

APEP CHOICES™
BENEFIT CHART



OHIO

PLAN 1	NETWORK	NON-NETWORK
Deductible	\$500 (Single) \$1,000 (Family)	\$1,000 (Single) \$2,000 (Family)
Benefit Percentage	90%	70%
Office Visit Copay	\$20 Office Visit Copay \$40 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$1,750 Family - \$3,500	Single - \$3,500 Family - \$7,000
PLAN 2	NETWORK	NON-NETWORK
Deductible	\$750 (Single) \$1,500 (Family)	\$1,500 (Single) \$3,000 (Family)
Benefit Percentage	90%	70%
Office Visit Copay	\$25 Office Visit Copay \$50 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$2,500 Family - \$5,000	Single - \$5,000 Family - \$10,000
PLAN 3	NETWORK	NON-NETWORK
Deductible	\$1,000 (Single) \$2,000 (Family)	\$2,000 (Single) \$4,000 (Family)
Benefit Percentage	90%	70%
Office Visit Copay	\$30 Office Visit Copay \$60 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$2,250 Family - \$4,500	Single - \$4,500 Family - \$9,000
PLAN 4	NETWORK	NON-NETWORK
Deductible	\$1,500 (Single) \$3,000 (Family)	\$3,000 (Single) \$6,000 (Family)
Benefit Percentage	90%	70%
Office Visit Copay	\$35 Office Visit Copay \$70 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$4,000 Family - \$8,000	Single - \$8,000 Family - \$16,000
PLAN 5	NETWORK	NON-NETWORK
Deductible	\$2,500 (Single) \$5,000 (Family)	\$5,000 (Single) \$10,000 (Family)
Benefit Percentage	90%	70%
Office Visit Copay	\$40 Office Visit Copay \$80 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$5,000 Family - \$10,000	Single - \$10,000 Family - \$20,000
PLAN 6	NETWORK	NON-NETWORK
Deductible	\$500 (Single) \$1,000 (Family)	\$1,000 (Single) \$2,000 (Family)
Benefit Percentage	80%	60%
Office Visit Copay	\$20 Office Visit Copay \$40 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$2,500 Family - \$5,000	Single - \$5,000 Family - \$10,000

PLAN 7	NETWORK	NON-NETWORK
Deductible	\$750 (Single) \$1,500 (Family)	\$1,500 (Single) \$3,000 (Family)
Benefit Percentage	80%	60%
Office Visit Copay	\$25 Office Visit Copay \$50 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$3,750 Family - \$7,500	Single - \$7,500 Family - \$15,000
PLAN 8	NETWORK	NON-NETWORK
Deductible	\$1,000 (Single) \$2,000 (Family)	\$2,000 (Single) \$4,000 (Family)
Benefit Percentage	80%	60%
Office Visit Copay	\$30 Office Visit Copay \$60 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$3,000 Family - \$6,000	Single - \$6,000 Family - \$12,000
PLAN 9	NETWORK	NON-NETWORK
Deductible	\$1,500 (Single) \$3,000 (Family)	\$3,000 (Single) \$6,000 (Family)
Benefit Percentage	80%	60%
Office Visit Copay	\$35 Office Visit Copay \$70 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$5,500 Family - \$11,000	Single - \$11,000 Family - \$22,000
PLAN 10	NETWORK	NON-NETWORK
Deductible	\$2,500 (Single) \$5,000 (Family)	\$5,000 (Single) \$10,000 (Family)
Benefit Percentage	80%	60%
Office Visit Copay	\$40 Office Visit Copay \$80 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$6,500 Family - \$13,000	Single - \$13,000 Family - \$26,000
PLAN 11	NETWORK	NON-NETWORK
Deductible	\$1,500 (Single) \$3,000 (Family)	\$3,000 (Single) \$6,000 (Family)
Benefit Percentage	100%	70%
Office Visit Copay	\$25 Office Visit Copay \$50 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$1,500 Family - \$3,000	Single - \$15,000 Family - \$30,000
PLAN 12	NETWORK	NON-NETWORK
Deductible	\$2,500 (Single) \$5,000 (Family)	\$5,000 (Single) \$10,000 (Family)
Benefit Percentage	100%	70%
Office Visit Copay	\$30 Office Visit Copay \$60 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$2,500 Family - \$5,000	Single - \$14,000 Family - \$28,000

PLAN 13	NETWORK	NON-NETWORK
Deductible	\$3,500 (Single) \$7,000 (Family)	\$7,000 (Single) \$14,000 (Family)
Benefit Percentage	100%	70%
Office Visit Copay	\$35 Office Visit Copay \$70 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$3,500 Family - \$7,000	Single - \$16,000 Family - \$32,000
PLAN 14	NETWORK	NON-NETWORK
Deductible	\$5,000 (Single) \$10,000 (Family)	\$10,000 (Single) \$20,000 (Family)
Benefit Percentage	100%	70%
Office Visit Copay	\$40 Office Visit Copay \$80 Urgent Care Visit Copay	Subject to deductible and benefit percentage
Out-Of-Pocket (including deductible)	Single - \$5,000 Family - \$10,000	Single - \$28,000 Family - \$56,000

APEP Choices		
Prescription Drug Plans Maximum Supply: 31 days retail; 90 days mail order. <i>If a Select Brand Name Drug or an Additional Brand Name Drug is chosen when a Generic Drug is available, then you are responsible for the Generic Drug copayment plus the difference between the cost of the Select Brand Name Drug or the Additional Brand Name Drug and the Generic Drug.</i>	Included: Discount Drug Card	
	High Plan - \$10/\$25/\$40; Mail Order - \$25/\$65/\$100	
	Medium Plan - \$15/\$40/\$60; Mail Order - \$40/\$100/\$150	
	\$500 deductible (Retail and/or Mail Order), then \$15/\$40/\$60; Mail Order - \$40/\$100/\$150	
Lifetime Policy Maximum	\$5 Million	
Network	PHCS~SuperMed Plus	
Hospital Services	NETWORK	NON- NETWORK
Hospital Facility Charges	Subject to network deductible and benefit percentage	
Emergency Admission		
Non-Emergency Admission	Subject to deductible and benefit percentage	
Emergency Room Services	Subject to network deductible and benefit percentage \$100 Copay (waived if admitted)	
Emergency Illness		
Non-Emergency Illness	Not Covered	
Outpatient Services (at hospital)	NETWORK	NON-NETWORK
Pre-admission testing, x-rays, lab, mammograms, outpatient surgery, CAT scans, MRIs, Ultrasounds	Subject to deductible and benefit percentage	
Physician Services	NETWORK	NON-NETWORK
Office visits, office surgery, x-rays and lab tests not sent to an independent lab	Subject to a Copay, then paid at 100%	Subject to deductible and benefit percentage

Physician Services	NETWORK	NON-NETWORK
Urgent Care Visit Copay	Subject to 2x regular office visit copay, then paid at 100%	Subject to deductible and benefit percentage
Allergy Testing & Serums	Subject to deductible and benefit percentage	
Allergy Injections	Copay waived. Paid at 100%	Subject to deductible and benefit percentage
Professional services for dislocation or subluxation of the vertebrae (includes office visits, x-rays, and therapies). Limited to 15 visits per benefit period	\$40 copay per visit, then 100%	Subject to deductible and benefit percentage
Inpatient Physician Fees Medical, surgical, consultations	Subject to deductible and benefit percentage.	
Radiology, Anesthesiology, Pathology	If network facility, then subject to network deductible and benefit percentage (regardless if non-network provider)	If non-network facility, then subject to non-network deductible and benefit percentage
Covered Services	NETWORK	NON-NETWORK
Preventive Care Benefits (Maximum Policy Limit \$1,000) Physical exams, immunizations, pelvic exams, prostate exams, bone density tests, colonoscopy, inoculations or prophylactic drugs for travel, Pap smears, and lab tests	Copay applies, then paid at 100% subject to maximum policy limit	Subject to deductible and benefit percentage
State mandated benefits may be covered differently. See the State Specific Mandates section.		
Outpatient Diagnostic Services performed at an Outpatient Surgical Center X-ray, nuclear medicine, mammograms, lab work sent to an independent lab	Copay per visit/service, then 100%	Subject to deductible and benefit percentage
CAT scans, MRIs, Ultrasounds	Subject to deductible and benefit percentage	
Other Covered Services	NETWORK	NON-NETWORK
Accident Benefit	Waive deductible for first 30 days for covered charges incurred within the first 30 days of an injury.	
Maternity	Included for all group sizes - subject to deductible & benefit percentage	
Screening Mammograms Do not count toward preventive care maximum	Paid at 100%	Subject to deductible and benefit percentage
Chemotherapy (regardless of location)	Subject to deductible and benefit percentage	
Infusion Therapy (regardless of location)		
Sclerotherapy (regardless of location)		
Physical, Occupational and Speech Therapy Professional Fees Limited to 45 visits per benefit period	Subject to deductible and benefit percentage	

Other Covered Services	NETWORK	NON-NETWORK
Skilled Nursing Facility Limited to 60 days per benefit period	Subject to deductible and benefit percentage	
Mental Health (included for all group sizes) Limited to 30 days inpatient, 40 visits outpatient per benefit period.	Subject to deductible and benefit percentage.	
Substance Abuse (included for all group sizes) Limited to 30 days inpatient, 40 visits outpatient, per benefit period. Inpatient admissions limited to 2 admissions per lifetime.	Subject to deductible and benefit percentage	
Home Health Care Limited to 60 visits per benefit period	Subject to deductible and benefit percentage	
Hospice Limited to \$200 per day, \$7,500 per benefit period (\$500 maximum for bereavement services)	Subject to deductible and benefit percentage	
Ambulance - Paid at the network benefit level. Emergency air ambulance subject to network deductible and benefit percentage, up to \$5,000 maximum payable per trip.		
Transplants - Lifetime benefit maximum is \$1,000,000 when performed in a designated transplant facility and includes \$10,000 for travel and lodging expenses for 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. \$1,000,000 combined lifetime maximum for designated and non-designated charges.		
TMJ (temporomandibular joint dysfunction), malocclusion, or misalignment of the jaw	Not Covered	
Eye Exam Plus 1 exam every 12 months	Subject to \$10 copay per exam	Not Covered
Covered Services - State Specific Mandates	NETWORK	NON-NETWORK
Well Child Care Applies to children under age 10. Limited to \$500 per benefit period for the 1st year (including \$75 for 1 hearing assessment) and \$150 per benefit period for the 2nd-9th years. Charges count towards the preventive care maximum.	Subject to a copay, then paid at 100%	Subject to deductible and benefit percentage
Biologically Based Mental Illness Covered same as any other illness	Subject to deductible and benefit percentage	
Optional Benefits	NETWORK	NON-NETWORK
Deductible Carry Over Available for Calendar Year Deductible option only	Covered charges incurred during the last 3 months of any calendar year which are applied to that year's deductible will also be applied to the next year's deductible	

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 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 233% 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 intentional misrepresentation by the employer or for coverage of an Insured Individual, 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 25 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 APEP Choices does not cover include:

No benefits are provided for: 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 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 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; 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.

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 except to treat diabetes; 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; Injectibles 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 APEP Choices Policy Form Number APEP II-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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