

Ohio Individual

Insurance Plans
for
Federally Eligible Individuals

AMERICAN  COMMUNITY
MUTUAL INSURANCE COMPANY

39201 Seven Mile Road, Livonia, Michigan 48152-1094

**American Community
Mutual Insurance Company**
Ohio Individual Insurance Plans for Federally Eligible Individuals

Benefits	Basic CMM	Standard CMM
(Issue age limit for individual policy open enrollment only - age 64)		
Calendar Year Deductible	\$1,000	\$750
Emergency Room Deductible (in addition to the Calendar Year Deductible) (Emergency room deductible is waived if admitted to Hospital)	\$75	\$75
Benefit Percentage—Percentage of Expenses Covered after the Calendar Year Deductible Applies to all Covered Sicknesses and Injuries	50% of the first \$10,000 100% thereafter	70% of the first \$16,667 100% thereafter
Calendar Year Maximum per Family Member	\$50,000	Not Applicable
Lifetime Maximum per Family Member	Not Applicable	\$1 Million
The following benefits are subject to deductible and benefit percentage		
Maternity and Routine Nursery (includes dependent children) *Complications are covered the same as any other sickness in both plans	None	\$3,000 per occurrence
Hospital Room and Board Maximum	Average Semi-Private	Average Semi-Private
Intensive Care Unit Maximum	3 times Average Semi-Private	3 times Average Semi-Private
Assisting Surgeon – when Medically Necessary	Not to exceed 20% of eligible charges	Not to exceed 20% of eligible charges
Mental Health/Substance Abuse Lifetime: Calendar Year: Eligible Charge:	\$5,000 Inpatient \$2,000 Outpatient \$550 \$50 per Visit	\$10,000 Inpatient \$2,000 Outpatient \$550 \$50 per Visit
Organ Transplants – Lifetime Maximum (Covers Heart, Heart/Lung, Lung, Liver, Bone Marrow, Kidney, Pancreas and Cornea.) Covered charges include initial testing and diagnosis, Immunosuppressant drug therapy before and after surgery, complications resulting from surgery, organ rejection or organ failure, repeat transplants of the same organ.	\$100,000	\$100,000
Skeletal Adjustment (Includes adjunctive therapy, vertebral manipulation and dislocation/subluxation services)	\$25/Visit 10 Visits/Year	\$25/Visit 10 Visits/Year
Outpatient Physical Therapy	\$40/Visit 20 Visits/Year	\$40/Visit 20 Visits/Year
Occupational and Speech Therapy (Total for both Therapies combined)	\$40/Visit 20 Visits/Year	\$40/Visit 20 Visits/Year
Well Child Care – Calendar Year Maximum Birth to Age 1 Age 1 through 8	\$500 \$150	\$500 \$150
Mammography – Calendar Year Maximum Age 35-39: One mammogram Age 40-49: One mammogram every two years; or Age 40-49: One mammogram per year for women with risk factors for breast cancer Age 50-64: One mammogram per year	\$85	\$85
Cytologic Screening (PAP Smear)	Covered	Covered
Outpatient Prescription Drug – Calendar Year Maximum	\$2,500	\$2,500
Convalescent Care – Calendar Year Maximum (Includes Extended Care Facilities, Convalescent Homes, Home Health Care, Hospice Care and Nursing Home Care)	\$5,000	\$5,000
Purchase or Rental of durable Medical Equipment (whichever costs less)	Covered – Not to exceed a 6 month period	Covered – Not to exceed a 6 month period

***Complications of Pregnancy** means a condition that is distinct from pregnancy, but is adversely affected by pregnancy. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, and conditions of comparable severity. It also includes conditions such as Emergency non-elective cesarean section, ectopic pregnancy, hypremesis gravidarum, and spontaneous abortion occurring when a viable birth is not possible. It does NOT include: false labor, occasional spotting, physician-prescribed rest during pregnancy, morning sickness, pre-eclampsia, or other conditions related to a difficult pregnancy.

GENERAL EXCLUSIONS

We will pay no benefit for charges due to any of the following. These charges are not Covered Charges and cannot be used to satisfy this policy's Deductible.

1. No benefits will be paid for charges due to a Pre-existing Condition. This limitation relates only to conditions treated during the six months immediately preceding the Effective Date. Benefits will be paid for such charges incurred after the end of the period of twelve consecutive months while insured under the policy. This exclusion does not apply to federally eligible individuals.
2. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication or for any Treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer, or surrogate pregnancy.
3. For any cosmetic surgery, unless required to restore a part of the body which has been altered as a result of the following events or conditions that occurred while the Family Member was insured by this Policy and for which benefits were paid in accordance with the terms of this Policy.
 - a. accidental bodily injury;
 - b. surgery; or
 - c. disease that was first diagnosed while the Family Member was insured by this Policy.
4. Rest cure, maintenance and Custodial Care.
5. Due to a Sickness or Injury arising out of, or in the course of, employment for wages or profit.
6. For eye refractions, eye glasses, or contact lens, including fittings and examinations, or eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy.
7. Any Sickness or Injury contracted while a member of the Military, Navy or Air Force of any country or combination of countries. This exclusion will not apply to a non-service connected Sickness or Injury of a veteran of the United States Armed Forces.
8. For services and supplies eligible for payment by a government or charitable program, except as required by law.
9. For hearing aids, including fittings and examinations.
10. For Sickness or Injury that results from participation in any assault, unlawful act, strike, civil disorder or riot.
11. Suicide or attempted suicide, whether or not sane, or intentionally self-inflicted injury.
12. For examination, Treatment or surgery of the teeth, gums or direct supporting structure, except for repair of Injury to sound natural teeth, (including their replacement) as a result of an accidental bodily Injury which occurs while the Family Member is insured. Treatment must be given within ninety (90) days of the date of the accident.
13. For a Sickness or Injury caused by any act of war, whether or not declared.
14. For surgery of the jaw or for any Treatment of temporomandibular joint (TMJ) disorder. Treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion.
15. For recreational or educational therapy or vocational rehabilitation.
16. For premarital or routine physical examinations, except as provided under Covered Charges or the Well Child Care Benefit.
17. For the Treatment of complications arising from or connected in any way with a surgical or medical Treatment or procedure not covered by this Policy, whether or not the Family Member was insured by this Policy at the time the non-covered Treatment or procedure was performed.
18. For foot care due to:
 - a. treatment of weak, strained or flat feet or instability or imbalance of the foot;
 - b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illnesses of similar medical seriousness.

19. For transportation, except local Emergency ambulance service to or from a Hospital or Nursing Facility right before or right after confinement.
20. For replacement of artificial limbs or artificial eyes.
21. For donation of any body organ by a Family Member.
22. For services performed by a person who ordinarily resides in the Family Member's home or is a close relative of the Family Member or by the Family Member's employer or partner.
23. Is due to care or treatment which is not Medically Necessary or which is Experimental, Investigational or Unproven.
24. Except as allowed under Covered Charges subject to limitations, for speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the Treatment of learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma.
25. For a private room in excess of the average semi-private room and board rate.
26. In excess of Usual, Customary and Reasonable Charges.
27. Charges for vitamins and food supplements.
28. Services or supplies for personal comfort or convenience.
29. Contraceptives, contraceptive methods or aids; sterilization or the reversal of sterilization; voluntary abortion.
30. Gender reassignment or charges due to complications of gender reassignment.
31. Treatment for hair restoration.
32. Treatment of acne.
33. Treatment of obesity, morbid obesity or Treatment for weight reduction purposes.
34. Charges for out-of-hospital, non-surgical services by a physician as the result of or related to distortion, misalignment or subluxation in the vertebral column which are charges in excess of \$25 per visit and charges for more than 10 visits.
35. Well newborn care in excess of the Well Child Benefit as shown on the Schedule.
36. Charges not listed or in excess of the transplant benefit as stated under Covered Charges.
37. Covered Charges which qualify for reimbursement under Medicare or which would have qualified for reimbursement under Medicare had the Family Member elected all the coverage and applied for Medicare benefits for which they were at any time eligible.
38. For normal childbirth, normal pregnancy or routine nursery care (except as provided on the Schedule), elective cesarean section or voluntarily induced abortion.
39. For blood or blood plasma which has been replaced.
40. Charges applied to the Deductible or Benefit Percentage under any benefit of the policy.
41. For services or Treatment not prescribed by a doctor or for services or Treatment not shown as Covered Charges.
42. For expenses incurred after the insurance terminates.
43. Charges which would not be made if no insurance existed.
44. For which the insured person is not legally obligated to pay.
45. For Treatment or services which are not generally accepted medical practices in the United States for a given illness.
46. For the Treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
47. For services or supplies prohibited by law.