

American's Equity Advantage HSA

For Groups with 2-50 Employees



AMERICAN  COMMUNITY
MUTUAL INSURANCE COMPANY

Benefit Chart
ILLINOIS



Benefit Chart

PLAN DETAILS

For all plans: Lifetime maximum: \$5,000,000. Network out-of-pocket maximum: \$5,000 individual, \$10,000 family. Non-network out-of-pocket maximum: \$10,000 individual, \$20,000 family. Out-of-pocket maximums include deductible. Both the deductibles and out-of-pocket maximums will “cross accumulate” or count toward each other. All covered expenses will apply toward the deductible.

PRESCRIPTION DRUG

Discount Card: Drug costs not applied to deductible. No benefits payable under the base plan, unless optional coverage is selected.

PHYSICIAN SERVICES

In Physicians’ Offices and Urgent Care Centers: Office visits, office surgery, lab tests not sent to an independent lab, x-rays, soft-tissue foot care (\$500 maximum per calendar year).

Professional Services for Dislocation or Subluxation of the Vertebrae: Office visits, x-rays, therapies. Maximum benefit of \$25 per visit, 1 visit per day, 40 visits per calendar year.

Allergy Testing, Serums and Injections

Inpatient Physician Fees: Medical, surgical, consultations, radiology, anesthesiology, pathology.

HOSPITAL SERVICES

Hospital Facility Charges

Outpatient Services: X-rays, lab, mammograms, outpatient surgery, pre-admission testing.

Emergency Room Services for Non-Emergency Illness

Emergency Room Services for Emergency Illness

OTHER COVERED SERVICES

Outpatient Surgical Center Facility Charges

Diagnostic Services: X-rays, nuclear medicine, mammograms, CAT scans, MRIs, ultrasounds, lab work sent to independent labs.

Physical and Occupational Therapy Professional Fees: Maximum of 60 visits per calendar year.

Skilled Nursing Facility: Maximum benefit of \$75 per day, 60 visits per calendar year.

Home Health Care Professional Fees: Maximum benefit of \$75 per day, 60 visits per calendar year.

Hospice: Maximum benefit of \$200 per day, \$7,500 per benefit period, \$500 bereavement maximum.

Mental Health: Included on groups with 2-14 employees; optional to groups of 15 or more employees. Inpatient/outpatient combined maximum payment is \$10,000 per calendar year.

Substance Abuse: Includes both alcohol and drugs. Inpatient benefit is paid as any other covered condition. Outpatient maximum is \$1,000 per calendar year.

Maternity: Included. Paid as any other covered condition. Includes pre-natal HIV testing.

Mandated Benefits: Annual pap and cervical smears, annual prostate exams, colorectal cancer screening, dental anesthesia, diagnosis and treatment of osteoporosis.

Ambulance

OPTIONAL BENEFITS

Preventive Care

Includes lab tests, immunizations, physical exams, pelvic exams and PAP smears, prostate exams, bone density tests, colonoscopy, inoculations or prophylactic drugs for travel. Benefits are payable to both network and non-network providers with a combined calendar year maximum benefit of \$500 per eligible person.

Option 1: When using a network provider, benefits are subject to deductible and network benefit percentage. When using a non-network provider, benefits are subject to deductible and non-network benefit percentage.

Option 2: When using a network provider, benefits are payable at 100%. When using a non-network provider, benefits are subject to non-network benefit percentage.

No coverage unless Option 1 or 2 is selected.

AMERICAN'S EQUITY ADVANTAGE HSA

PLAN 1	PLAN 2	PLAN 3	PLAN 4
Deductible: \$1,500 individual, \$3,000 combined family Benefit percentage: 90% network, 70% non-network	Deductible: \$1,500 individual, \$3,000 combined family Benefit percentage: 80% network, 60% non-network	Deductible: \$2,500 individual, \$5,000 combined family Benefit percentage: 100% network, 70% non-network	Deductible: \$2,500 individual, \$5,000 combined family Benefit percentage: 90% network, 60% non-network
Included	Included	Included	Included
Subject to deductible, then 90% network, 70% non-network	Subject to deductible, then 80% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network
Subject to deductible, then 90% network, 70% non-network	Subject to deductible, then 80% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network
Subject to deductible, then 90%	Subject to deductible, then 80%	Subject to deductible, then 100%	Subject to deductible, then 90%
Subject to deductible, then 90% network, 70% non-network	Subject to deductible, then 80% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network
Subject to deductible, then 90%	Subject to deductible, then 80%	Subject to deductible, then 100%	Subject to deductible, then 90%
Subject to deductible, then 90% network, 70% non-network	Subject to deductible, then 80% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network
Subject to deductible, then 70%	Subject to deductible, then 60%	Subject to deductible, then 70%	Subject to deductible, then 60%

Prescription Drug Coverage

Option 1: Benefits are subject to deductible and paid at **network** benefit percentage.

Option 2: Benefits are subject to deductible and paid at **non-network** benefit percentage.

If Option 1 or 2 is selected, coverage includes contraceptive drugs and devices approved by the FDA.

Supplemental Accident

Option 1: For eligible expenses incurred within the first 90 days of an accidental injury, this benefit provides first-dollar coverage of \$500 per accident. Benefits are paid at 100% for both network and non-network services.

Option 2: For eligible expenses incurred within the first 90 days of an accidental injury, this benefit provides first-dollar coverage of \$1,000 per accident. Benefits are paid at 100% for both network and non-network services.

PLAN 5	PLAN 6	PLAN 7	NOTES
Deductible: \$3,500 individual, \$7,000 combined family Benefit percentage: 100% network, 70% non-network	Deductible: \$3,500 individual, \$7,000 combined family Benefit percentage: 90% network, 60% non-network	Deductible: \$5,000 individual, \$10,000 combined family Benefit percentage: 100% network, 70% non-network	
Included	Included	Included	
Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	
Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	
Subject to deductible, then 100%	Subject to deductible, then 90%	Subject to deductible, then 100%	
Subject to deductible, then 100% network, 70% non-network	Subject to deductible, then 90% network, 60% non-network	Subject to deductible, then 100% network, 70% non-network	
Subject to deductible, then 70%	Subject to deductible, then 60%	Subject to deductible, then 70%	

24-Hour Occupational Coverage

Covers medical expenses that result from a work-related injury. Please refer to the "Optional Medical Benefits" section of your brochure for details.

Annual Deductible Reduction Benefit

This benefit allows eligible expenses that are incurred during the last three months of a calendar year to be used to reduce the next year's calendar year deductible. This benefit applies only if the deductible was not met in the previous year. This benefit is limited to \$500 and is only available on Plans 3-7.

Benefit Chart

ADDITIONAL COVERED SERVICES	
Diabetic Services	Includes nutritional counseling and diabetic training.
Fertility Treatment	Groups of 26 or more employees are eligible for this benefit. Charges for diagnosis and treatment of infertility, including prescription drugs, are covered.
Mastectomy	Mastectomy, breast reconstruction, two post-operative breast prostheses, surgery and reconstruction of the other breast to produce a symmetrical appearance. Post-mastectomy care including inpatient care for a length of time determined by the attending physician to be medically necessary; and one physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.
Medical Services Received as a Result of Criminal Sexual Assault or Attempted Assault	Deductible, benefit percentage and copay do not apply
Transplants	Lifetime benefit maximum is \$1,000,000 when performed in a designated transplant facility and includes \$10,000 for travel or lodging expenses for one companion. Lifetime benefit maximum is \$150,000 when performed in a non-designated transplant facility.

Covered charges for in-network are network-negotiated rates. Covered charges for non-network are the usual, customary and reasonable charges for your area.

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's 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.

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, fraud or misrepresentation by the insured individual, or the individual's representative;
2. Non-payment of premium;
3. Non-compliance with minimum participation requirements;
4. If American Community no longer offers that particular type of coverage in the market;
5. Payment is not received by American Community on time;
6. The minimum employer contribution rules are not met.

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 and 50% of all dependents 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 on a full-time basis with a normal work week of 30 or more hours. Owners and partners are considered eligible employees.

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), and a dependent of the employee for Federal Income Tax purposes.

General Exclusions & Limitations

THE FOLLOWING EXCLUSIONS AND LIMITATIONS APPLY TO ALL BENEFITS: 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 law 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 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 in excess of the \$2,500 lifetime maximum; 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, other than morbid obesity; 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; Charges for care, treatment, or services provided by an employee's employer.

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 anorexiant and amphetamines, and weight loss products; Cosmetics, dietary supplements, health or beauty aids; Needles and syringes; 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; 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, except growth disorders that are Medically Necessary; Emergency contraceptive kits or contraceptive drugs and devices that are not approved by the Food and Drug Administration.

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.

This benefit chart is a brief description of the highlights of the American's Equity Advantage HSA. 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.