

## Coverage On Demand™

For Individuals & Families

Ohio Benefit Chart

| Coverage Levels  |   |  |  |  |
|--|---|--|--|--|
|  | Initial Level   | Additional Coverage Levels                               |  |  |
| Maximum Benefits Payable at each level, per person per benefit period for all covered charges  | Level 1<br>Up to \$5,000  | Level 2*<br>Up to \$15,000                               | Level 3*<br>Up to \$30,000                   | Level 4*<br>Over \$30,000                    |
| <b>Benefit Percentages</b> per person per benefit period for all covered charges. (Network / Non-Network)  | AC pays: 80% / 50%<br>You pay: 20% / 50%  | Once activated, AC pays: 100% / 70%<br>You pay: 0% / 30% | Once activated, AC pays: 100%<br>You pay: 0% | Once activated, AC pays: 100%<br>You pay: 0% |
| <b>Individual Deductibles per benefit period</b><br>Family Deductible: At least 2 family members must separately meet the individual deductible. | \$250 ~ \$500 ~ \$1,000<br>Both network and non-network covered charges apply toward the benefit period deductible. |  |  |  |
| <b>Lifetime Policy Maximum</b> per person  | \$5 Million   |  |  |  |
| <b>Provider Networks Available</b>   | PHCS~SuperMed Plus  |  |  |  |

| Accident Benefit |   |
|------------------|---|
| <b>Accident</b>  | Applies to any covered charges incurred due to an injury when treatment is received within 30 days after the injury is sustained. We will waive the deductible and pay the covered charges at the applicable benefit percentage. The deductible will be applied to any covered charges incurred after the 30-day limit has been met. However, if a single accident causes injury to more than one family member, only one deductible will be applied to any covered charges incurred after the 30-day limit has been met. |

|   | Level 1   | Level 2*  | Levels 3 & 4*   |
|---|---|---|---|
| <b>Physician Services</b>   | Benefit percentages apply after the deductible is met.  |   |   |
| <b>In Office and Urgent Care Centers</b><br>Visits for sickness, injury, surgery, or follow-up, including lab tests, X-rays, consultations, equipment, supplies, and injections (except allergy injections)   |   |   |   |
| <b>In-Hospital Services</b><br>Surgery; consultations; radiology; anesthesiology; pathology; physical, occupational and speech therapy  | Network Services: AC pays 80%, you pay 20%<br>Non-Network Services: AC pays 50%, you pay 50%                                      | Network Services: AC pays 100%, you pay 0%<br>Non-Network Services: AC pays 70%, you pay 30%                                      | Network & Non-Network Services: AC pays 100%, you pay 0%                                      |
| <b>Allergy Testing, Serums, and Injections</b><br>\$500 maximum benefit per person per benefit period   |   |   |   |
| <b>Outpatient Spinal Manipulation</b><br>\$500 maximum benefit per person per benefit period  |   |   |   |
| <b>Preventive Care (age 10 and older)</b><br>\$400 maximum benefit per person per benefit period<br>• Immunizations<br>• Routine Physical Exams<br>• PSA Testing<br>• Routine Mammograms<br>• Pap Smear<br>• Colonoscopy<br>• Inoculations or Prophylactic Drugs for Travel<br>• Bone Density Tests | <b>Deductible does not apply.</b><br>Network Services: AC pays 80%, you pay 20%<br>Non-Network Services: AC pays 50%, you pay 50% | <b>Deductible does not apply.</b><br>Network Services: AC pays 100%, you pay 0%<br>Non-Network Services: AC pays 70%, you pay 30% | <b>Deductible does not apply.</b><br>Network & Non-Network Services: AC pays 100%, you pay 0% |
| <b>Well Child Care Benefit</b><br>\$500 first year of life, including hearing screening (limited to \$75); \$150 per year for second through ninth year of life   |   |   |   |

\* Activation Fee required to move from one Coverage Level to the next.

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|--|--|--|--|
| <b>Hospital Services</b>   | Benefit percentages apply after the deductible is met.                                       |  |  |
| <b>Outpatient Services</b><br>Pre-admission testing, outpatient surgery, X-rays, lab tests   | Network Services: AC pays 80%, you pay 20%<br>Non-Network Services: AC pays 50%, you pay 50% | Network Services: AC pays 100%, you pay 0%<br>Non-Network Services: AC pays 70%, you pay 30% | Network & Non-Network Services: AC pays 100%, you pay 0% |
| <b>Inpatient</b><br>Non-emergency admissions   |  |  |  |
| <b>Inpatient</b><br>Emergency admissions   | Network & Non-Network Services: AC pays 80%, you pay 20%                                     | Network & Non-Network Services: AC pays 100%, you pay 0%                                     | Network & Non-Network Services: AC pays 100%, you pay 0% |
| <b>Emergency Room Services</b><br>Emergency sickness or injury (see Accident Benefit on page 1)  |  |  |  |
| Non-Emergency sickness   | Not Covered  | Not Covered  | Not Covered  |
| <b>Other Covered Services</b>  | Benefit percentages apply after the deductible is met.                                       |  |  |
| <b>Emergency Ambulance</b>   | Network & Non-Network Services: AC pays 80%, you pay 20%                                     | Network & Non-Network Services: AC pays 100%, you pay 0%                                     | Network & Non-Network Services: AC pays 100%, you pay 0% |
| <b>Diagnostic Services</b><br>X-rays and lab tests, nuclear medicine, diagnostic mammograms, MRIs, CAT Scans, and ultrasounds                          |  |  |  |
| <b>Facility Charges for Outpatient Surgery</b><br>For procedures performed in a free-standing outpatient surgery center or other non-hospital facility |  |  |  |
| <b>Home Health Care</b><br>Maximum of 20 visits per person per benefit period  |  |  |  |
| <b>Hospice</b><br>Up to \$200 per day, a lifetime maximum of \$15,000 or 6 months, whichever comes first; Bereavement support services up to \$500     | Network Services: AC pays 80%, you pay 20%<br>Non-Network Services: AC pays 50%, you pay 50% | Network Services: AC pays 100%, you pay 0%<br>Non-Network Services: AC pays 70%, you pay 30% | Network & Non-Network Services: AC pays 100%, you pay 0% |
| <b>Physical, Occupational and Speech Therapy</b><br>Maximum of 60 visits per person per benefit period for all therapies combined                      |  |  |  |
| <b>Skilled Nursing Facility</b><br>60 days per person per benefit period   |  |  |  |
| <b>Alcoholism Treatment</b><br>\$550 maximum benefit per person per benefit period   |  |  |  |
| <b>Outpatient Mental Health</b><br>\$550 maximum benefit per person per benefit period   |  |  |  |
| <b>Biologically Based Mental Illness</b><br>Inpatient and outpatient services  |  |  |  |

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|---|--|--|---|
| <b>Other Covered Services</b>   | Benefit percentages apply after the deductible is met.   |  |   |
| <b>Organ Transplants</b><br>Combined lifetime maximum benefit is \$1 million for both designated and non-designated transplant facilities. 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 person per day). Lifetime benefit maximum is \$150,000 when performed in a non-designated transplant facility. | Designated Transplant Facility: AC pays 80%, you pay 20%<br>Non-Designated Transplant Facility: AC pays 50%, you pay 50%   | Designated Transplant Facility: AC pays 100%, you pay 0%<br>Non-Designated Transplant Facility: AC pays 70%, you pay 30% | Designated & Non-Designated Transplant Facility: AC pays 100%, you pay 0% |
| <b>Optional Benefits</b>  | Do not count toward the maximum benefit payable at each level  |  |   |
| <b>Maternity Benefit for all Females on the Policy</b><br>270-day waiting period from the effective date of the maternity coverage  | Network & Non-Network Services: AC pays 100%, you pay 0%<br><b>Deductible does not apply.</b>  |  |   |
| <b>Dental Benefit</b><br>\$1,000 maximum benefit per person per benefit period  | Type I procedures: 6-month waiting period, then 80%<br>Type II procedures: 12-month waiting period, \$100 benefit period deductible, then 50%  |  |   |
| <b>Outpatient Prescription Drug Program</b>   | Covered charges for outpatient prescription drugs count toward maximum benefits payable at each level, however, these covered charges are subject to the copayment percentage shown below. <b>Benefits are not subject to the benefit period deductible.</b> |  |   |
| <b>Prescription Drug Card Program</b><br>Up to 31 days per prescription or refill.  | You pay 40% copay then AC pays 60%   |  |   |
| <b>Mail Order Drug Program</b><br>Up to 90 days per prescription or refill of maintenance drugs.  |  |  |   |

For prescriptions filled at a non-participating pharmacy, the family member will have to pay the entire cost of the prescription or refill and submit a claim to the prescription drug administrator for reimbursement. Reimbursement is limited to the maximum reimbursement amount paid to a participating pharmacy (plan cost). In addition to the copayment, the family member is responsible for the cost of each prescription or refill above the plan cost plus a processing fee.

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## Activation Fees

Each family member has the right to activate Additional Coverage Levels under the policy for the current Benefit Period without submitting proof of insurability. Additional Coverage Levels must be activated in order (first Level 2, then Level 3, then Level 4) for each family member. Activation fees vary by age and Coverage Level and will be outlined in your Welcome Kit. See the Coverage On Demand policy for additional information.

## Benefit Period

Benefit Period means the 12-month period beginning on the effective date of your policy and reoccurring every 12 months thereafter.

## Pre-existing Conditions Limitation

The plan does not pay for any expense incurred due to a pre-existing condition during the 12-month period starting on the effective date of coverage.

The 12-month period will be reduced for any family member by the length of time the family member had prior coverage, which was continuous to a date not more than 30 days before the effective date of coverage under the policy.

Pre-existing condition means a sickness or injury that:

- Is diagnosed or treated by a physician within six months prior to the effective date of a family member's coverage, or
- Produced symptoms within six months prior to the effective date of a family member's coverage that would cause a reasonably prudent person to seek medical advice, diagnosis, care or treatment.

## Third Party Reimbursement, Standard Coordination of Benefits (COB), Medicare Coordination, and Subrogation

Coverage On Demand contains certain provisions that may reduce benefits under the plan; a full description is contained in the policy.

## Eligibility

The following are considered eligible for coverage:

- The key applicant and his or her spouse, and
- The key applicant's children and his or her spouse's children and adopted children (regardless of whether a final order granting adoption is ultimately issued), provided they are:
  - Not married
  - Dependent on the key applicant for at least 50% of their support
  - Less than 22 years of age at the time of application.

## Underwriting

The health history provided on the application determines the policy provisions and premium. Therefore, it is important that applicants answer all questions accurately and thoroughly.

If the agent assists in completing the application, the applicant should review the answers before signing. The applicant's signature attests to the completeness and accuracy of the answers.

Reviews conducted after the policy is issued may reveal health information that wasn't disclosed on the application. This may result in rescission of coverage, increased premiums, and/or exclusion riders or claims being denied under the policy's pre-existing exclusion.

## General Exclusions and Limitations

Some of the services that the Coverage On Demand Plan does NOT cover include:

Pre-existing conditions for the 12-month period starting on the effective date of coverage; Charges in excess of the usual, customary, and reasonable charges for non-network services and supplies; Charges for services that are experimental, investigational, unproven or for research; Charges arising from war, commission of a felony, or participation in a riot or insurrection; Any sickness contracted or injury received while a member of the military; Charges for sickness or injury that are covered by workers' compensation insurance or similar laws; Travel expenses, except as provided in the policy; Preventive medical care, except when provided by the preventive care benefit, or if listed under covered charges; Charges for dental services or supplies, unless the dental benefit rider is purchased; Cosmetic treatment, except as provided in the policy; Care covered under a government program; Eyeglasses; Contact lenses; Eye exams and surgery; Hearing aids; Contraceptives; Pregnancy, unless the maternity benefit rider is purchased; Sterilization; Abortion; Treatment for hair restoration; Treatment of acne; Treatment for substance abuse except as provided under the alcoholism treatment benefit; Examination, diagnosis or treatment of malocclusion or misalignment of the jaw; Charges for services that are not medically necessary; Treatment received in a hospital emergency room for a non-emergency sickness; Charges for which benefits are not provided in the policy.

**A complete list of exclusions and limitations is included in the Coverage On Demand Group policy. See Group Policy Form OTP-ICDHP-PAYG for complete terms and conditions.**



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