

Triple Tier™

For Individuals & Families



Ohio Benefit Chart

Plan 1	Network	Non-network	
Deductible	\$1,000 (Single) \$2,000 (Family)	\$2,000 (Single) \$4,000 (Family)	
Out-of-Pocket Maximum Includes Deductible	\$5,000 (Single) \$10,000 (Family)	\$10,000 (Single) \$20,000 (Family)	
Lifetime Policy Maximum	\$5 million per person		
	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER*	OUTPATIENT SERVICES
Network	\$40 Copay per visit, then 100%	Deductible, then 90%	Deductible, then 70%
Non-network	\$80 Copay per visit, then 50%	Deductible, then 50%	Deductible, then 50%

Plan 2	Network	Non-network	
Deductible	\$3,000 (Single) \$6,000 (Family)	\$6,000 (Single) \$12,000 (Family)	
Out-of-Pocket Maximum Includes Deductible	\$7,000 (Single) \$14,000 (Family)	\$14,000 (Single) \$28,000 (Family)	
Lifetime Policy Maximum	\$5 million per person		
	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER*	OUTPATIENT SERVICES
Network	\$50 Copay per visit, then 100%	Deductible, then 90%	Deductible, then 70%
Non-network	\$100 Copay per visit, then 50%	Deductible, then 50%	Deductible, then 50%

Networks Available	PHCS ~ SuperMed Plus
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* ER: \$50 Copay (waived if admitted). ER Physician Services: Network deductible, then 80%.

Accident Benefit	
Accident	We will waive the copay and 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 and deductible will be applied to any covered charges incurred after the 30-day limit has been met.
Common Accident	If a single accident causes injury to more than one family member, only one deductible will be applied to any covered charges associated with the common accident and incurred after the 30-day limit has been met under the Accident Benefit.

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 <ul style="list-style-type: none"> Sickness or Injury Office Surgery & Follow-up Visits Lab Tests (not sent to an independent lab) Consultations X-rays 	Network: Subject to copay per visit, then we pay 100% Non-Network: Subject to copay per visit, then we pay 50%		
Allergy Testing, Serums & Injections Maximum Benefit: \$500 per person per calendar year	Network: We pay 100% (copay does not apply) Non-Network: Subject to copay per visit, then we pay 50%		
Spinal Manipulation Maximum Benefit: \$500 per person per calendar year	Network: Subject to copay per visit, then we pay 100% Non-Network: Subject to copay per visit, then we pay 50%		

	Tier I	Tier II	Tier III
COVERED EXPENSES	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Physician Services			
Preventive Care Maximum: \$500 per person per calendar year <ul style="list-style-type: none"> • Routine Physical Exams (age 10 and older) • Lab Tests • X-rays • Pap Smears • Immunizations (age 10 and older) • Prostate Exams • Bone Density Tests • Colonoscopy • Inoculations or Prophylactic Drugs for Travel • Screening Mammograms 	Network: Subject to copay per visit, then we pay 100% Non-Network: Subject to copay per visit, then we pay 50%		
Well Child Care Benefit \$500 first year of life including hearing screening (limited to \$75). \$150 per year for second through ninth year of life.			
Hospital, Hospital Emergency Room and Ambulance Services, Surgical, Diagnostic Center			
Ambulance Emergency Only		Network & Non-Network Services: Subject to Network deductible, then we pay 90%	
Hospital Emergency Room Doctor Charges Emergency Only		Network & Non-Network Services: Subject to Network deductible, then we pay 80%	
Hospital Emergency Room <ul style="list-style-type: none"> • Facility Charge • Emergency Illness (Non-Emergency Illness is not covered) • Emergency Injury (see Accident Benefit on page 1) 		Network & Non-Network Services: \$50 copay per visit (waived if admitted), then subject to Network deductible, then we pay 90%	
Physician or Surgeon Services <ul style="list-style-type: none"> • Medical • Surgery • Consultations 		Network: Subject to deductible, then we pay 90% (while confined in a hospital) Non-Network: Subject to deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to deductible, then we pay 50%
Medical Services and Supplies furnished by the hospital <ul style="list-style-type: none"> • Intensive Care (Room & Board) • Room & Board (semi-private) • Routine Nursing Care • Medication and Medical Supplies • Meals 			
Professional Fees <ul style="list-style-type: none"> • Radiology • Anesthesiology • Pathology 			
Physical Occupational & Speech Therapy Maximum Benefit: 30 visits per person per calendar year for all therapies combined			
Durable Medical Equipment			

	Tier I	Tier II	Tier III
COVERED EXPENSES	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Hospital, Hospital Emergency Room and Ambulance Services, Surgical, Diagnostic Center			
Organ Transplants Combined lifetime maximum benefit is \$1 million per person 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.		Network: Subject to deductible, then we pay 90% Non-Network: Subject to deductible, then we pay 50%	
Hospice Care Maximum Benefit: \$200 per day per person; Lifetime Maximum: \$15,000 or 6 months per person, whichever comes first; \$500 for bereavement support services			
Skilled Nursing Facility Maximum Benefit: 30 days per person per calendar year			
Home Health Care Maximum Benefit: 30 visits per person per calendar year			
Outpatient Mental Health Maximum Benefit: \$550 per person per calendar year			
Biologically Based Mental Illness Inpatient & Outpatient			
Alcoholism Treatment Maximum Benefit: \$550 per person per calendar year			
Ancillary & Diagnostic Services <ul style="list-style-type: none"> • 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 deductible, then we pay 50% (while confined in a hospital)	Network: Subject to deductible, then we pay 70% Non-Network: Subject to deductible, then we pay 50%
Optional Benefits			
Maternity	Covered under Tier II Maternity benefit for all females covered under the policy. 270-day waiting period from the effective date of the maternity benefit rider.		
Dental Benefit Maximum Benefit: \$1,000 per person per calendar year	Type I procedures: 6-month waiting period, then 80% Type II procedures: 12-month waiting period, \$100 calendar year deductible, then 50%		
Prescription Drug Plan			
Drug card: 31-day maximum supply plus refills	Generic: 20% copay, minimum \$10 Select Brand Name: 30% copay, minimum \$30 Additional Brand Name: 50% copay, minimum \$50		
Mail Order: 90-day maximum supply plus refills	Generic: 20% copay, minimum \$25 Select Brand Name: 30% copay, minimum \$80 Additional Brand Name: 50% copay, minimum \$140		

Prescription Drug Program

Prescription Drug benefits are payable if Prescription Drugs are obtained from any of the following:

1. A Participating Pharmacy;
2. A Non-Participating Pharmacy; or
3. The mail order pharmacy.

For Prescription Drugs obtained at a Participating Pharmacy

The Prescription Drug Card must be presented at the time the prescription is filled. If the Prescription Drug Card is not presented at the time the prescription is filled, the maximum amount that will be reimbursed is the plan cost.

For Prescription Drugs obtained at a Non-Participating Pharmacy

The family member will have to pay the entire cost of the prescription drug each time it is filled. Then the family member must submit a claim to the prescription drug administrator for reimbursement. Reimbursement for each prescription drug filled at a Non-Participating Pharmacy is limited to the Plan Cost. In addition, the family member is responsible for the cost of each prescription or refill above the plan cost plus a processing fee.

Mail Order Drug Program

This program applies to prescription drugs, including maintenance drugs that are obtained through the mail order pharmacy. Benefits are subject to the copay and maximum drug supply indicated above.

Mandatory Generic Provision

If an Additional Brand Name Drug or Select Brand Name Drug is chosen when a Generic Drug is available, then the family member is responsible for the Generic Drug copay plus the difference between the cost of the Additional Brand Name Drug or Select Brand Name Drug and the cost of the Generic Drug.

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 your 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 group policy.

Pre-existing condition means a sickness or injury that:

- Is diagnosed or treated by a physician within 6 months prior to the effective date of a family member's coverage, or
- Produced symptoms within 6 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.

Standard Coordination of Benefits (COB), Medicare Coordination, and Subrogation

Triple Tier contains certain provisions that may reduce benefits under the plan; a full description is contained in the group 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 certificate 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 group policy's pre-existing condition exclusion.

General Exclusions and Limitations

Some of the services that the Triple Tier 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; 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 in 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 group policy.

A complete list of exclusions and limitations is included in the Triple Tier Group Policy. See group policy form OTP-ICDHP-TIER issued to American's Individual Trust, for complete terms and conditions.



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