



Triple Tier™

For Groups of 2-50 Employees

Benefit Chart and Plans for Ohio

Ohio



PLAN CHOICES	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Plan 1 — Network Services	Network: You pay \$40 Copay per visit, then we pay 100%	Network Deductible: \$1,000 (Single) \$2,000 (Family)	
		We pay 90%	We pay 70%
		Out-of-Pocket Maximum: \$5,000 (Single) \$10,000 (Family)	
Plan 2 — Network Services	Network: You pay \$50 Copay per visit, then we pay 100%	Network Deductible: \$3,000 (Single) \$6,000 (Family)	
		We pay 90%	We pay 70%
		Out-of-Pocket Maximum: \$7,000 (Single) \$14,000 (Family)	
Non-Network (Unless otherwise specified)	You pay 2x network Copay per visit, then we pay 50%	You pay 2x network deductible, then we pay 50%	You pay 2x network deductible, then we pay 50%
Lifetime Policy Maximum	\$5 million		
Networks Available	SuperMed Plus ~ PHCS		

Accident Benefit	
Accident	We will waive the copay or deductible and pay the covered charges at the benefit percentage shown on the policy schedule for services incurred within 30 days of an injury. The copay or deductible will be applied to any covered charges incurred after the 30-day limit has been met.

COVERED EXPENSES	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Physician Services			
Office Visits, Urgent Care or Office Surgery Sickness or Injury Office Surgery & follow-up visits Lab Tests (not sent to an independent lab) Consultations X-rays			
Preventive Care Maximum: \$500 per person per benefit period Routine Physical Exams Lab Tests X-rays Pap Smears Immunizations Prostate Exams Pelvic Exams Bone Density Tests Colonoscopy Inoculations or Prophylactic Drugs for Travel	Network: Subject to Copay per visit, then we pay 100% Non-Network: Subject to 2x network Copay per visit, then we pay 50%		
Screening Mammograms	Network: We pay 100% Non-Network: Subject to 2x network Copay per visit, then we pay 50%		
Allergy Testing, Serums & Injections Maximum: \$500 per person per benefit period	Network: We pay 100% (Copay does not apply) Non-Network: Subject to 2x network Copay per visit, then we pay 50%		
Spinal Manipulation Maximum: \$500 per benefit period	Network: Subject to Copay per visit, then we pay 100%		
Well Child Care Benefit \$500 for first year of life, including hearing screening (limited to \$75) \$150 per year for second through ninth year of life	Non-Network: Subject to 2x network Copay per visit, then we pay 50%		

	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Hospital, Hospital Emergency Room and Ambulance Services, Surgical, Diagnostic Center			
Maternity		Network: Subject to deductible, then we pay 90% Non-Network: Subject to 2x network deductible, then we pay 50%	
Physician or Surgeon Services Medical Surgery Consultations		Network: Subject to deductible, then we pay 90% (while confined in a hospital) Non-Network: Subject to 2x network deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to 2x network deductible, then we pay 50%

COVERED EXPENSES	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Medical Services and Supplies furnished by the hospital Intensive Care (Room & Board) Room & Board (semi-private) Routine Nursing Care Medication and Medical Supplies Meals		Network: Subject to deductible, then we pay 90% (while confined in a hospital) Non-Network: Subject to 2x network deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to 2x network deductible, then we pay 50%
Ambulance <i>Emergency Only</i>		Network & Non-Network Services: Subject to Network deductible, then we pay 90%	
Hospital Emergency Room Doctor Charges <i>Emergency Only</i>		Network & Non-Network Services: Subject to Network deductible, then we pay 80%	
Hospital Emergency Room Facility Charge Emergency Illness Emergency Injury		Network & Non-Network Services: \$50 Copay per visit (waived if admitted), then subject to Network deductible, then we pay 90%	
Non-Emergency Illness		Network: Subject to deductible, then we pay 50% Non-Network: Subject to 2x network deductible, then we pay 50%	
Organ Transplants Lifetime benefit maximum is \$1 million when performed in a designated transplant facility and includes \$10,000 for travel or lodging expenses for the insured and one companion (meals and lodging are limited to \$150 per day). Lifetime benefit maximum is \$150,000 when performed in a non-designated transplant facility.		Network: Subject to deductible, then we pay 90% Non-Network: Subject to 2x network deductible, then we pay 50%	
Hospice Care Maximum Benefit: \$200 per day \$500 for support services Lifetime Maximum: \$7,500			
Skilled Nursing Facility Maximum Benefit: \$75 per day for room & board, 30 days per benefit period			
Professional Fees Radiology Anesthesiology Pathology		Network: Subject to deductible, then we pay 90% (while confined in a hospital) Non-Network: Subject to 2x network deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to 2x network deductible, then we pay 50%
Home Health Care Maximum Benefit: 30 visits per benefit period		Network: Subject to deductible, then we pay 90%	
Physical, Occupational & Speech Therapy Maximum Benefit: 30 visits per benefit period for all therapies combined		Non-Network: Subject to 2x network deductible, then we pay 50%	
Durable Medical Equipment			
Ancillary & Diagnostic Services Diagnostic X-ray and Lab Tests Nuclear Medicine Diagnostic Mammograms MRI, CAT Scans, Ultrasounds X-ray Therapy, Radiation Therapy Chemotherapy		Network: Subject to deductible, then we pay 90% (while confined in a hospital) Non-Network: Subject to 2x network deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to 2x network deductible, then we pay 50%
Mental Health Combined Inpatient & Outpatient Maximum \$5,000 per benefit period \$10,000 per Lifetime Outpatient Maximum: \$1,000 per benefit period		Network: Subject to deductible, then we pay 90% Non-Network: Subject to 2x network deductible, then we pay 50%	
Substance Abuse Combined Inpatient & Outpatient Maximum per benefit period Alcohol: \$1,000 Drugs: \$1,000			
TMJ (Temporomandibular Joint Dysfunction, malocclusion, or misalignment of the jaw) \$1,000 Lifetime Maximum	Subject to copay, deductible, and benefit percentages		

Prescription Drug Plans

Included Prescription Drug Plan	Generic Drugs Only: \$10 Copay
Optional Prescription Drug Plans	High Plan: \$10 / \$25 / \$40; Mail Order \$25 / \$60 / \$100 Medium Plan: 10% / 30%; Mail Order \$25 / \$75 Generic Drugs Only / Mail Order: Generic \$10; Mail Order \$25 / \$60 / \$100 Mail Order Program: \$25 / \$60 / \$100

Pre-Existing Condition Limitation

A pre-existing condition is an illness for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period prior to the insured individual's enrollment date. No benefits are payable for pre-existing conditions until the individual has been covered under the policy for 12 months if a timely enrollee, or 18 months if a late enrollee. This exclusion does not apply to pregnancy, newborn children, or adopted children under age 19, if such children become covered within 31 days of birth, adoption, or placement for adoption.

Creditable Coverage Towards Pre-Existing Condition Limitation

An employee and/or dependent who was covered under a health benefit plan before the effective date of this plan will be given credit toward satisfaction of the pre-existing condition limitation under this plan (if any applies). The credit will be for the length of time the person was covered under the prior health benefit plan(s). Such credit applies only if fewer than 63 days have elapsed since coverage under the prior health benefit plan ended. Should an individual be subject to a pre-existing condition limit after crediting prior coverage, the employer will receive a letter indicating the time each individual has left until such limitation expires.

Employer Waiting Period

The Waiting Period is the period of time, established by an employer, that must pass before an individual is eligible for benefits. The Waiting Period is not considered a gap in coverage for purposes of calculating periods of creditable coverage. American Community will not impose a Waiting Period.

Rating Guidelines

When a group is issued, American Community prices it according to the group's demographics (i.e. number of employees, employee age, employee gender, geographical location) and the plan's features (i.e. payment provisions, levels of benefits and limits on benefits, such as for pre-existing conditions). Further considerations may include employee and dependent health status and type of business. Rates change at the beginning of each month when an employee enters a new age bracket. The premium rate for a class will never be more than 208% of our new business rate for that class of business. American Community will not reclassify a group to a less favorable class at renewal. We must give a group 30 days notice of a rate change.

Rate Changes and Characteristics

Any increase is limited to the change in the new business rate since the group's last increase, plus up to an additional 15% per year, assuming the group's demographic and plan characteristics remain the same. For example, if the new business rate has increased 3% since the group's last increase, the most the current increase could be is 3%, plus up to 15%, for a total increase of 18%. The increase over and above the new business rate could vary from group to group based on age, gender, geographic area, group size, health status and industry, unless otherwise prohibited by law.

Simplified Underwriting

Underwriting of new business is performed on a "whole group" basis. When submitting a new group, all full-time, eligible employees must submit an application.

Information contained in both the employer and employee applications will be used to determine the risk and the rates to be used for the group as a whole. If the group meets the eligibility requirements, all eligible applicants will be covered. Proposed rates and actual rates may differ if the enrollment census changes from the proposal census or due to additional medical risk disclosed at enrollment. All groups are classified by industry based on the Standard Industrial Classification. Certain industries are considered unstable, hazardous or high risk and will require an additional premium.

Renewability

This plan is renewable for insured employees and dependents at the option of the employer, except in any one of the following cases:

1. Fraud or misrepresentation by the employer or, for coverage of an insured individual, fraud or misrepresentation by the insured individual, or the individual's representative;
2. Non-payment of premium;
3. Failure to meet participation requirements;
4. Non-compliance with employer contribution requirements;
5. American Community elects not to renew a particular plan in the small group market in this state;
6. American Community elects not to renew all its health benefit plans delivered or issued for delivery to small group employers in this state.

Group Participation Guidelines

The employer is required to meet and maintain the following minimum participation requirements:

1. For Life Insurance, Accidental Death and Dismemberment and Weekly Income benefits, 100% of the employer's eligible employees must apply.
2. For all other coverages:
 - Groups of 2 to 5 employees — 100% of eligible employees
 - Groups of 6 or more employees — 75% of eligible employees
 - All group sizes — At least 50% of all employees of an eligible class must enroll.

These participation requirements apply to both new groups and inforce groups.

Employee Eligibility

An eligible employee is an employee who works at least 30 hours per week (or as otherwise determined by the employer) and is receiving earnings reportable to the IRS. Owners and partners are eligible if they meet the same requirements as an eligible employee.

Dependent Eligibility

An eligible dependent is a spouse and/or an unmarried, legally dependent child from birth to age 19, or to age 25 if a student in an accredited college or university (12 credit hours minimum).

Group Eligibility

An eligible employer is an employer who employed an average of at least 2 but not more than 50

eligible employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Contract workers, commissioned salespersons with no base salary, associated professions and work-for-fee persons are not eligible.

Groups with employees located in states other than where the group is located will be considered only if certain conditions are met. If acceptable, area rating factors may apply.

General Exclusions & Limitations

Some of the services that the Triple Tier Plan does not cover include:

Any illness or dental benefit, including accidental bodily injury, which arises out of or in the course of any employment with any employer; or for which the Insured Individual is entitled to benefits under any Worker's Compensation Law or Occupational Disease Law; or for which the Insured Individual receives any settlement or redemption from a worker's compensation carrier, except as provided in the policy; Losses which are due to war or any act of war, whether declared or undeclared; Charges incurred or disability claimed while an Insured Individual is not under the direct care of a doctor; Losses due to committing or attempting to commit a felony; Charges which are not necessary to the care or treatment of an illness, or which are illegal, or which are experimental, investigational or unproven; Charges which would not have been made if no insurance existed; Charges which an Insured Individual is not legally obliged to pay; Charges which are in excess of the usual, customary and reasonable charges for services and materials for non-network services and materials; Charges for treatment by a doctor which is not within the scope of his or her license; Charges for which benefits are not provided in the policy; Charges for dental services or supplies for treatment of the teeth, gums or alveolar processes if dental benefits are not included in the policy; Charges for the purchase of hearing aids; Charges for eye glasses or contact lenses or the fitting of them, if vision benefits are not included in the policy; Charges for treatment for cosmetic purposes or for cosmetic surgery except as provided in the policy; Charges for services of a person who usually lives in the same household as the Insured Individual, or who is a member of his or her immediate family or the family of his or her spouse; Charges for services or supplies furnished by an agency of the United States Government or a foreign government agency, unless excluding them is prohibited by law; Charges due to a Pre-existing Condition as provided in the policy; Charges for professional services in connection with care for dislocations and subluxations of the vertebrae in excess of the maximum amount provided in the policy; Charges for Treatment of Temporomandibular Joint Dysfunction (TMJ), malocclusion or misalignment of the jaw in excess of the \$1,000 lifetime maximum; Charges for vitamins and food supplements; Charges for contraceptives, contraceptive materials, and contraceptive devices of any kind except as provided in the policy; Charges for routine examinations and immunizations, except as provided in the policy; Charges for treatment of obesity, or weight loss; Charges for prescription drugs when the Insured Individual is not confined unless covered under the transplant benefit or the Prescription Drug Coverage option is included in the policy; Charges for care, treatment, or services provided by an employee's employer.

THE FOLLOWING EXCLUSIONS APPLY TO THE PRESCRIPTION DRUG COVERAGE OPTIONS IF INCLUDED IN THE POLICY: The following are not prescription drugs for purposes of the policy, and no benefits will be payable for: Non-federal legend drugs; All fluoride products; drugs for weight loss, including anorexians and amphetamines, and weight loss products; Cosmetics, dietary supplements, health or beauty aids; Needles and syringes; Therapeutic devices or appliances; Drugs for which the primary purpose is to stimulate hair growth; Immunization agents, biological sera, blood or blood plasma; Any prescription refilled after one year from the doctor's original order or in excess of number of refills specified; Medication for which the cost is recoverable under any Worker's Compensation or Occupational Disease Law, or any state or governmental agency; Medication which is to be taken by or administered to the Insured Individual, in whole or in part, while they are a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals; Medication furnished by any other drug or medical service for which no charge is made to the Insured Individual; Medication or drugs delivered or administered to the Insured Individual by the prescriber; Medication or drugs labeled, "Caution — Limited by Federal Law to Investigational Use", or experimental drugs even though a charge is made to the Insured Individual; All vitamins; Drugs to deter smoking; All fertility drugs; Injectables or any prescription directing parenteral administration or use, except insulin; Oral, injectable or topical agents to improve physical or cosmetic appearance; Federal legend drugs for which a non-prescription equivalent is available, regardless of dose; Drugs for the treatment of onychomycosis (nail fungus); Growth hormones or medications; or contraceptive devices and emergency contraceptive kits.

This benefit chart is a brief description of the highlights of the Triple-Tier PPO Plan, Policy Form TIER-CONT-OH. It is not intended to be a full description of coverage. The master policy is issued to a trust in the state of Ohio. Should an employee apply for coverage and be accepted, a Certificate of Insurance will be issued with a complete description of benefits and exclusions. The certificate includes complete details of all plan provisions and is the governing document in case of discrepancies.



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