



Triple Tier™

For Individuals and Families

Benefit Chart and Plan
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	PHCS ~SuperMed Plus		

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.

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	Network: Subject to copay per visit, then we pay 100% Non-Network: Subject to 2x network copay per visit, then we pay 50%		
Preventive Care Maximum: \$500 per person per calendar year Routine Physical Exams Lab Tests X-rays Pap Smears Immunizations Prostate Exams Pelvic Exams Bone Density Tests Colonoscopy Inoculations or Prophylactic Drugs for Travel Screening Mammograms			
Allergy Testing, Serums & Injections Maximum: \$500 per person per calendar year		100% (copay does not apply)	
Spinal Manipulation Maximum: \$500 per person per calendar year	Network: Subject to copay per visit, then we pay 100%		
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.	Non-Network: Subject to 2x network copay per visit, then we pay 50%		

Hospital, Hospital Emergency Room and Ambulance Services, Surgical, Diagnostic Center	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
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%
Medical Services and Supplies furnished by the hospital Intensive Care (Room & Board) Room & Board (semi-private) Routine Nursing Care Medication and Medical Supplies Meals			

COVERED EXPENSES	Tier I	Tier II	Tier III
	OFFICE VISITS / PREVENTIVE CARE	INPATIENT / ER	OUTPATIENT SERVICES
Ambulance <i>Emergency Only</i>		Network & Non-Network Services: Subject to Network deductible, then we pay 90%	
Hospital Emergency 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 (Non-Emergency Illness is not covered) Emergency Injury		Network & Non-Network Services: \$50 copay per visit (waived if admitted), then subject to Network deductible, then we pay 90%	
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%	
Hospice Care Maximum Benefit: \$200 per day \$500 for support services Lifetime Maximum: \$15,000 or 6 months, whichever comes first		Non-Network: Subject to 2x network deductible, then we pay 50%	
Skilled Nursing Facility Maximum Benefit: \$75 per day for room & board, 30 days per calendar year			
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 calendar year		Network: Subject to deductible, then we pay 90% Non-Network: Subject to 2x network deductible, then we pay 50%	
Physical, Occupational & Speech Therapy Maximum Benefit: 30 visits per calendar year for all therapies combined			
Durable Medical Equipment			Network: Subject to deductible, then we pay 70%
Ancillary & Diagnostic Services Diagnostic X-ray and Lab Tests Nuclear Medicine Diagnostic Mammograms MRI, Cat Scans, Ultrasounds X-ray Therapy, Radiation Therapy and 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)	Non-Network: Subject to 2x network deductible, then we pay 50%

Other Covered Services (Mandates)	
Post-Delivery Care	If maternity benefit is selected, coverage for inpatient care (48/96 hours) and follow-up care for a mother and her newborn. Covered services include education and training, assessment of home support systems, performance of medically necessary tests and any other recommended services. Coverage for doctor office visits and home healthcare visits. Treatment of gestational, insulin-dependent or non-insulin dependent diabetes.
Prosthesis, Reconstructive Surgery (Mastectomy)	Reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, 2 prostheses, and coverage of physical complications at all stages of mastectomy, including lymphedemas.

Optional Benefits	
Maternity	Covered under Tier II For all females covered under the policy. 270-day waiting period from the effective date of the maternity benefit rider
Dental Benefit Calendar year maximum benefit is \$1,000	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 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.

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.

A sickness that appeared or an injury sustained prior to the effective date of the family member's coverage, that was fully disclosed on the application and was not excluded from coverage by a rider, is not a pre-existing condition.

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.

Third Party Reimbursement, 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 policy.

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; 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 for professional ambulance service; 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 mental or nervous disorders or illnesses, or emotional conditions; Treatment for substance abuse; 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 Triple Tier Policy. See policy form ICDHP-TIER for complete terms and conditions.



39201 Seven Mile Road, Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000 (734) 591-4628 Fax
www.american-community.com