- **Convalescent Care** — See this heading under *General Limitations and Exclusions*.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*.
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*.
- **Domiciliary Care** — See this heading under *General Limitations and Exclusions*.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*.
- **Growth Hormones** — We allow benefits for growth hormones if appropriate based on medical necessity.
- **Patient Education** — Benefits are available for education programs, such as diabetes management and colostomy care, when medically necessary and prescribed by the patient's physician.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.
- **Temporomandibular Joint Surgery or Therapy** — See this heading under *General Limitations and Exclusions*.
- **Therapies** — See this heading under *General Limitations and Exclusions*.
- **Transfers** — See this heading under *General Limitations and Exclusions*.
- **Vision** — See this heading under *General Limitations and Exclusions*.
- **Weight Loss Programs** — Services and supplies related to weight loss (such as Weight Watchers, NutriSystems, etc.) are not covered. For details, see *General Limitations and Exclusions, Obesity and Weight Loss*.

Medical Emergencies

Definition - The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. We cover emergency services necessary to screen and stabilize a Insured without prior authorization from us if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed. To be eligible for this benefit, the Insured must seek emergency care within 48 hours after the injury or onset of illness.

Hospital Benefits

Inpatient: Benefits include charges for a semiprivate room and covered Ancillary Services, and are Paid as set forth under **Medical Care for General Conditions**. If you receive outpatient emergency services in a Hospital and are admitted as an inpatient on the same day, then outpatient charges will be included in the Hospital's bill for inpatient services.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Hospital or Other Facility (See **Medical Care for General Conditions**).

Medical-Surgical Benefits

Inpatient: Inpatient benefits are Paid as set forth under **Medical Care for General Conditions**.

Outpatient: Outpatient services are covered as any other outpatient medical care when provided by a Physician. (See **Medical Care for General Conditions**.) Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Mental Health, Alcohol, or Drug Abuse Care

Definition

- **Mental health conditions** — are those that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). Anorexia Nervosa and Bulimia Nervosa, eating disorders, are classified as manifest mental disorders. Biologically Based Mental Illness conditions are considered medical conditions, not mental health conditions, and are covered as any other physical Illness.
- **Alcoholism or drug abuse conditions** — are those requiring rehabilitation treatment from alcohol or drug abuse.
- **Inpatient care charges** — charges billed by a Physician, Hospital, or Alcoholism Treatment Center for services provided while you are confined as an inpatient in a Hospital or Alcoholism Treatment Center. Partial Hospitalization for Mental health or alcoholism is also considered to be inpatient care. Partial Hospitalization is no less than four and no more than 12 hours of continuous psychiatric care in a Hospital.
- **Outpatient care charges** — charges billed by a Physician, Hospital, Alcoholism Treatment Center, Other Professional Provider, or Other Facility for services provided in the Physician's or Other Professional Provider's office, the outpatient department of a Hospital, Alcoholism Treatment Center, Other Facility, or your home.
- **Pre-certification** - You must contact Hines prior to In-Network, inpatient or outpatient treatment for a mental health or substance abuse condition. Please call Hines at (800) 670-7718..

Benefits

Inpatient: Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit. Benefits include charges for a semiprivate room and covered Ancillary Services. (See **Room Expenses and Ancillary Services**.) Partial Hospitalization benefits only apply when you are receiving therapy in the Hospital for no less than four and no more than 12 hours a day.

Outpatient: Please refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts for this benefit.

Limitations and Exclusions

- **Biofeedback** — See this heading under *General Limitations and Exclusions*.
- **Charges** made for any non-emergency Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.

- **Diagnosis** — Benefits for Mental Health are provided only for the diagnoses of manifest mental disorders. These disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*.
- **Domiciliary Care** — See this heading under *General Limitations and Exclusions*.
- **Duration of Care** — We will only Pay for services that can be expected to improve your Mental Health, alcoholism, or drug abuse condition in a reasonable period of time as determined by us or our medical consultants.
- **Learning Deficiency and/or Behavioral Problem Therapies** — See this heading under *General Limitations and Exclusions*.
- **Private Room Expenses** — Under no circumstances will private room benefits be allowed for treatment of Mental Health, Alcohol, or Drug Abuse. See this heading under *General Limitations and Exclusion*.
- **Professional Services — Mental Health** — Professional services for Mental Health must be performed by a Physician, licensed clinical psychologist, or Other Professional Provider who is properly licensed or certified to engage in the independent practice of psychotherapy. Other Professional Providers (except registered nurses or licensed clinical social workers) must be acting under the direct supervision of a Physician or a licensed clinical psychologist. All claims must include evidence of such supervision. All Providers, whether performing services or supervising the services of others, must be acting within the scope of their respective licenses.
- **Professional Services in Alcoholism Treatment Center** — We will not Pay for the services of an independent Physician or Other Professional Provider if such care is provided in an Alcoholism Treatment Center. Such professional care should be provided by a salaried employee of the Alcoholism Treatment Center.
- **Therapies** — See this heading under *General Limitations and Exclusions*.
- **Transfers** — See this heading under *General Limitations and Exclusions*.

Organ Transplants

Definition - A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of organs or tissue from a person for the purpose of treatment and re-implanting the removed organ or tissue into the same person.

The following transplant procedures are covered under this provision:

- bone marrow transplant for a Insured with aplastic anemia, leukemia, severe combined immunodeficiency disease, or Wiskott-Aldrich syndrome
- corneal transplant
- kidney
- liver transplant for a child under age 18 with congenital biliary atresia
- peripheral stem cell

Inpatient or Outpatient Benefits: When the transplant recipient or donor is a Member, the surgical procedure, storage, and transportation costs directly related to the donation of an organ or bone marrow to be used in a covered transplant are considered Covered Services.

Major Organ Transplants Coverage is available for services and supplies related to a major organ transplant, limited to one or more of the following:

- heart
- heart-lung
- liver
- lung

- pancreas-kidney

To be considered Covered Services, services must be related to a covered major organ transplant.

Prior authorization —The Provider is responsible for ensuring prior authorization is received from Hines before scheduling a pre-transplant evaluation. A case manager will be assigned to the Insured and must be contacted with the results of the evaluation.

Inpatient: Coverage is available only when the transplant is performed at a facility with a transplant program approved by AMHIC. The case manager will work with the Insured's Provider to determine the most appropriate facility for the procedure. We will pay the average expenses of a semiprivate room and covered Ancillary Services provided by an AMHIC approved Hospital or Other Facility.

Outpatient: Services provided by an AMHIC approved Hospital or Other Facility are covered when ordered by your Physician. Covered Services include medical expenses (not including dental evaluation or treatment) when authorized.

Organ Procurement: Organ acquisition/procurement costs for the surgical removal, storage, and transportation of a heart, liver, lung, pancreas, or kidney acquired from a cadaver are covered.

Limitations and Exclusions

- **Convalescent Care** — See this heading under *General Limitations and Exclusions*.
- **Custodial Care** — See this heading under *General Limitations and Exclusions*.
- **Donor Specification** — We will only cover an organ transplant from a human donor. (For example: transplant of a non-human animal organ or artificial organ is not covered.)
- **Incidental Surgical Procedures** — Additional benefits are not allowed for those procedures that are routinely performed during the main surgery.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*.
- **Medicare Eligibility Insured** — Who are now eligible for, or who are anticipating receiving eligibility for Medicare benefits are solely responsible for contacting Medicare to ensure that the transplant will be eligible for Medicare benefits.
- **Other Organ Transplants** — Organ transplant other than those listed under Bone Marrow, Cornea, Kidney, Specified Liver, and Peripheral Stem Cell Transplants or Major Organ Transplants will be subject to medical policy and criteria.
- **Prior Benefit Authorization** — All services and supplies received in connection with organ transplant procedures covered by this section must be pre-authorized by our medical director.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.

Preventive Care for Adults

Definition Routine Physicals — Services provided by a Physician for the prevention of disease. A comprehensive "check up" for the purpose of monitoring health.

Medical-Surgical Benefits

Outpatient: Services and supplies are covered for routine physicals for Insured over the age of 19, including blood tests, cholesterol tests, stress tests, prostate screening, pap smears, baseline mammogram, annual mammograms, pelvic exams, related laboratory and X-ray services for routine and non-diagnostic purposes, and immunizations. Preventive services are limited to a maximum payment of \$500, with the exception of charges for an annual mammogram and colonoscopy, which do not have a maximum. Any expenses for services that exceed these maximum limits are your financial responsibility and are not covered under this Certificate.

Limitations and Exclusions

- **Child Care Services** — Benefits for children to age 19 are available under the subsection entitled **Preventive Child Care Services**
- **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
- **Inpatient or Emergency Room Care** — We will not Pay for preventive care services received while you are an inpatient, or in the emergency room of a Hospital or Other Facility
- **Routine Exams** — We will not Pay for routine exams related to insurance, licensing, employment, school, sports or camp

Preventive Child Care Services

Definition:

- **Preventive Care** — services provided by a Physician for the prevention of disease. This includes well-child visits for the purpose of monitoring health.
- **Well-child visit** — a visit that includes the following components: age-appropriate physical exam (but not a complete physical exam unless this is age-appropriate), immunizations, vaccinations and routine blood tests.

Medical-Surgical Benefits

Outpatient: Benefits are provided for well-child visits (as defined above) for children under age 19. Refer to the *Summary of Benefits* for your Deductible, Copay and Coinsurance amounts.

Limitations and Exclusions

- **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
- **Inpatient or Emergency Room Care** — We will not pay for preventive care services received while you are an inpatient or in the emergency room of a Hospital or Other Facility
- **Routine Exams** — We will not pay for routine exams related to insurance, licensing, employment, school, sports or camp **See *General Limitations and Exclusions***

Rehabilitation and Habilitative Therapies: Occupational, Physical, and Speech

Definition:

- **Occupational therapy** — The use of educational, vocational, and rehabilitative techniques to improve a patient's functional ability lost or impaired by disease or accidental Injury to live independently.
- **Physical therapy** — The use of physical agents to treat Disability resulting from disease or accidental Injury. Physical agents used include heat, cold, electrical currents, ultrasound, ultraviolet radiation, massage, and therapeutic exercise.
- **Speech therapy (also called speech pathology)** — services used for diagnosis and treatment of speech and language disorders aimed at restoring the level of speech the patient had attained prior to the onset of a disease, surgery or occurrence of an accidental Injury.

Hospital Benefits Inpatient and Outpatient: When provided by a Hospital or other facility the following types of therapy are covered as set forth under **Medical Care for General Conditions:**

- Occupational therapy
- Physical therapy
- Speech therapy

Medical-Surgical Benefits

Outpatient: When prescribed and/or provided by a Physician, the following types of therapy are covered:

- Cardiac Rehabilitation programs, excluding cardiac classes
- Occupational therapy when your Physician requires that a properly accredited occupational therapist (OT) or certified occupational therapy assistant (COTA) perform such therapy
- Physical therapy performed by a Physician or registered physical therapist
- Speech therapy performed to correct a speech impairment when therapy is aimed at restoring the level of speech that the individual had attained prior to the onset of a disease, surgery or occurrence of an Accidental Injury.
- Benefits for Insured over the age of 5 are limited to those recommended by the Physician for medical conditions that, in the judgment of the Physician and AMHIC will result in significant improvement with treatment and would not normally be expected to improve without intervention.
- Habilitative services (including occupational, physical and speech therapies) for treatment of congenital or genetic birth defects to enhance the ability of dependent children under age 21 to function. A congenital or genetic birth defect is defined as a defect existing at or from birth and includes a hereditary defect, autism, autism spectrum disorder and cerebral palsy.

Limitations and Exclusions

- **Occupational and Physical Therapy** — We will not Pay for occupational or physical therapy services to maintain function at the level to which it has been restored, or when no further significant practical improvement is achieved
- **Speech Therapy** — We will not Pay for speech therapy or diagnostic testing related to the following conditions:
 - Learning disorders
 - Stuttering, at any age
 - Behavioral disorders
 - Personality, developmental, behavioral, voice or rhythm disorders when these conditions are not the direct result of a medical syndrome or condition, as diagnosed by the Insured's Provider, neurologist, or other related specialist
 - Long term therapy (speech therapy is considered long term if the Physician does not believe significant improvement is possible within 60 sessions)
 - Deafness
 - Disorders of cognitive etiology
 - Sensory integration therapy
- **Habilitative Therapy** — We will not Pay for Habilitative services delivered through early intervention or school services

Room Expenses and Ancillary Services

Definitions:

- **Ancillary Services** — services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers, and Other Facilities bill for and regularly make available for the treatment of the Insured's condition. Such services include, but are not limited to:
 - Use of operating room, recovery room, emergency room, treatment rooms, and related equipment.
 - Intensive and coronary care units.
 - Drugs and medicines, biologicals (medicines made from living organisms and their products), and pharmaceuticals.
 - Dressings and supplies, sterile trays, casts, and splints.
 - Diagnostic and therapeutic services.

- Blood processing and transportation costs, blood handling charges, and administration (the cost of blood, blood plasma, and blood derivatives is not included).
- **Room expenses** — expenses that include the cost of your room, general nursing services, and meal services for yourself.
- **Skilled nursing facility** — a state-licensed facility providing inpatient nursing care at the level that requires a registered nurse to deliver or supervise the delivery of care for a continuous 24-hour period.

Hospital Benefits

Inpatient: Semiprivate room charges and Ancillary Services provided by a Hospital or Alcoholism Treatment Center are covered when you are admitted for a covered condition. Benefits are Paid as set forth under **Medical Care for General Conditions and Mental Health, Alcohol, or Drug Abuse Care**. An inpatient Hospital admission requires the recommendation of a Physician and Pre-certification by us.

Skilled Nursing Facility Admissions: For Covered Services, you must be admitted to a skilled nursing facility within 14 days of a Hospital stay that lasted 3 or more days. Coverage is available to each Insured for up to 100 days per Member's Benefit Year in a skilled nursing facility. Covered services include semiprivate room expenses and Ancillary Services.

Outpatient: Ancillary services billed by a Hospital or Other Facility are covered. For additional outpatient Hospital Benefits, see the following sections:

- Hemodialysis
- Laboratory, Pathology, X-ray, and Radiology Services
- Rehabilitation Therapies: Occupational, Physical, and Speech

Limitations and Exclusions:

- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*
- **Discharge Day Expense** — See this heading under *General Limitations and Exclusions*
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*
- **Mental Health, Alcohol, or Drug Abuse Care** — For details on how benefits for room expenses and Ancillary Services related to these special conditions are Paid, see Mental Health, Alcoholism, or Drug Abuse Care
- **Personal or Convenience Items** — See this heading under *General Limitations and Exclusions*
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*

Supplies, Equipment, and Appliances

Definitions:

- **Durable medical equipment** — any equipment that can withstand repeated use, is made to serve a medical purpose, is useless to a person who is not ill or injured, and is appropriate for use in the home.
- **Medical supplies** — expendable items (except prescription drugs) required for the treatment of an Illness or Injury.
- **Prosthesis** — any device that replaces all or part of a missing body organ or body Insured.
- **Orthopedic appliance** — a rigid or semi-rigid support used to eliminate, restrict, or support motion in a part of the body that is diseased, injured, weak, or deformed.

Hospital Benefits

Inpatient: We will allow benefits for the following items as set forth under **Medical Care for General Conditions**:

- Medical supplies used while you are in the Hospital
- Use of durable medical equipment owned by the Hospital while you are Hospitalized

Outpatient: Covered expenses include medical supplies used during covered outpatient visits. (See **Medical Care for General Conditions**).

Medical-Surgical Benefits The following medical supplies are covered not subject to the annual maximum payment:

- Medical supplies not available from a Pharmacy, including but not limited to:
 - Colostomy bags and other supplies required for their use.
 - Catheters.
 - Dressings for cancer, diabetic and decubitus ulcers (bed sores), and burns.

NOTE: Some diabetic supplies are covered under the *Prescription Drugs and Medicines* of this Certificate. Coverage is not provided for such diabetic supplies under both sections of the Certificate. For a diabetic supply to be covered under this section of the Certificate, you must first receive a denial of benefits from the participating Pharmacy.

- We will pay reasonable charges for the rental of durable medical equipment. However, equipment rental will be allowed up to the purchase price only.
- The following prostheses and orthopedic appliances are covered, as well as their fitting, adjustment, repair, and replacement because of wear or a change in your condition necessitating a new appliance:
 - Artificial arms, legs, or eyes.
 - Leg braces, including attached shoes.
 - Arm and back braces.
 - Maxillofacial prostheses.
 - Cervical collars.
 - Surgical implants.
 - Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.
- Either one set of prescription eyeglasses or one set of contact lenses (whichever is appropriate for your medical needs) is covered when necessary to replace the human lenses absent at birth or lost through intraocular surgery or ocular Injury. Further replacement is covered only if your Physician recommends a change in prescription
- We allow benefits for oxygen and the equipment needed to administer it (one permanent and one portable unit per patient)

Limitations and Exclusions

- **Deluxe or Luxury Items** — If the supply, equipment, or appliance you order includes more features or is more expensive than you need for your condition, then we will allow only up to the Network or Reasonable and Customary Benefit Allowance for the item that would have met your medical needs. (Examples of deluxe or luxury items: motorized equipment when manually operated equipment can be used, wheelchair sidecars, contact lenses when prescription glasses can be used, and “fashion” eyeglass frames or lenses.) We cover deluxe equipment **only** when additional features are required for effective medical treatment, or to allow you to operate the equipment without assistance.
- **Equipment** — Items such as air conditioners, purifiers, humidifiers, exercise equipment, whirlpools, waterbeds, biofeedback equipment, and self-help devices that are not medical in nature are not covered, **regardless** of the relief they may provide for a medical condition
- **Hearing Aids** — Prescriptions for hearing aids and related services and supplies are not covered unless the loss of hearing is due to a covered Illness or accidental Injury
- **Hospital Beds** — We will not Pay for Hospital beds (including water beds or other floatation mattresses) prescribed for chronic back pain **Medical Supplies** — Items that do not serve a

useful medical purpose or that are used for comfort, convenience, personal hygiene, or first aid are not covered. (Examples: Support hose, bandages, adhesive tape, gauze, and antiseptics).

- **Physician's Certification** — With all supplies, equipment, and appliances, we require a Physician's certification that such items are a necessary expense and are medically required for the Insured's condition
- **Reasonable Charges** — Benefits for all supplies, equipment, and appliances are limited to charges that are reasonable in relation to your condition and to the average charges billed by most suppliers for comparable items
- **Replacements** — We will not Pay for replacement, upgrade, or improved supplies, equipment, and appliances without documentation of medical necessity

Surgery

Definition - Any variety of technical procedures for treatment or diagnosis of anatomical disease or Injury including, but not limited to: cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, other invasive procedures. Covered surgical services also include usual and related anesthesia, and pre- and post-operative care, including recasting.

Hospital Benefits

Inpatient: We will allow benefits for a semiprivate room and covered Ancillary Services as set forth under **Medical Care for General Conditions**.

Outpatient: Services provided by a Hospital or Other Facility are covered.

Medical-Surgical Benefits

Inpatient and **Outpatient:** The benefit allowance for surgery performed by a Physician includes Payment for preoperative visits, local administration of anesthesia, follow-up care, and recasting. More than one surgery performed by one or more Physicians during the course of only one operative period is called a "multiple surgery." Because allowances for surgery include benefits for pre- and post-surgical care, total benefits for multiple surgeries are reduced so that pre- and post-surgery allowances of the major surgery are not duplicated.

The following guidelines apply to surgical procedures:

Assistant Surgeon Fees – The amount eligible will be based on 20% of the Network or Reasonable and Customary allowance for the covered surgical procedure.

Co-Surgery Fees – If two or more surgeons work together as primary surgeons for the same surgical procedure, benefits for all surgeons will not exceed the Network or Reasonable and Customary allowance for that procedure.

Multiple Surgical Procedures – If two or more surgical procedures are performed through the same incision, benefits for the primary procedure will be based on 100% of the Network or Reasonable and Customary allowance and all other eligible procedures will be based on 50% of the Network or Reasonable and Customary allowance.

Limitations and Exclusions

- **Ambulatory Surgery** — We will not Pay for inpatient Hospital room charges or other charges that would not be incurred if you could have safely had surgery performed in the Physician's office or in the outpatient department of a Hospital or Other Facility
- **Assistant Surgery and Other Services by Same Physician** — The following rules apply when the assistant surgeon also bills for other services that are benefits under this Certificate:

- When the assistant surgeon also bills for medical care for the same condition that requires surgery, an allowance will be Paid only for care provided up to the date of surgery.
- When the assistant surgeon bills for medical care for a condition that is not related to the reason for surgery, both medical care and assistant surgery services are covered
- **Convalescent Care** — See this heading under General Limitations and Exclusions
- **Cosmetic Surgery** — See this heading under General Limitations and Exclusions
- **Custodial Care** — See this heading under General Limitations and Exclusions
- **Dental Surgery** — For a complete description of benefits allowed for dental surgery, see **Dental Services**
- **Diagnostic Admissions** — See this heading under *General Limitations and Exclusions*
- **Eligible Procedures** — Assistant surgery benefits are available only for surgical procedures of such complexity that they require an assistant, as determined by us. When an assistant is present only because the Hospital or Other Facility requires such services, assistant surgery benefits are not allowed.
- **Hospital Residents, Interns, and Employees** — If assistant surgery is performed by a resident, intern, or other salaried employee or person paid by the Hospital, we will not allow Medical-Surgical Benefits for the assistant surgery.
- **Isolation Charges** — See this heading under *General Limitations and Exclusions*
- **Obesity and Weight Loss** — We will Pay for surgery required as the result of obesity **only when we give prior benefit authorization**. Such surgery is limited to once per Insured, per Lifetime. For details, please see this heading under *General Limitations and Exclusions*
- **Orthognathic (Jaw) Surgery** — The only circumstance under which benefits will be allowed for upper or lower jaw augmentation or reduction procedures is when restoration is required as the result of an accidental Injury which occurred after the Member's Membership Effective Date. We will not pay for upper or lower jaw augmentations or reductions even if the condition is due to a genetic characteristic. NOTE: This limitation applies regardless of any pre-existing conditions clause or waiver thereof, we must give written authorization for such surgery benefits in advance of the date of services. This benefit requires prior benefit authorization.
- **Other** — The **Limitations and Exclusions** that apply to **Surgery** benefits also apply to surgical assistant services. Assistant surgery expenses for non-covered surgical procedures will not be Paid.
- **Private Room Expenses** — See this heading under *General Limitations and Exclusions*.
- **Replacements** — Replacement of a previously approved implant for cosmetic purposes.
- **Restorative or Reconstructive Surgery** — See this heading under *General Limitations and Exclusions*
- **Second and Third Surgical Opinion** — The second and third surgical opinion program is designed to help you decide if other acceptable treatment methods are available for your condition.
- **Sex-Change Operations** — See this heading under *General Limitations and Exclusions*
- **Sterilization Reversals** — Reversals of sterilization procedures are not covered
- **Temporomandibular Joint Surgery or Therapy** — See this heading under *General Limitations and Exclusion*.
- **Vision** — See this heading under *General Limitations and Exclusions*

Prescription Drugs and Medicines

The benefits described below are administered by the prescription benefits manager, Express Scripts. Benefits are provided for generic, formulary brand and non-formulary brand prescription drugs under a 3-tier Prescription Drug Plan. Co-payment amounts are as follows:

Prescription Drug Card	Co-payment per Prescription	
	Retail (30-day supply)	Mail Order (90-day supply)
Generic Drugs	\$10.00	\$ 20.00
Formulary Brand Drugs	\$30.00	\$60.00
Non-formulary Brand Drugs	\$ 50.00	\$ 100.00
Over-the-Counter Option	Retail Pharmacy	
Non-sedating antihistamines and Prilosec	\$10.00	

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”.

Generic versions of brand name drugs are reviewed and approved by the FDA (Food & Drug Administration). Generic drugs have the same active ingredients and come in the same strength and dosage form as the brand name drug. If you choose the generic drug, you will always pay the lowest Copay.

OVER-THE-COUNTER OPTION - In addition to the above prescription benefits, your Plan provides benefits for Over-the-Counter (OTC) non-sedating antihistamines, when prescribed by a doctor. To be eligible for benefits, you must present your prescription to the pharmacist when you purchase the drug. You will only be required to pay the Generic Copay. Examples of OTC non-sedating antihistamines include Claritin, Allegra, Clarinex and Zyrtec,

The Plan also provides benefits for the OTC proton pump inhibitor, Prilosec, when prescribed by a doctor. You will only be required to pay the Generic Copay at the time you purchase Prilosec with a prescription from your doctor.

If you purchase your OTC drug from a non-participating Pharmacy or do not have your Identification Card with you at the time of purchase, you may submit a claim directly to Express Scripts. To do so, please complete a prescription drug claim form, attach the prescription from the doctor and the receipt you received from the Pharmacy and send it to Express Scripts. The plan will pay the cost of the drug, less the Generic Copay amount.

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher Copay.

Express Scripts

The administrator of the Prescription Drug Plan is Express Scripts. The Prescription Drug Plan's network of participating pharmacies is nationwide and they display a decal in their window or near the Pharmacy department. You may contact Express Scripts on the web at www.express-scripts.com or by calling Member Services at (800) 235-4357 for a list of participating pharmacies. You can also call NCAS' Customer Service at (703) 934-6227 or (800) 888-6227.

When you present your Identification Card to a participating Pharmacy, your cost for a prescription or a refill will be the prescription drug co-payment as indicated in the Schedule of Benefits. For maintenance prescription drugs you can obtain a larger quantity (90-day supply), saving you trips to the Pharmacy and prescription co-payment expenses by using the Mail Service Prescription Drug Program.

Covered Services - Prescription drugs, unless otherwise stated below, must be Medically Necessary and not experimental/investigative, in order to be a covered service. For certain prescription drugs, the prescribing Physician may be asked to provide additional information before AMHIC can determine medical necessity. AMHIC may, in its sole discretion, establish quantity limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits established by AMHIC, or utilization guidelines. Prior authorization may be required for certain drugs.

Covered Services include:

- Prescription legend drugs, including self-administered injectable drugs.
- Injectable insulin and syringes used for administration of insulin.
- Anorexiant for children under age 18.
- Prescribed oral contraceptive and contraceptive devices.
- Prescribed pre-natal vitamins.
- Prescribed nicorette gum or patches.
- Tretinoin (sold under such brand names as Retin-A®) – For Insureds up to the age of 30. “Prior authorization” is required for patients age 30 or older and must be prescribed for “Acne Treatment” only.
- Certain supplies, equipment or appliances obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma). Contact AMHIC to determine approved covered supplies.
- Prescription Drugs approved by the FDA or otherwise, intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction like Viagra) are limited to 6 pills per month. If certain supplies, equipment or appliances are not obtained through a Network Pharmacy or mail service they may be covered as medical supplies, durable medical equipment and appliances instead of under prescription drug benefits under other sections of this Certificate. (“Prior authorization” is required.)

Limitations and Exclusions

- **Anorexiant** — For anyone age 18 and over are not covered
- **Antihistamines** – Brand name prescription non-sedating antihistamines
- **Appetite suppressants** — drugs prescribed for weight control or appetite suppressants are not covered
- **Cosmetic services** — Medications or preparations used for cosmetic purposes (such as preparations to promote hair growth, including but not limited to Rogaine®, preparations for preventing hair growth, including but not limited to Viniqa®, or medicated cosmetics) are not covered

- **FDA Approval** — Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. AMHIC may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology
- **Fertility drugs** — Fertility medications or non-fertility drugs used to treat infertility are not covered
- **Formulas/Vitamins** — Benefits are not allowed for special formula food or food supplements (unless for metabolic formulas for the treatment of inherited enzymatic disorders, see Covered Services in this subsection for benefits), vitamins, folic acid or minerals, except for legend prenatal vitamins
- **Growth Hormones** — We must give written authorization for such therapy in advance of the date of service. Please contact the Customer Service Department (Prescription Drug) for additional information
- **Tretinoin (sold under such brand names as Retin-A®) for Insureds over age 30** — Prescription drugs for Insured over age 30 must be accompanied by a “prior authorization” and be for “Acne Treatment”
- **Other non-covered items** — Benefits are not allowed for:
 - Delivery charges
 - Charges for the administration of any drug
 - Drugs consumed at the time and place where dispensed or where the prescription order is issued, including but not limited to samples provided by a Physician
 - Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse
 - Hypodermic needle, syringe, or similar device, except when used for administration of a Covered Drug when prescribed in accordance with the terms of this section
 - Therapeutic devices or appliances, including support garments and other non-medicinal substances (regardless of intended use)
 - Drugs and supplies unless specifically included as a covered drug
 - Medication or supplies when benefits are available under a personal Injury protection contract or no-fault motor vehicle insurance
 - Medication or supplies where cost is recoverable under any Workers Compensation or occupational disease law or any state or governmental agency, except Medicaid, or medication furnished by any other drug or medical service for which no charge is made to the Insured
- **Prescriptions** — Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have over-the-counter bio-equivalents are not covered even if written as a prescription (except as specified in the Summary of Benefits). Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) are not covered, except for injectable insulin. Some prescription drugs may not be covered even if you receive a Prescription Order from your Physician
- **Prior Authorization** — Prescription drugs which are not prior authorized by Express Scripts are not considered covered drugs eligible for reimbursement under this section, unless otherwise specified in this section
- **Quantity** — Prescription Drugs which are dispensed in quantities which exceed the applicable limits established by AMHIC, at its sole discretion are not covered
- **Refills** — Refills in excess of the number the prescription drug or maintenance prescription drug order calls for or refilled after one year from the date of such order
- **Smoking cessation** — Non prescribed Nicorette, nicotine patches, or any other drug containing nicotine or other smoking deterrent medications are not covered

- **Travel** — Prescription Drugs dispensed for the purpose of international travel are not covered
- **Overseas** — Prescription drugs purchased overseas are not covered.

HOW TO FILE A CLAIM FOR PRESCRIPTIONS

Member Pharmacies - Many pharmacies participate in the Prescription Plan program. When you go to a participating Pharmacy, show your AMHIC Identification Card. It provides the Pharmacy with important information about your coverage. The Pharmacy will collect your co-payment and fill your prescription(s).

Non-Member Pharmacies or Member Pharmacies When the Participant Does Not Use the Prescription Plan Card - You must submit a claim directly to the Prescription Plan when you purchase a prescription from a non-Member Pharmacy, do not use your card at a Member Pharmacy or purchase an eligible over-the-counter prescribed drug. The Prescription Plan will only pay the maximum contracted price for each prescription, less your co-payment. The maximum contracted price used for reimbursement will probably be less than the amount you are charged, with the exception of an OTC drug. Reimbursement will be sent directly to you. To submit a claim, please call Express Scripts' Customer Service at: (800) 235-4357 or visit their website at: www.express-scripts.com and login your account information.

Mail Service Prescription Drug Program - The Mail Service Prescription Drug Program provides benefits for maintenance drugs which require a prescription by law to purchase, and insulin. The maximum quantity which can be claimed is a 90-day supply which is more than can be obtained under the regular Prescription Drug Plan. Use of the Mail Service Prescription Drug Program will save you trips to the Pharmacy and minimizes the prescription co-payments. Please visit www.express-scripts.com to order these drugs on-line or call Express Scripts' Customer Service at: (800) 235-4357 for assistance.

Participants Who Continue Coverage Under COBRA – Follow the directions given above.

Definitions:

- **Brand Name Prescription Drug** — the initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).
- **Copay** — the predetermined fixed-dollar or percentage amount which the Insured must pay for each separate prescription drug order, maintenance prescription drug order or refill of a covered drug.
- **Generic Prescription Drug** — drugs which have been determined by the FDA to be bioequivalent to brand name drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a brand name drug and is its bioequivalent, generic drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart brand name drug. On average, generic drugs cost about half as much as the counterpart brand name drug.
- **Formulary Prescription Drug** - A formulary is a list of FDA-approved prescription drugs and supplies developed by Express Scripts' Pharmacy and Therapeutics Committee which represents the current clinical judgment of practicing health care practitioners based on a review of current data, medical journals, and research information. In your Pharmacy benefit plan, the formulary drug list is used as a guide for determining the amount that you pay as a

Copayment for each prescription, with drugs listed on the formulary typically available at a lower Copayment to you. To access Express-Scripts' formulary list, your Physician can log on to www.express-scripts.com.

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- **Mail Service** — a prescription drug program which offers a convenient means of obtaining maintenance prescription drugs by mail if the Insured takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy mail service which has entered into a reimbursement agreement with us, and sent directly to the Insured's home.
- **Maintenance Prescription Drug** — prescription drugs that are used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.
- **Multisource Brand** — a Brand drug that has a Generic alternative.
- **Network Pharmacy** — means a Pharmacy acceptable as a participating Pharmacy by AMHIC to provide covered drugs to Insured under the terms and conditions of this subsection.
- **Non-Network Pharmacy** — a Pharmacy which does not participate in this program. Charges incurred at Non-Network Pharmacies will be paid based on the Network Pharmacy reimbursed charges.
- **New FDA Approved Drug Product or Technology** — the first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use. New FDA Approved Drug Product or Technology does not include:
 - New formulations;
 - A new dosage form or new formulation of an active ingredient already on the market;
 - Already marketed drug product but new manufacturer;
 - A product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
 - Already marketed drug product, but new use;
 - A new use for a drug product already marketed by the same or a different firm; or
 - A newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications)
- **Pharmacy** — an establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a non-Network Provider.
- **Pharmacy and Therapeutics Committee** — a committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.
- **Prescription Legend Drug** — a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a Prescription Legend Drug under this Certificate.
- **Prescription Order** — a written request by a Physician for a drug or medication and each authorized refill for same.
- **Prior Authorization** — the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee. To obtain prior authorization, please request that your doctor contact Express Scripts before

prescribing a drug that requires prior authorization. If the prescription drug is approved by Express Scripts, you will pay the applicable copay, If the drug is not approved, you will be responsible for the full cost. To call Express Scripts, please use the Express Scripts phone number shown on your identification card.

SECTION 7

GENERAL LIMITATIONS AND EXCLUSIONS

These General Limitations and Exclusions apply to **all** benefits described in this Certificate. **We will not allow benefits for any of the following services, supplies, situations, or related expenses:**

Alcohol-related– Services when the Injury or Illness is the result of the illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Artificial Conception — Any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, such as artificial insemination, "test tube" fertilization, drug-induced ovulation or other artificial methods of conception.

Auto Accident Injuries — Services or supplies resulting from an automobile accident that are covered under applicable No-Fault insurance laws. (See *Section 11: Automobile No-Fault Insurance Provisions* for further information.)

Autologous hematopoietic– Support and all expenses for or related to such procedure (e.g., autologous bone marrow transplantation or stem cell rescue) for any symptom, disease or condition for which this procedure is considered Experimental.

Biofeedback — Services related to biofeedback.

Cardiac Rehabilitation or Education — Non-Medically Necessary Rehabilitation or education classes for cardiac conditions are not covered.

Charges– For any non-emergency Inpatient Hospital admission occurring on a Friday or Saturday in conjunction with a surgical procedure to be performed during the following week. A Sunday admission will be eligible only for procedures scheduled to be performed early Monday morning.

Charges– For services received as a result of Injury or Sickness caused by or contributed to by engaging in an Illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Convalescent Care — Benefits for care provided during the period of recovery from Illness, Injury, or surgery are limited to those normally received for a specific condition, as determined by our medical consultants. Benefits for convalescent care are included in the Physician's or surgeon's reimbursement.

Cosmetic Surgery — Cosmetic surgery is beautification or aesthetic surgery to improve an individual's appearance by surgical alteration of a physical characteristic. Cosmetic surgery for psychiatric or psychological reasons, or to change family characteristics or conditions due to aging is not covered. Benefits for cosmetic surgery and related expenses are allowed only when such surgery is required as the result of accidental Injury. We must give written authorization for such surgery benefits in advance of the date of services.

Custodial Care — Services to assist the Insured in activities of daily living, not requiring the continuous attention of skilled medical or paramedical personnel, are not covered, regardless of where they are furnished, and by whom they were recommended.

Diagnostic Admissions — If you are admitted as an inpatient to a Hospital for diagnostic procedures, and could have received these services as an outpatient without endangering your health, then we will **not** Pay for Hospital room charges or other charges that would not have been incurred if you had received the services as an outpatient.

Discharge Day Expense — We do not consider a discharge day as a day in the Facility. Charges from the facility for the discharge day are not covered.

Domiciliary Care — Care provided in a residential institution, treatment center, half-way house, or school because a Member's own home arrangements are not appropriate, and consisting chiefly of room and board, is **not** covered, even if therapy is included.

Duplicate (Double) Coverage — If you are covered by more than one health coverage Membership, then total benefit Payments will not be more than 100 percent of total covered expenses. (See *Section 13: Duplicate Coverage and Coordination of Benefits* for further information.)

Experimental or Investigative Procedures — Any treatment, procedure, drug or device that has been found by AMHIC not to meet the eligible-for-coverage criteria, which are listed and defined in *Section 2: Definitions* under Experimental/Investigational. The determination that a service is not considered eligible-for-coverage or is Experimental/Investigational can be made by AMHIC either before or after the service is rendered. We do not cover treatment or procedures which are Experimental/Investigational, or which are not proven to be effective, as determined by our medical director and/or appropriate medical/surgical authorities selected by us.

Foreign Government Institutions and Facility Services — Services and supplies furnished by any Foreign (non-U.S.) Government.

Genetic Counseling — Services related to genetic counseling, including but not limited to; discussion of family history or tests results to determine the sex or physical characteristics of an unborn child, or testing for inherited susceptibility. Genetic tests to evaluate risks for certain types of conditions may be covered based on medical policy, review and criteria and after appropriate authorization.

Government Institutions and Facility Services — Outpatient services and supplies furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, unless we authorize Payment in writing before the services are performed. Services and supplies furnished by a Veterans Administration facility for a service-connected Disability are not covered.

Hair Loss — Wigs, or artificial hairpieces except for the treatment of a serious medical condition and this benefit is limited to one per Insured per calendar year. We do not cover drugs, hair transplants or implants even if there is a Physician prescription, and a medical reason for the hair loss.

Holistic or homeopathic medicine including services or accommodations provided in connection with holistic or homeopathic treatment or supplies.

Hypnosis — Services related to hypnosis, whether for medical or anesthesia purposes, are not covered.

Isolation Charges — We will only Pay private room expenses under your Hospital Benefits if your medical condition requires that you be isolated to protect you or other patients from exposure to dangerous bacteria or diseases. Conditions that qualify for isolation benefits include severe burns and conditions that require isolation according to public health laws.

Learning Deficiency and/or Behavioral Problem Therapies — Special education, counseling, therapy, or care for learning deficiencies or behavioral problems for any reason.

Legal Payment Obligations — Benefits for services for which you have no legal obligation to pay, or charges made only because benefits are available under this Certificate. We will not allow benefits for services for which the Insured has received a professional or courtesy discount, or for services provided by the Insured upon him/herself, or by a family Insured.

Massage Therapy, rolfing, holistic and naturopathic healing and treatments.

Medically Necessary — You are liable for expenses for services and supplies that are not Medically Necessary (as defined in *Section 2: Definitions*). Our decision as to whether a service or supply is Medically Necessary is based upon the opinions of our medical or surgical consultants as to what is “approved and generally accepted medical or surgical practice.” **The fact that a Physician may prescribe, order, recommend, or approve a service does not, of itself, make it Medically Necessary or an allowable expense, even though it is not specifically listed as an exclusion.** Claims for services that are not Medically Necessary may be denied either before or after Payment.

Military Treatment of an Illness or Injury that is the result of war or any act of war, declared or undeclared or occurring while you are on duty with any military, naval or air force of any country or international organization.

Non-covered Services— Any services, supplies, or drugs related to non-Covered Services or complications arising from such non-Covered Services are not a benefit (such as non-covered artificial conception, cosmetic surgery, sex-change operations, and Experimental/Investigational procedures).

Nutritional Therapy — Vitamins, dietary/nutritional supplements, special foods, baby formulas, mother’s milk or diets, even if the substance is prescription and the sole source of nutrition.

Obesity and Weight Loss — Obesity in itself is not considered an Illness or disease, and benefits are not allowed solely for its evaluation and treatment. Benefits will only be allowed for obesity when a surgical procedure is required due to Morbid Obesity. Morbid obesity is defined as a condition in which persistent and uncontrollable weight gain causes a threat to life based on current guidelines used by AMHIC. Surgery benefits will not be allowed unless written authorization is given by us in advance of the date of surgery, regardless of the medical necessity for the surgery. You are limited to one surgical treatment per Lifetime. Surgery benefits will not be provided for subsequent procedures to correct further Injury or Illness resulting from the Insured’s noncompliance with prescribed medical treatment.

Personal Comfort or Convenience — Services and supplies used primarily for your personal comfort or convenience that are not related to the treatment of your condition. (Examples: guest trays, beauty or barber shop services, gift shop purchases, long distance telephone calls, television, admission kits, and personal laundry services.)

Post Termination Benefits — Hospitalization, services, supplies, or other benefits of this Certificate which are provided to you after your coverage terminates, even if the Hospitalization, services, or supplies were made necessary by an accident, illness, or other event which occurred before or while coverage was in effect.

Pre-existing Conditions — A pre-existing condition is any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the date of enrollment of the individual in this plan. Pregnancy or Genetic information in the absence of any diagnosis of a condition related to the information are not considered pre-existing conditions. The Plan will **not** pay more than \$500 per Insured per condition for Covered Services or supplies related to a pre-existing condition for ten consecutive months after the date of enrollment. If you had prior coverage within 63 days of your Effective Date, the pre-existing Waiting Period will be applied for the portion which is not covered by Health Insurance Portability and Accountability Act of 1996 (HIPAA) Creditable Coverage. NOTE: Newly adopted child, newborn child, or children placed for adoption are not subject to the pre-existing condition exclusion above if enrolled within 31 days of eligibility.

Prior Benefit Authorization— The Plan must give written authorization for certain services in advance of the date of services.

Private Room Expenses — If you have a private room in a Hospital or Alcoholism Treatment Center for any reason other than isolation, covered charges are limited to the semiprivate room rate, whether or not a semiprivate room is available. Under **no** circumstances will private room benefits be allowed for treatment of Mental Health, alcoholism, or drug abuse.

Report Preparations — Charges for preparing medical reports, itemized bills, or claim forms.

Restorative or Reconstructive Surgery — Restorative or reconstructive surgery restores or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a congenital defect, to a level considered normal. A congenital defect or anomaly is defined as existing at or dating from birth, disorders due to inappropriate growth are not considered congenital. Such surgery may have a coincidental cosmetic effect.

Benefits for restorative or reconstructive surgery and related expenses are allowed only when such surgery is required as the result of a congenital anomaly, accidental Injury, disease process or its treatment. Benefits are provided for reconstruction of the breast on which a mastectomy has been performed and reconstruction of the other breast to produce a symmetrical appearance.

Benefits are provided for prostheses and physical complications for all stages of mastectomy including lymph edemas. Coverage for such services is provided as any other physical illness, subject to the same Deductible, Copay and Coinsurance. If a Member chooses not to have surgical reconstruction after a mastectomy, we will provide coverage for external prostheses.

The Plan must give written authorization for such benefits in advance of the date of services.

Services, supplies, care or treatment to you or your covered Dependent for Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances. This exclusion does not apply if the Injury resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

Services Not Identified — Any service or supply not specifically identified as a benefit in this Certificate.

Sex-Change Operations — Services or supplies related to sex-change operations, reversals of such procedures, or complications of such procedures.

Sexual Dysfunction — Services, supplies, or prescription drugs for the treatment of sexual dysfunction, except for Viagra under the Prescription Drug Program and limited to [6] pills a month.

Taxes — Sales, service, or other taxes imposed by law that apply to benefits covered under this Certificate.

Temporomandibular Joint Surgery or Therapy — We will cover Medically Necessary appliances and medical care for the treatment of temporomandibular joint disorder. We will not cover any surgical treatment for this disorder, regardless of the reason(s) such services are necessary.

Therapies — Therapies and self-help programs not specifically covered under this Certificate include, but are not limited to:

- Recreational, sex, primal scream, and sleep therapies.
- Self-help, stress management, smoking cessation, and weight loss programs.
- Transactional analysis, encounter groups, and transcendental meditation (TM).
- Sensitivity or assertiveness training and rolfing.
- Religious or marital counseling.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification, or arthritis class.
- Myotherapy or massage therapy.
- Services for sensory integration disorder.

Third-Party Liability (Subrogation) — Services or supplies resulting from a condition or Injury for which someone else is legally responsible. (See *Section 12: Third-Party Liability— Subrogation* for further information.)

Transfers — The transfer of a patient from one Physician to another for inpatient care of the same condition is covered when the days each Physician is responsible for care are not duplicated.

Travel Expenses — Travel expenses for you or your Physician.

Vision — We do not Pay for any routine refractive examinations, eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the Insured from wearing contact lenses), or prescriptions for such services and supplies. We do not Pay for any surgical, medical, or Hospital services and/or supplies rendered in connection with radial keratotomy or any procedure designed to correct farsightedness, nearsightedness, or astigmatism. We do not Pay for eyeglasses or contact lenses and the necessary prescriptions. We do not Pay for any Vision Exam.

War — Services or supplies required for disease or injuries resulting from war, civil war, insurrection, rebellion, or revolution.

Workers' Compensation Services or supplies resulting from a work-related Illness or Injury. (See *Section 10: Workers' Compensation* for further information.)

SECTION 8

GENERAL PROVISIONS

Advance Benefit Confirmation If you wish to know what benefits will be Paid before receiving a service or sending a claim to us, we may require you to submit a written request for such information. In some cases, we may require a written statement from your Physician identifying the circumstances of your case and the specific services that will be provided.

Assignment of Benefits All Network benefits in this Plan will be paid directly to Network Providers. These Payments fulfill our obligation to the Insured for these services.

Catastrophic Events In case of fire, flood, war, civil disturbance, court order, strike, or other cause beyond our control, we may be unable to process your claims on a timely basis. No suit or action in law or equity may be taken against us because of a delay caused by any of these events.

Changes to the Plan We may amend this Plan when authorized by AMHIC. We will give your Employer any amendments within 60 days following the Effective Date of the amendment. If your Employer requests a change which reduces or eliminates coverage, such change shall have been either requested in writing or signed by the Employer.

No Employee of your Employer, NCAS, or any contracted vendor may change this Plan by giving incomplete or incorrect information, or by contradicting the terms of this Plan. Any such situation will not prevent us from administering this Plan in strict accordance with its terms.

Contracting Entity The Member hereby expressly acknowledges his/her understanding that the Plan constitutes a Certificate solely between the Employer and AMHIC, is a mutual association insurer under District of Columbia captive law. The Member further acknowledges and agrees that he/she has not entered into the Plan based upon representations by any person other than AMHIC and that no person, entity, or organization other than AMHIC shall be held accountable or liable to the Member for any of AMHIC's obligations created under the Plan. This paragraph shall not create any additional obligations whatsoever on the part of AMHIC other than those obligations created under other provisions of the Plan.

Disclaimer of Liability AMHIC has no control over any diagnosis, treatment, care, or other service provided to a Member by any Facility or Professional Provider, and is not liable for any loss or Injury caused by any health care Provider by reason of negligence or otherwise.

Disclosure of Your Medical Information Ordinarily, the Plan cannot release your medical information without your written consent. That information is strictly confidential. The Plan may, however, release your medical information without notice or consent when:

- Requested in connection with utilization summaries or review provided to a third party, such as your Employer, if that third party funds all or a part of the cost of your claims.
- Peer and utilization review boards and our medical consultants need such information to ensure that you are getting appropriate and Medically Necessary care and services that are covered under this Plan.
- We receive a judicial or administrative subpoena for such information.
- The District of Columbia Department of Insurance, Securities and Banking (DISB) requests such information.
- The information is required for:
 - Workers' Compensation proceedings;
 - No-Fault auto insurance cases;
 - Third-party liability (subrogation) proceedings; and

- Coordination of benefits.

We cannot release to you information provided to us by a Provider without the Provider's written consent.

Exam of Insured We reserve the right and opportunity to request a medical examination of a Member when a claim is filed, and as often as we may reasonably require during processing of a claim under this Plan.

Execution of Papers On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Plan.

Fraudulent Insurance Acts It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the District of Columbia Department of Insurance & Securities Regulation (DISR) within the department of regulatory agencies.

Member's Legal Expense Obligations You and your Dependents are liable for any actions which may prejudice our rights under this Plan. If we must take legal action to uphold our rights and prevail in that action, we will be entitled to receive and you will be required to pay our legal expenses, including attorney's fees and court costs.

Non-Contestable This Plan shall not be contested except for non-payment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made for the purpose of effecting coverage under the Plan with respect to a Insured shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Plan after such insurance had been in force for a period of two years during such Insured's Lifetime, unless such statement is contained in written instrument signed by the Insured making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

Paragraph Headings The paragraph and section headings used throughout this Plan are for reference only. They are not to be used by themselves for interpreting the provisions of the Plan.

Payment in Error If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments made in error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments made in error.

Payment of Premium by Your Employer Since your Employer has contracted with us to pay claims under a special financial arrangement, claims administration may be handled in one of the following ways:

- Funds for payment of your claims are held by your Employer, and are used to pay submitted claims. If the claims funds agreed upon by your Employer and us are not maintained by your Employer, payments for submitted claims will not be made.
- Funds for payment of your claims are paid to us by your Employer. If the claims funds agreed upon by your Employer and us are not remitted by your Employer, payments for submitted claims will not be made.

Claims not paid because of insufficient claims funds should be submitted for payment to and are the liability of your Employer.

Provider Contracts Network Providers and Non-Network Providers may have agreed to an additional discount, which is calculated after the Maximum Network Allowance or Reasonable and Customary Allowance, Deductible, Copay and Coinsurance. For example, we may receive an additional Network discount of 10 percent. AMHIC would reimburse the Network Provider or Non-Network Provider the balance of the benefit allowance minus your Deductible, Copay and Coinsurance, and minus the additional 10 percent. The amount of the additional discounts, if any, varies by Provider and by the type of health care plan you have with AMHIC. Certain discounts are not passed directly on to you for purposes of calculating your Deductible, Copay and Coinsurance.

Release of Medically-Related Information You must provide us with whatever information is necessary to determine benefits on your claims. We may obtain information from any insurance company, organization, or person when such information is necessary to carry out the provisions of this Plan. Such information may be exchanged without consent of or notice to the Member.

You agree to cooperate at all times (including while you are Hospitalized) by allowing us access to your medical records to investigate claims and verify information provided in your application and/or health statement. If you do not cooperate with us, you forfeit your right to benefit Payments on claims subject to investigation and acknowledge our right to cancel your coverage.

To help us determine which services and supplies qualify for benefits, you authorize all Providers of health care services or supplies to provide us with any medically related information pertaining to your treatment.

You waive all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Research Fees We reserve the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters, or other forms.

Reserve Funds No Member is entitled to share in any reserve or other funds that may be accumulated or established by us, unless a right to share in such funds is granted by AMHIC.

Sending Notices All notices to the Member are considered to be sent to and received by the Member when deposited in the United States mail with postage prepaid and addressed to either: The Member at the latest address appearing on our Membership records; or The Member's Employer.

SECTION 9

HOW TO FILE HEALTH CARE CLAIMS

In-Network Providers

Before you use a Provider listed in the Network directory, call the Provider or the Network to verify that the Provider is still a Member. Simply present your NCAS Identification Card at the time you receive services. The Provider will file a claim with the Network and will be directly reimbursed for the services you receive.

Out-of-Network Providers

MEDICAL SERVICES – Benefits are not provided for services rendered by Out-of-Network Providers, with the exception of ambulance and emergency room care. Reimbursement of medical expenses provided by Out-of-Network Providers is handled by NCAS. Claims for benefits may be filed by a Provider or by the Participant. Payment will be made by NCAS either to the Provider or the Participant.

You do not need a claim form to file your claims. You should mail your itemized bill from the Provider and be sure to include the following information on the bill:

- | | |
|-------------------------------------|-----------------------------|
| a. Employee Name | f. Procedure Code |
| b. Employee's Identification Number | g. Diagnosis Code |
| c. Patient Name | h. Date of Service |
| d. Employer Name or Group Number | i. Charge for Each Service. |
| e. Provider's Tax ID Number (TIN) | |

Balance due bills are not acceptable. The bill for processing claims must include all the information described above. All claims and written inquiries should be sent to:

AMHIC c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022
(703) 934-6227 or 1-800-888-6227

NOTE ON HOSPITAL CHARGES - Claims for inpatient admissions are usually filed by the Hospital. Most Hospitals will verify that your health coverage is in effect and will then take care of the paperwork on behalf of the patient. If you do receive a bill for inpatient services, do not pay it until you are certain that your claim has been settled. In some instances, the Participant is responsible for balances. When you are unsure, ask the Hospital or NCAS for guidance.

Remember - Authorization is required from the Managed Care Vendor prior to all non-emergency Hospital admissions and the next business day following an emergency admission. Failure to call the Managed Care Vendor may reduce your benefits (*Refer to Section 5*).

Call Hines at: (800) 670-7718

When Claims Should Be Filed All claims must be submitted within 12 months after the expenses are incurred; otherwise, they are not eligible for reimbursement. After claims are received, each claim will be granted or denied by NCAS within the number of days specified in this section of the booklet for the specific type of claim. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time. The Claims Processor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Processor will furnish the Plan Participant with a Written Notice of this denial. This Written Notice will be provided after the receipt of the Claim within the specified timeframe noted below. The Written Notice will contain the following information:

- the specific reason or reasons for the denial;
- specific reference to those Plan provisions on which the denial is based;
- a description of any additional information or material necessary to correct the claim and
- an explanation of why such material or information is necessary; and appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

CLAIM APPEAL PROCEDURES

Claims for benefits under the Plan must be filed in the manner and within the time limits stated above. If a Participant or a Participant's Spouse or Dependent (hereinafter referred to as a "Claimant") is denied any Benefit under this Plan, the Claimant may request review of the claim with the Claims Administrator. The claims procedures do not preclude an authorized representative of a Claimant from acting on behalf of such Claimant in pursuing a benefit claim or appeal of an adverse benefit determination. The Claims Administrator shall review the claim itself or appoint an individual or an entity to review the claim.

The Claim Appeal Procedures divides claims into several categories, with different time frames and requirements as described below. If you have any questions, contact the Claims Administrator.

I. INITIAL BENEFIT DETERMINATION

Urgent Care Claims - A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

For urgent care claims, the Claims Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the Claimant.

The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

Pre-Service Claims - A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

For a pre-service claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims - A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

For a post-service claim, the Claims Administrator shall notify the Claimant of the Plan's adverse benefit determination no later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to the failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims - If the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments shall constitute an adverse initial benefit determination. These determinations shall be known as concurrent care decisions.

In such a case, the Claims Administrator shall notify the Claimant of the adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Calculation of Time Period - For purposes of the time periods specified, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in

accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination accompanies the claim. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination shall be tolled from the date the notification of the extension is sent to the Claimant until the date the Claimant responds to the request for additional information.

Manner and Content of Denial of Initial Claims - If the Claims Administrator denies a claim, it must provide to the Claimant, in writing or by electronic communication:

- (a) The specific reasons for the adverse determination;
- (b) A reference to the specific plan provisions on which the determination is based;
- (c) A description of any additional information or material necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502 (a) following an adverse benefits determination on review;
- (e) In the case of an adverse benefit determination by the Plan, the following must be provided:
 - (i) A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination or a statement that the same will be provided upon request by the Claimant and without charge; or
 - (ii) If the adverse benefit determination is based on the Plan's medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the exclusion or limit to the Claimant's medical circumstances or a statement that the same will be provided upon request by the Claimant and without charge.

In the case of an adverse benefit determination concerning an urgent care claim, the information described in this section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished not later than three days after the oral notification.

II. APPEAL PROCEDURES

First Appeal - In addition to having the right to review documents and submit comments as described above, a Claimant has a right to file an appeal to the Plan within 180 days from the date of the initial notice. The Claimant's appeal request should include the patient's name, identification number, and any additional documentation to be reviewed. When reviewing the appeal, the Plan must meet the following requirements:

- (a) The Plan provides for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- (b) The Plan provides that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations

with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- (c) The Plan provides for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit review determination;
- (d) The Plan provides that the health care professional engaged for purposes of consultation be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- (e) The Plan provides in the case of a claim involving urgent care, for an expedited review process pursuant to which:
 - (i) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - (ii) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Second Appeal - If the claim is denied on appeal, under the procedures described above, the Claimant may request that the claim be reviewed a second time. The request for this second level of review must be received by the Claims Administrator within 30 days of the date of the second adverse benefit determination notice.

The appeal should state in detail the reasons that you believe your claim should be granted, and should identify specifically any facts or reasons that you believe support your claim; you should refer specifically to provisions of the Plan upon which you rely. You should attach to the appeal copies of any documents that support your claim and send all information to the Claims Administrator.

Decision on your appeal will, in the absence of extraordinary circumstances, be made within 60 days after its receipt. The decision will be in writing and will be sent to you at the address indicated on your Appeal, or to any legal counsel or other representative that you specify. The Claims Administrator's decision on your Appeal will explain the specific reasons for the decision. An interpretation of the terms of the Plan adopted by the Claims Administrator in deciding your Appeal shall be at the Claims Administrator's discretion and shall not be subject to further review or dispute by the Plan.

Extra-Contractual Appeals Policy, Second Level Appeal Process – The Director of Program Support of Select Benefit Plan Administrator (SPBA) may direct NCAS the plan claim administrator, to pay benefits outside the terms of the Plan document if the Employee has filed a written first level appeal that explains the basis of his/her appeal and NCAS has first declined that appeal if one of the following criteria is met:

- (a) To the extent necessary to restore equity where the claimant was misadvised by SBPA, Wachovia Insurance Services or NCAS staff as to the availability of a benefit or benefit payments for a particular procedure or course of treatment. The claimant must provide documentation that a "prudent layperson" would have relied on. A prudent layperson refers to a clear-thinking adult with an average knowledge of

health and medicine.

- (b) To the extent the approval of payment will result in savings (current or future) for the plan.

Process – This second level appeal process requires the claimant to file a written second level of appeal within fifteen (15) working days of the date of the denial letter from NCAS. The claimant must state why they want to appeal the first level of denial and the reasons why they disagree with the first level appeal denial.

Second level of appeal letters should be sent to NCAS. If the claimant does not file the second level appeal request within fifteen (15) working days of the date of the denial letter, the second level of appeal will be denied unless it is determined that a good cause prevented the timely submission such as serious illness, hospitalization, other serious family matters, etc.

Approval – Approval by the Executive Committee of AMHIC is required for an appeal which will result in a payment over \$1,000, or if payment is for a second payment to the same claimant. The Director of Program Support for SBPA may approve payments for under \$1,000.

Denial – If the second level of appeal is denied, the claimant will receive a written denial letter within 15 (fifteen) days of receipt of the second appeal letter. The decision at the second level of appeal is final. There is no further appeal available.

III. DEADLINE FOR APPEAL DECISIONS

Urgent Health Benefit Claims - In case of urgent care health claims, the Claims Administrator shall notify the Claimant of the Plan's determination on review as soon as possible, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

Pre-Service Health Benefit Claims - In the case of a pre-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review not later than 15 days after receipt of the Claimant's request for review of the adverse determination.

Post-Service Health Benefit Claims - In the case of a post-service health claim, the Claims Administrator shall notify the Claimant of the Plan's benefit determination on review, not later than 30 days after receipt of the Claimant's request for review of the adverse determination.

Calculation of Time Periods - For purposes of the time periods specified in this Section, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the benefit determination on review shall be tolled from the date the notification requesting the additional information is sent to the Claimant until the date the Claimant responds.

Manner and Content of Notice of Appeal Decision- Upon completion of its review of an adverse initial claim determination, the Claims Administrator will provide the Claimant with written or electronic notification of a plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall contain:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is

based;

- (c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
- (d) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to the Claimant upon request;
- (e) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided without charge upon request.

IV. MISCELLANEOUS

Summary of Appeal Procedures – The appeal procedures described above are intended to reflect, in detail, the Claims Procedures Regulations issued by the Department of Labor. The following summarizes the steps involved:

1. Initial Claim Determination – Regulations require that the claim be identified as urgent, concurrent, pre-service and post-service. After a claim is filed, the Claims Administrator is required to notify the claimant of its decision within a specified period of time, contingent on the type of claim. If the claim is denied, the Claims Administrator is required to provide specific information regarding its decision.
2. Claims Administrator (1st Level of Appeal) – If the claimant disagrees with the claim denial, he can file an appeal with the Claims Administrator. When submitting the request for appeal and reviewing the appeal, the Claimant and the Claims Administrator must follow the guidelines specified in Section II. The Claims Administrator must respond to the Claimant's request for appeal according to the guidelines explained in Section III above.
3. Claims Administrator (2nd Level of Appeal) – If the claimant's first request for appeal is denied, the claimant can request a second review. This request can be made to the Claims Administrator. The claimant must follow the guidelines explained above.
4. Claims appeals should be sent to:

AMHIC c/o NCAS
P.O. Box 10136
Fairfax, VA 22038-8022

Failure of Plan to Follows Procedures - If the Plan fails to follow the claims procedures required by this Article, a Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedy under ERISA section 502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Preemption of State Law - With respect to any insured benefit under this Plan, nothing in this Section shall be construed to supersede any provision of any applicable State law that regulates

insurance, except to the extent that such law prevents application of this Section.

Statute of Limitations - Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Claims Administrator has been rendered (or deemed rendered).

SECTION 10

WORKERS' COMPENSATION

This section explains how benefits may be Paid on claims for services resulting from a work-related Illness or Injury.

Services and supplies resulting from work-related Illness or Injury are not a benefit under this Plan. This exclusion from coverage applies to expenses resulting from occupational accidents or sickness covered under:

- Occupational disease laws.
- Employer's liability.
- Municipal, state, or federal law.
- Workers' Compensation Act.

In order to recover benefits for a work-related Illness or Injury, you must pursue your rights under the Workers' Compensation Act or any of the above provisions which may apply to your situation. This includes filing an appeal with the Industrial Commission.

Conditional claims may be paid by us during the appeal process if you sign a reimbursement agreement to reimburse us for 100 percent of benefits Paid for you.

We will not pay benefits for services and supplies resulting from a work-related Illness or Injury even **if other benefits are not Paid because:**

- You fail to file a claim within the filing period allowed by the applicable law.
- You obtain care which is not authorized by Workers' Compensation insurance.
- Your Employer fails to carry the required Workers' Compensation insurance. In this case, your Employer becomes liable for any Employee's work-related Illness or Injury expenses.
- You fail to comply with any other provisions of the law.

SECTION 11

AUTOMOBILE NO-FAULT INSURANCE PROVISIONS

This section explains how we will coordinate the benefits of this Certificate with the benefits of an automobile No-Fault insurance policy.

A complying policy is an insurance policy that provides at least the minimum coverage required by law, and any state or federal law providing similar benefits through legislation or No-Fault statute.

How We Coordinate Benefits With Complying Policies Your benefits under this Plan will be coordinated with the minimum coverages required under the state jurisdiction. If a complying policy provides coverages in excess of the minimums required by state law, then we will coordinate benefits with those coverages in effect.

What We Will Pay

- The Plan will pay up to the complying policy's Deductible amount for those services which are covered under this Plan.
- After we pay up to the complying policy's Deductible amount, the complying policy is primary and is responsible for all benefits payable under the No-Fault statute. If there is more than one complying policy, each will have to pay its maximum No-Fault statutory coverages before we will become liable for any further Payments.
- If there is a complying policy in effect, and you waive or fail to assert your rights to such benefits, we will not pay benefits which could be available under a complying policy.
- The Plan may require proof that the complying policy has paid all benefits required by law prior to making any payments to you. Upon payment, AMHIC will be entitled to exercise our rights under this Plan and under the No-Fault law. You must fully cooperate with AMHIC to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases.

What Happens if You Do Not Have a Complying Policy The Plan will not pay benefits for injuries received by the Member, while he/she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile No-Fault complying policy as required by law. Benefits will be provided under the terms of the Plan for injuries sustained by a Member who is a non-owner operator, passenger, or pedestrian involved in a motor vehicle accident if that Member is not covered by a complying policy. In that event, we may exercise our rights under *Section 12: Third-Party Liability — Subrogation*.

SECTION 12

THIRD-PARTY LIABILITY — SUBROGATION

Third-party liability exists when someone else is legally responsible for your condition or Injury. AMHIC will not pay for any services or supplies under this Plan for which a third party is liable.

We may, however, provide benefits under these conditions:

- When it is established that a third-party liability does not exist; or
- When you guarantee in writing to reimburse us if the third party later settles with you for any amount, or if you recover any damages in court.

Our Rights When Third-Party Liability Exists When a third party is or may be liable for the costs of any covered expenses payable to you or on your behalf under this Plan, we have subrogation rights. This means that we have the right, either as co-plaintiffs or by direct suit, to enforce your claim against a third party for the benefits paid to you or on your behalf.

When you fail to cooperate in satisfying our subrogation interest, and we must file a lawsuit against you or the third party in order to enforce our rights under this provision, you or any Dependent receiving benefits under this Plan shall be responsible for attorneys' fees and costs incurred by us.

Your Obligations When Third-Party Liability Exists If a third party is or may be liable for the costs of any expenses payable to you or on your behalf under this Plan, then you must do the following:

- Promptly notify us of your claim against the third party.
- You and your attorney must provide for the amount of benefits Paid by us in any settlement with the third party or the third party's insurance carrier.
- If you receive money for the claim by suit, settlement, or otherwise, you must fully reimburse us for the amount of benefits provided you under this Plan. You may not exclude recovery for our health care benefits from any type of damages or settlement recovered by you.
- Cooperate in every way necessary to help us enforce our subrogation rights.
- You may not take any action that might prejudice our subrogation rights.

SECTION 13

DUPLICATE COVERAGE AND COORDINATION OF BENEFITS

This section explains how we coordinate benefits when you have coverage with more than one group or group-type health insurance or health benefits plan.

Duplicate (Double) Coverage Duplicate (Double) Coverage under this Plan and under any other group or group-type health insurance or health benefits plan or blanket coverage. The total benefits received by you, or on your behalf, from all plans combined for any claim for Covered Services will not exceed 100 percent of the total covered charges.

Definition For this section the following terms are used:

- **Plan** refers to any of these that provides benefits or services for, or because of, medical or dental care or treatment:
 - Group insurance or group-type coverage, including coverage provided by group practice, pre-payment, individual practice coverage, or self-funded plans and group health maintenance organization coverage. "Plan" also includes coverage provided by exclusive or preferred Provider organizations, but excludes school accident-type coverage.
 - Coverage under labor management trustee plans, union welfare plans, and Employer organization plans. Coverage under a governmental program required or provided by law, except Medicaid.

We consider each policy, contract, or other arrangement for benefits a separate "plan." That part of any such Contract or agreement which reserves the right to take the benefits or services of other plans into consideration in determining its own benefits is also considered to be a separate "plan."

- **Primary Plan** refers to the plan which has first responsibility (liability) for a claim. The primary plan must pay up to its full liability.
- **Secondary Plan** refers to the plan (or plans) which has second responsibility (liability) for a claim.

Conditions of Coordination of Benefits The provisions of this section establish the primary and secondary plans. When we are the primary plan, we Pay benefits under the terms of this Plan. When we are the secondary plan, we Pay only the difference between benefits that would be payable by the primary plan and the amount that would be payable under this Plan in the absence of a coordination of benefits provision, so long as that difference is not more than we would normally Pay.

Effect on Benefits You have an obligation to provide us with current and accurate information regarding the existence of other coverage. **Benefits payable under another plan include benefits that would be payable under that plan whether or not a claim is made and include benefits that would have been paid but were refused because the claim was not sent to the plan on a timely basis.**

Your benefits under this Plan will be reduced by the amount that such benefits would duplicate benefits payable under the Primary Plan.

How We Determine Which Plan is Primary and Which is Secondary We will determine the primary plan and secondary plan according to the following rules. These rules are considered and applied in sequence. When any rule establishes one plan as primary and one as secondary, the subsequent rules do not apply.

- A plan is primary if it does not have order of benefit determination rules or it has rules which differ from those permitted by District of Columbia law.
- A plan is primary if the Member claiming benefits is the person in whose name the policy is issued but is not a Dependent under that coverage.
- If both plans cover the Member as a Dependent, the benefits of the plan of the parent whose birthday occurs earlier in the year are primary before those of the plan of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the plan that has covered **the parent** and Dependent(s) longest is primary over the plan which has covered the **other parent** and Dependent(s) for a shorter period of time.
- When the parents are separated or divorced, and the parent with custody of the child has not remarried, the custodial parent's plan is primary. The plan of the parent without custody is secondary.
- When the parents are divorced and the parent with custody has remarried, the custodial parent's plan is primary. The stepparent's plan is secondary, and the plan of the parent without custody pays **after** the stepparent's plan.
- The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent).
- When the above rules do not establish the order of benefit determination, the plan which has covered the Member for the longest period of time is primary.

Right to Receive and Release Necessary Information We may release to or obtain from any insurance company or other organization or person any information which we may need to carry out the terms of this section. You will furnish to us such information as may be necessary to carry out the terms of this section.

Convenience of Payment When Payments that would have been made under this Plan have already been made under another plan, we reserve the right to Pay directly to the other plan any amounts that are necessary to carry out the intent of this section. Any such Payments to the other plan will be considered as benefits Paid to you or on your behalf for Covered Services under this Plan.

Right of Recovery If we have overpaid for Covered Services under this provision, we shall have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the Payments were made, at anytime within 18 months from the date of Payment.

Execution of Papers You must, upon request, execute and deliver those materials and papers that may be necessary to carry out the provisions of this section.

EFFECT OF MEDICARE

Active Employees and Spouses Age 65 and Over - When an Employee in Active Service who is age 65 or over and when the covered Dependent Spouse of any such Employee who is age 65 or over becomes eligible for Medicare, the individual must choose either of the following options:

- a. Primary coverage under this Plan (under this option, benefits provided under this Plan will be paid without regard to Medicare);
- b. Sole coverage provided under Medicare (under this option, coverage under this Plan will terminate).

If the individual does not choose either of the above options in writing, this Plan will be primary.

Retirees and Spouses Age 65 and Over – AMHIC eligible retirees and Spouses who are eligible for Medicare must be enrolled in Medicare Parts A & B. Medicare is primary and the plan will be secondary for the participant if the individual is age 65 and over and retired. Medicare is primary and the plan will be secondary for the dependent Spouse if both the participant and their covered dependent Spouse are 65 and retired.

If the Medicare eligible retiree (or Spouse) does not enroll in Medicare Parts A & B and provide the appropriate proof of enrollment, the AMHIC plans will pay as if Medicare were primary.

Disability Due to End Stage Renal Disease (ESRD) - If a Participant becomes eligible for benefits under Medicare as a result of Disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payer for the first 30 months of Disability, in addition to the 3 month Waiting Period or a maximum of 33 months, when applicable. After the initial 30 or 33 months, Medicare will be the primary payer as determined by the Social Security Act and the Omnibus Reconciliation Acts, as amended.

Disability (other than End Stage Renal Disease) and Medicare - Medicare is the primary payer for individuals entitled to Medicare due to Disability (other than End Stage Renal Disease) and under age 65 who have coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a family Member then Medicare is the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

COBRA and MEDICARE

Medicare due to ESRD at the time of COBRA election – Medicare is the secondary payer for individuals entitled to Medicare due to ESRD who have coverage under another group health plan for the first 30 months of Medicare entitlement. After 30 months, Medicare becomes the primary payer.

Medicare due to Age at the time of COBRA election – Medicare is the primary payer and the COBRA plan the secondary payer. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a Spouse of any age then Medicare is the secondary payer.

Medicare due to Disability at the time of COBRA election - Medicare is the primary payer for individuals entitled to Medicare due to Disability and under age 65 who have COBRA coverage under a plan covering 100 or more employees. However, if the coverage under the group health plan is by virtue of the “current employment status” of the individual or a family Member then Medicare is the secondary payer.

SECTION 14

PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan agrees to the following:

1. The Plan will not disclose PHI to Association Mutual Health Insurance Company (AMHIC), in its capacity as The Plan, unless it receives a certification by The Plan that the plan documents have been amended to incorporate the required provisions.
2. PHI may be disclosed from the Group Health Plan to Members of AMHIC's designated administrator, as necessary, for AMHIC to carry out the Plan Administration functions as The Plan. The disclosure may be made without the authorization of the individual to whom the information pertains if the plan documents meet the requirements of this Policy and the Standards for Employee Welfare Benefit Plan documents: Privacy of Protected Information policy. The following disclosures are NOT permitted without the individual's authorization:
 - 2.1 Disclosures by a health insurance company or health maintenance organization that provides benefits to AMHIC associations through its Group Health Plan, if the disclosures do not comply with the provisions of the plan documents;
 - 2.2 Disclosures to the Employer for purposes of employment-related actions, or for decisions in connection with any other benefit or employee benefit plan offered by AMHIC.
3. The Plan agrees it will not use or further disclose PHI received from the Group Health Plan other than as permitted or required by the plan documents or as required by law.
4. The Plan agrees that it will ensure that any agents, including any subcontractor, to whom it provides PHI received from the Group Health Plan will not use or further disclose PHI received other than as permitted or required by the plan documents or as required by law, and it agrees to the same restrictions and conditions within this amendment that apply to The Plan with respect to such information.
5. The Plan will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.
6. The Plan will agree to report to the Group Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted or required by the plan documents of which it becomes aware.
7. The Plan will agree to permit individuals to have access to any PHI, which it has received from the Group Health Plan, in accordance with AMHIC's Rights of Access to Protected Health Information policy.
8. The Plan will agree to make available protected health information for amendment and incorporate any amendments to protected health information in accordance with AMHIC's Individual Requests to Amend Health Information policy.
9. The Plan will agree to make available the information required to provide an accounting of disclosures in accordance with AMHIC's Accounting of Disclosures of

Health Information policy.

10. The Plan will agree to make its internal practices books, and records relating to the use and disclosure of protected health information received from the Group Health Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Group Health Plan with Federal privacy regulations regarding PHI.
11. The Plan will agree, if feasible, to return or destroy all PHI received from the Group Health Plan that The Plan still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
12. In order to provide adequate separation between The Plan and the Group Health Plan, those employees or classes of employees described below, under the control of The Plan may be given access to PHI for disclosure. Any employee or person who receives PHI relating to Payment, Health Care Operations, or other matters pertaining to the Group Health Plan in the ordinary course of business are included in this description.
 - 12.1 Those who are assigned to the administration of the Group Health Plan. This includes claim processing, maintenance of enrollment and eligibility records, analysis of payment and utilization data, and other matters pertaining to the ordinary course of business of the Group Health Plan.
 - 12.2 Others who are authorized to have access to PHI on behalf of AMHIC in its role as The Plan, for purposes permitted by the plan documents.
13. The Plan will agree to restrict the access to and use of PHI received from the Group Health Plan by staff (as described in item 12 above) to the Plan Administration functions that The Plan performs for the Group Health Plan.
14. The Plan agrees to implement an effective mechanism for resolving any issues of noncompliance in the event any Member of the staff who is authorized to have access to the Group Health Plan's PHI violates any of the provisions of the plan documents as set forth in this policy and will include disciplinary action up to and including termination of employment.

SECTION 15

HIPAA SECURITY STANDARDS

Plan Sponsor Obligations - Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the AMHIC in its capacity as the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter or more frequently upon the Plan's request.

SIGNATURE PAGE

APPROVED AND ACCEPTED

IN WITNESS, Whereof, this document is executed at:

Silver Spring MD
City State

By: Rhona N. Byer
Signature

Rhona N. Byer, Executive Director
Name and Title

10/8/08
Date

ON BEHALF OF:

Association Mutual Health Insurance Company Network Health Benefit Plan

S. Saly
Witness Signature

10/8/08
Date

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.

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
NETWORK ONLY HEALTH BENEFIT PLAN**

Amendment 2

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 ADD that HIV screening is covered when performed in a hospital emergency room as follows:

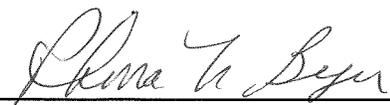
TYPE OF EXPENSE	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Hospital and Other Facility Expenses		
Emergency Room – for HIV screening	100%	100%
Professional Expenses		
Emergency Care in Emergency Room - for HIV screening	100%	100%

The foregoing amendment is effective April 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

7/20/09
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
Birthing 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.

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
NETWORK ONLY HEALTH BENEFIT PLAN**

Amendment 3

The Association Mutual Health Insurance Company Network Only 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 #10.) 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, 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 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, and non-covered services

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

This section has been amended to ADD a copay as follows:

Other Eligible Expenses		
Urgent Care	\$50 copay, then 100%	Not Covered

6. Section 2, Summary of Benefits, Mental Health and Substance Abuse – This section is AMENDED to reflect the addition of a copay for Inpatient Hospital or Residential Care services and a decrease to the Outpatient copay as follows:

	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 *	\$200 copay per confinement, then 100%	Not Covered
Inpatient Physician Visits	80% After deductible	Not Covered
Outpatient*	\$25 copay per visit, then 100%**	Not Covered
** 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.

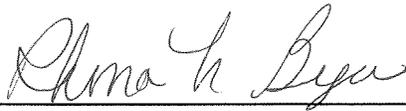
The foregoing amendment is effective January 1, 2010.

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
Network Only Health Benefit Plan

12/04/09
Date

By: 
Authorized Signature

**ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
NETWORK ONLY HEALTH BENEFIT PLAN**

Amendment 4

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

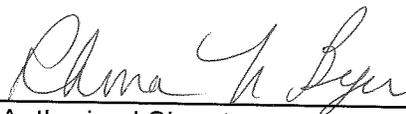
1. **Section 4, Membership Eligibility, Enrollment, Effective Date, Termination, and COBRA, Who is Eligible? - Dependents** – This section is AMENDED to reflect an INCREASE to the age limit for a child and REMOVAL of the full-time student requirement as follows:
 - a) A legal Spouse as defined by applicable state law.
 - b) A child who is the natural or legally adopted child of the Participant, through the end of the year in which the child becomes age 26.
 - c) Your same or opposite-gender Domestic Partner as defined by the Association Mutual Health Insurance Company Domestic Partner Policy;
 - d) A child age 26 and older who is incapable of self-support because of mental incompetence or severe physical handicap and is Dependent on the Participant for financial support, as certified by a Physician and us. The condition must begin before or during the month in which the child reached age 26. We require proof acceptable to us of the child's physical or mental Disability each Insured's Benefit Year.
 - e) Any child of a Participant who does not qualify as a Dependent under subsections b or d above, solely because the child is not primarily Dependent upon the Participant for support so long as over half of the support of the child is received by the child from the Participant pursuant to a multiple support agreement.

The foregoing amendment is effective May 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 Health Insurance Company
Network Only Health Benefit Plan

6/30/10
Date

By: 
Authorized Signature

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY
NETWORK ONLY HEALTH BENEFIT PLAN

Amendment 5

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 for Network Only 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. **Professional Expenses** - Physician Office Visit – Primary Care Physician (PCP): The copay is INCREASED to a \$25 copay per visit, then 100%;
- d. **Professional Expenses** - Physician Office Visit – Primary Care Physician (PCP): The definition of a PCP is expanded to include Psychiatrist and Psychologist;
- e. **Professional Expenses** – Physician office visit – Specialist: The copay is INCREASED to a \$35 copay per visit, then 100%;
- f. **Other Eligible Expenses** – Acupuncture: The copay is INCREASED to a \$35 copay per visit, then 100%;
- g. **Other Eligible Expenses** – Allergy Testing: The *Primary Care Physician* copay is INCREASED to a \$25 copay, then 100%, and the *Specialist* copay is INCREASED to a \$35 copay, then 100%;
- h. **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 \$25 copay per visit – PCP;
- i. **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 \$35 copay per visit, then 100% - Specialist;
- j. **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 PPO Provider (In-Network) benefit is 100%, and the Non-PPO Provider (Out-of-Network) benefit is Not Covered;
- k. **Mental Health and Substance Abuse** - Outpatient: The Pre-certification requirement is REMOVED;
- l. **Prescription Drugs** - Formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to \$35, and the Mail Order (90-day supply) copay has INCREASED to \$70;
- m. **Prescription Drugs** - Non-Formulary Brand Drugs: The Retail (30-day supply) copay has INCREASED to \$70, and the Mail Order (90-day supply) copay has INCREASED to \$140.

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 #3, 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 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
Network Only Health Benefit Plan

11/18/10
Date

By: 
Authorized Signature

ASSOCIATION MUTUAL HEALTH INSURANCE COMPANY

NETWORK ONLY 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 benefit, 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. Please refer to Section 5.</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
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
<p>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 and non-covered services.</p>	

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 - for HIV screening	100%	100%
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%
Emergency Care in Emergency Room - for HIV screening	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, OB/GYN, Psychiatrist, Psychologist)	\$25 copay per visit, then 100%	Not Covered
Physician office visit - Specialist	\$35 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 InforMed is required. Contact them prior to admittance to an In 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	PPO Provider (In-Network)	Non-PPO Provider (Out-of-Network)
Other Eligible Expenses		
Acupuncture (maximum of \$2,000 per calendar year)	\$35 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	\$25 copay, then 100% \$35 copay, then 100%	Not Covered
Ambulance	Not available In-Network, seek Non-Network Provider	\$75 Copay, then 100% of Allowed Benefit
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 Center	\$50 copay, then 100%	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)	\$25 copay per visit – PCP \$35 copay per visit - Specialist, 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		
Preventive and Wellness Services for eligible adults and children in compliance with the Patient Protection and Affordable Care Act of 2010.	100%	Not Covered
Mental Health and Substance Abuse		
Inpatient Hospital or Residential Care in a Hospital or Non-Hospital Residential Facility *	\$200 copay per confinement, then 100%*	Not Covered
Inpatient Physician Visits	80% After deductible	Not Covered
Outpatient	\$25 copay per visit, then 100%	Not Covered

* Pre-certification from InforMed is required. Contact them prior to admittance to an In 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	\$20
Formulary Brand Drugs	\$35	\$70
Non-formulary Brand Drugs	\$70	\$140
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	

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.
10. 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.