



INDIVIDUAL HEALTH INSURANCE - NETWORK PROVIDER PLAN
A MAJOR MEDICAL EXPENSE PLAN

WRITTEN PLAN DESCRIPTION

READ YOUR PLAN CAREFULLY. This written plan description provides a very brief description of the important features of your plan. This is not the insurance contract and only the actual plan provisions will control. The plan itself sets forth, in detail, the rights and obligations of both you and American Community Mutual Insurance Company (herein after referred to as "We, Us, Our"). It is, therefore, important that you **READ YOUR PLAN CAREFULLY.**

This is not a policy of workers' compensation insurance. The employer does not become a subscriber to the workers' compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the workers' compensation laws. The employer must comply with the workers' compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.

1. Coverage is provided by American Community Mutual Insurance Company.

American Community Mutual Insurance Company is an insurance company, and the insurance contract provides Network Provider benefits.

2. To obtain additional information:

Please write to, call, or visit our website using the following addresses and toll-free number:

Mail: American Community Mutual Insurance Company
39201 Seven Mile Road, Livonia, Michigan 48152-1094
Call: 1-800 991-2642
Website: www.american-community.com

3. The difference between a Network and a Non-Network Provider:

A **Network Provider** is a hospital, physician, or other provider or supplier of health care services that has signed an agreement with the network named by Us at the time services are rendered. Network Providers have agreed to accept previously negotiated rates as payment in full for covered services.

A **Non-Network Provider** is a hospital, physician, or other provider or supplier of health care services that has not signed an agreement with the network named by Us at the time services are rendered. Covered charges for Non-Network Providers are based on Usual, Customary and Reasonable (UCR) charges, which may be less than the actual billed charges. Non-Network Providers can bill you for amounts exceeding the UCR charges.

4. Covered Charges and Benefits

PLAN CHOICE	Community Flex 100		Community Flex 80		Community Flex 60					
	Network	Non-Network	Network	Non-Network	Network	Non-Network				
DEDUCTIBLES										
Individual Calendar Year Deductible	\$5,000	\$10,000	\$1,000	\$2,000	\$500	\$1,000				
	\$7,500	\$15,000	\$1,500	\$3,000	\$1,000	\$2,000				
	\$10,000	\$20,000	\$2,500	\$5,000	\$1,500	\$3,000				
			\$3,500	\$7,000	\$2,500	\$5,000				
			\$5,000	\$10,000	\$3,500	\$7,000				
			\$7,500	\$15,000	\$5,000	\$10,000				
					\$7,500	\$15,000				
Family Calendar Year Deductible and Family Out-of-Pocket Met collectively by 2 or more persons			\$2,000	\$4,000	\$1,000	\$2,000				
			\$3,000	\$6,000	\$2,000	\$4,000				
	\$10,000	\$20,000	\$5,000	\$10,000	\$3,000	\$6,000				
	\$15,000	\$30,000	\$7,000	\$14,000	\$5,000	\$10,000				
	\$20,000	\$40,000	\$10,000	\$20,000	\$7,000	\$14,000				
		\$15,000	\$30,000	\$10,000	\$20,000					
				\$15,000	\$30,000					
Benefit Percentage Options	100%		80% of \$10,000		80% of \$20,000		60% of \$10,000		60% of \$20,000	
	Network	Non-Net	Network	Non-Net	Network	Non-Net	Network	Non-Net	Network	Non-Net
	100%	70% of \$10,000	80% of \$10,000	50% of \$10,000	80% of \$20,000	50% of \$20,000	60% of \$10,000	50% of \$20,000	60% of \$20,000	50% of \$20,000
Out-of-Pocket Maximums (Includes deductible)	Network 100%	Non-Net 70% of \$10,000	Network 80% of \$10,000	Non-Net 50% of \$10,000	Network 80% of \$20,000	Non-Net 50% of \$20,000	Network 60% of \$10,000	Non-Net 50% of \$20,000	Network 60% of \$20,000	Non-Net 50% of \$20,000
	\$5,000	\$13,000	\$3,000	\$7,000	\$5,000	\$12,000	\$4,500	\$11,000	\$8,500	\$11,000
	\$7,500	\$18,000	\$3,500	\$8,000	\$5,500	\$13,000	\$5,000	\$12,000	\$9,000	\$12,000
	\$10,000	\$23,000	\$4,500	\$10,000	\$6,500	\$15,000	\$5,500	\$13,000	\$9,500	\$13,000
			\$5,500	\$12,000	\$7,500	\$17,000	\$6,500	\$15,000	\$10,500	\$15,000
			\$7,000	\$15,000	\$9,000	\$20,000	\$7,500	\$17,000	\$11,500	\$17,000
		\$9,500	\$20,000	\$11,500	\$25,000	\$9,000	\$20,000	\$13,000	\$20,000	
						\$11,500	\$25,000	\$15,500	\$25,000	
Network & Non-Network Charges to Deductible & Benefit Percentage	Network charges apply to the Network deductible and benefit percentage. Non-Network charges apply to the Non-Network deductible and benefit percentage.									
Lifetime Policy Maximum	\$5 million per family member									
Network Available	PHCS									

ACCIDENT BENEFIT	
Accident	If a family member sustains an injury, we will waive the deductible (copays still apply) and pay the covered charges related to the injury at the appropriate benefit percentage for services incurred within 30 days of the injury. The 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.

PHYSICIAN SERVICES	Community Flex 100		Community Flex 80		Community Flex 60	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
In Physician's Office Office Visits for Sickness, Injury, or Follow-up, including X-rays and lab tests performed in the office (see Other Covered Services for lab work sent to an independent lab)	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
Urgent Care Office Visits for Sickness, Injury, or Follow-up, including X-rays and lab tests performed in the office (see Other Covered Services for lab work sent to an independent lab)						
Surgery, Equipment, Supplies, Injections (other than allergy injections)						
Diagnostic Services: Nuclear medicine; non-routine mammograms; M.R.I.; cat scans; ultrasounds received during an Office Visit at a Physician's office or Urgent Care Center						
Chemotherapy, Infusion Therapy and Sclerotherapy (vein surgery or treatment)						
Allergy Testing & Serums \$500 Calendar Year maximum per family member						
Allergy Injections						
In Hospital Services Surgery, Consultations, Radiology, Anesthesiology, Pathology, Physical, Occupational, and Speech Therapy						
Outpatient Spinal Manipulation \$500 Calendar Year maximum per family member						

	Community Flex 100		Community Flex 80		Community Flex 60	
PREVENTIVE CARE SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
Preventive Care HPV Immunizations, Bone Density Test, Colorectal Cancer Exams, Lab work sent to an independent lab, PSA Testing, Routine Mammograms, Pap Smears, all other preventive care services not listed below.	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
\$1,000 Calendar Year maximum per family member for the following: Immunizations age 6 and older (except HPV), Routine Physical Exams, Lab performed in the office						
Immunizations Up to age 6 (except for HPV)	We pay 100%					
Newborn Hearing Screening Limited to screening from birth to age 30 days. Diagnostic follow-up testing from birth to age 24 months.	We pay 100%	We pay 70%	We pay 80%	We pay 50%	We pay 60%	We pay 50%

	Community Flex 100		Community Flex 80		Community Flex 60	
HOSPITAL SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
Inpatient Non-emergency admissions	Deductible, then we pay 100%	Additional \$500 copay, then Deductible, then we pay 70%	Deductible, then we pay 80%	Additional \$500 copay, then Deductible, then we pay 50%	Deductible, then we pay 60%	Additional \$500 copay, then Deductible, then we pay 50%
Emergency admissions	Deductible, then we pay 100%	Network Deductible, then we pay 100%	Deductible, then we pay 80%	Network Deductible, then we pay 80%	Deductible, then we pay 60%	Network Deductible, then we pay 60%
Outpatient Surgery	Deductible, then we pay 100%	Additional \$500 copay, then Deductible, then we pay 70%	Deductible, then we pay 80%	Additional \$500 copay, then Deductible, then we pay 50%	Deductible, then we pay 60%	Additional \$500 copay, then Deductible, then we pay 50%
Diagnostic Services Pre-admission Testing, X-rays, Nuclear Medicine, Ultrasounds, MRIs, Non-routine Mammograms, Lab Tests	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%

	Community Flex 100		Community Flex 80		Community Flex 60	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
EMERGENCY ROOM						
Emergency Room/Physician – Emergency Injury Copay waived if admitted within 24 hours See Accident Benefit on page 2	\$250 copay, then Deductible, then we pay 100%	\$250 copay, then Network Deductible then we pay 100%	\$250 copay, then Deductible, then we pay 80%	\$250 copay, then Network Deductible, then we pay 80%	\$250 copay, then Deductible, then we pay 60%	\$250 copay, then Network Deductible, then we pay 60%
Emergency Room/Physician – Emergency Sickness Copay waived if admitted within 24 hours						
Non-emergency Sickness & Injury	Not Covered					
	Community Flex 100		Community Flex 80		Community Flex 60	
OTHER COVERED SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
Air Ambulance	Network Deductible, then 80% (does not apply to out-of-pocket maximum)					
Ambulance (except air)	Deductible, then we pay 100%	Network Deductible, then we pay 100%	Deductible, then we pay 80%	Network Deductible, then we pay 80%	Deductible, then we pay 60%	Network Deductible, then we pay 60%
Radiology or Diagnostic Services Outside of Hospital X-rays, MRIs, CAT Scans, Non-routine Mammograms, Nuclear Medicine, Ultrasounds, Lab Tests (including lab work sent by a physician to an independent lab)						
Outpatient Physical, Occupational and Speech Therapy 20 visits per family member per Calendar Year per therapy						
Home Health Care 20 visits per Calendar Year	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
Hospice Up to \$200 per day, a lifetime maximum of \$10,000 or 6 months, whichever comes first						
Skilled Nursing Facility 60 days per Calendar Year						
Developmental Delays Limited to children less than 3 years of age						
Reconstructive Surgery For craniofacial abnormalities Under age 18						
Durable Medical Equipment	Deductible, then 50% (does not apply to out-of-pocket maximum)					
Organ Transplants Combined maximum lifetime benefit of \$1 million per person	Designated Transplant Facility: \$1 million maximum lifetime benefit Non-designated Transplant Facility: \$700,000 maximum lifetime benefit					
Maternity	Not Covered					
Mental Health	Not Covered (except Organic Brain Disease)					
Accidental Death and Dismemberment	Primary Insured \$10,000; Spouse \$2,500; and Dependent Child \$1,000					

OPTIONAL BENEFITS

GOLD BENEFITS

<p>Office Visit Office Visit Charge X-Ray & Laboratory performed in the office</p>	<p>Network: Copay per visit, then we pay 100% Deductible: \$500-\$3,500 \$30 copay \$5,000-\$10,000 \$40 copay Non-Network: Non-Network Deductible and Benefit Percentage</p>
<p>Allergy Injections</p>	<p>Network: 100% - No copay applies Non-Network: Non-Network Deductible and Benefit Percentage</p>
<p>Urgent Care Office Visit Charge X-Ray & Laboratory performed in the office</p>	<p>Network: Two times the office visit copay, then we pay 100% Non-Network: Non-Network Deductible and Benefit Percentage</p>
<p>Preventive Care Immunizations (age 6 and older) except for HPV; Routine Physical Exams; Laboratory performed in the office</p>	<p>Network: Office Visit Copay, then we pay 100% up to \$1,000 calendar year maximum per family member Non-Network: Deductible and Benefit Percentage</p>
<p>Accident Benefit</p>	<p>If a family member sustains an injury, we will waive the deductible (copays still apply) and pay the covered charges related to the injury at the appropriate benefit percentage for services incurred within 30 days of the injury. The deductible will be applied to any covered charges incurred after the 30-day limit has been met.</p>
<p>Emergency Room – Sickness and Injury</p>	<p>\$150 Copay, then Network Deductible and Benefit Percentage Copay waived if admitted within 24 hours Non-emergency sickness and injury is not covered.</p>

PRESCRIPTION DRUG OPTIONS

<p>Generic Plan Option Generic Drugs only</p>	<p>Retail: Up to 31-day supply 20%, \$15 Minimum Mail Order: Up to 90-day supply 20%, \$35 Minimum</p>	
<p>Four Tier Plan Option</p>		
	<p>Retail: Up to 31-day supply</p>	<p>Mail Order: Up to 90-day supply</p>
<p>Generic:</p>	<p>20%, \$15 Minimum</p>	<p>20%, \$40 Minimum</p>
<p>Select Brand:</p>	<p>30%, \$30 Minimum</p>	<p>30%, \$80 Minimum</p>
<p>Additional Brand:</p>	<p>50%, \$60 Minimum</p>	<p>50%, \$150 Minimum</p>
<p>Specialty: \$250 Maximum per Rx \$2,500 out-of-pocket maximum per calendar year</p>	<p>25% (No Minimum) 31-day supply</p>	

For prescriptions filled at a non-network 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 network 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.

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.

DENTAL OPTION

<p>Dental Benefit \$1,000 calendar year maximum</p>	<p>Type 1 procedures: 6-month waiting period, then we pay 80% Type 2 procedures: 12-month waiting period, \$100 calendar year deductible, then we pay 50%</p>
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Covered Charges include the following:

1. Hospital room and board and routine nursing care for Confinement in a Hospital. The most We will consider is the semi-private rate for each day of Confinement.
2. Room and board and nursing care in an Intensive Care Unit.
3. Room and board, nursing care, medical services and supplies while Confined in a Skilled Nursing Facility, subject to the maximum benefit shown on the Schedule.
4. Medical services and supplies furnished by the Hospital.
5. Treatment given in a Hospital emergency room for an Emergency condition, Sickness or Injury.
6. Treatment given in an Outpatient section of a Hospital, Free Standing Outpatient Surgery Center, or similar facility.
7. Physician's medical care.
8. Surgeon's medical care or surgery. If two or more procedures are performed at the same operative session, the most We will consider:
 - a. For procedures performed by a Network Provider is the Preferred Provider Network charge for the most expensive procedure and 50% of the Preferred Provider Network charge for the remaining procedures; or
 - b. For procedures performed by a Non-Network Provider is the Usual, Customary, and Reasonable Charge for the most expensive procedure and 50% of the Usual, Customary, and Reasonable Charge for the remaining procedures.
9. Services of an assistant surgeon or technical surgical assistant, but no more than 20% of the amount allowed for the surgery.
10. Anesthetics and their administration.
11. X-rays, lab tests, and other diagnostic services.
12. Radiation therapy and chemotherapy.
13. Services by a licensed physical therapist, occupational therapist, or Speech Therapist, for Rehabilitation of a covered Sickness or Injury only, subject to the maximum benefit shown on the Schedule. See Covered Charges for therapy of Developmental delays.
14. Medications provided while Confined, except medications used to treat medical conditions that are not covered under the Policy or have been excluded from coverage by amendment or rider to this Policy.
15. Injectable Prescription Drugs are covered subject this policy's Deductible and Benefit Percentage if there is no Outpatient Prescription Drug Benefit Rider included in the policy. If the Outpatient Prescription Drug Benefit Rider attached to this policy provides coverage for Generic Drugs only, then injectable Prescription Drugs are covered subject to this policy's Deductible and Benefit Percentage. If the Outpatient Prescription Drug Benefit Rider attached to this policy includes coverage for Specialty Drugs, then injectable Prescription Drugs that are administered in a Physician's office are covered subject to this policy's Deductible and Benefit Percentage.
16. Emergency ambulance service, either by air or ground or any other form of ambulance needed to transport the Family Member to the nearest Hospital capable of treating the Family Member's condition.
17. Oxygen.
18. Second opinion for surgery.
19. Blood and blood derivatives.
20. Prosthetics, except myo-electric or microprocessor prosthetics and dental prosthetics.
21. Casts, splints, trusses, braces (except dental), crutches and surgical dressings.
22. Purchase or rental of Durable Medical Equipment for kidney dialysis for the personal and exclusive use of the patient. The total purchase price to be eligible will be on a monthly pro-rata basis during the first 24 months of ownership but only so long as dialysis treatment continues to be medically required. We will consider as eligible all charges for supplies, materials and reports necessary for the proper operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient. No benefits are paid for Covered Charges which were reimbursed by Medicare.

23. Rental, up to the purchase price, of Durable Medical Equipment for other than kidney dialysis. If Durable Medical Equipment includes comfort, luxury, or convenience items or features that exceed what is Medically Necessary for the situation or needed to treat the condition, only charges for the standard item will be payable. For example, the coverage for a motorized wheelchair will be limited to the coverage provided for a non-motorized wheelchair.
24. Medically Necessary Treatment of congenital defects and birth anomalies. Coverage includes, but is not limited to, benefits for expenses arising from medical and dental Treatment (including orthodontic and oral surgery Treatment) involved in the management of birth defects known as cleft lip and cleft palate.
25. Transplant Procedures up to the Combined Maximum Lifetime Transplant Benefit shown on the Schedule. Benefits will be paid for Transplant Procedures, Transplant Services, and Organ Procurement and Acquisition Expenses as defined in the Policy and subject to the maximum benefits shown on the Schedule.
26. Charges for mastectomy.
If the attending Physician determines it is Medically Necessary, Covered Charges include Inpatient care for a minimum of:
 - a. 48 hours following a mastectomy; and
 - b. 24 hours following a lymph node dissection.
27. Charges for breast reconstructive surgery, postoperative breast prostheses, and Treatment of physical complications at all stages of the mastectomy, including lymphedemas. Breast reconstructive surgery includes reconstruction of the breast on which the mastectomy was performed and reconstructive surgery of the other breast to produce symmetry.
Coverage will be subject to the Benefit Period Deductible and Benefit Percentage. Coverage will not be subject to dollar limits other than the Maximum Lifetime Benefit.
28. Allergy testing and serums.
29. Allergy injections.
30. Outpatient spinal manipulation, including non-surgical care for dislocations or partial dislocations of the spine, x-rays and lab tests, up to the maximum benefit shown on the schedule.
31. Notwithstanding anything in this Policy to the contrary, the following services and therapy are Covered Charges if necessary as a result of and related to an Acquired Brain Injury: Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation, Neurobehavioral, Neurophysiological, Neuropsychological, or Psychophysiological Testing or Treatment, Neurofeedback Therapy, Remediation, Post-Acute Transition Services, or Community Reintegration Services.
32. Charges for Treatment of diabetes and conditions associated with diabetes, including:
 - a. Office visits and consultations with Physicians, including appropriate specialists;
 - b. Immunizations for influenza and pneumococcus;
 - c. Inpatient services and Physician services when a Family Member is confined to a Hospital, rehabilitation facility or a Skilled Nursing Facility;
 - d. Inpatient and Outpatient laboratory and diagnostic imaging services;
 - e. Diabetes Equipment and Supplies;
 - f. Diabetes Self-Management Training; and
 - g. Immunizations for diphtheria, haemophilus influenzae type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunizations required by law. These benefits will not be subject to a deductible, coinsurance, or copayment when provided to a child from birth to age six (6).
 Diabetes Self-Management Training will be covered upon the following occurrences:
 - a. The initial diagnosis of diabetes;
 - b. The written order of a Physician or practitioner indicating that a significant change in a Family Member's symptoms or condition requires changes in a Family Member's self-management regime;
 - c. The written order of a Physician or practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.
 As new or improved treatment and monitoring equipment or supplies become available and are approved by the United States Food and Drug Administration, such equipment or supplies shall be covered if determined to be Medically Necessary and appropriate by a treating Physician or other practitioner through a written order.
33. Charges for Telemedicine Medical Service and Telehealth Service.
34. Charges for Organic Brain Disease.
35. Charges for Reconstructive Surgery for Craniofacial Abnormalities for children under age 18.
36. The following charges will be covered for a child under age three (3) with Developmental delays if they are determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code:
 - a. Occupational therapy evaluations and services;
 - b. Physical therapy evaluations and services;
 - c. Speech therapy evaluations and services;
 - d. Dietary or nutritional evaluations.
 These charges will be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan. The cost of therapies covered here will not be applied to any annual maximum or the Lifetime Maximum Benefit.

37. Consultations, examinations, procedures and medical services provided on an outpatient basis that are related to the use of prescription drugs and devices approved by the United States Food and Drug Administration for use as a contraceptive are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in this policy.
38. Contraceptive devices that are surgically implanted and approved by the Food and Drug Administration are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in this policy. Benefits are subject to the Benefit Provisions of the Policy and are not covered under the Outpatient Prescription Drug Benefit Rider.
39. Contraceptive drugs and devices that are not surgically implanted are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in this Policy. Benefits are subject to the terms, conditions, and limitations contained on the Outpatient Prescription Drug Benefit Rider included in the policy.
40. The following hospice services:
 - a. Home health aide services under the supervision of a registered nurse or licensed therapist;
 - b. Home health services performed by a licensed registered nurse or licensed therapist;
 - c. Physical therapy;
 - d. Respiratory and inhalation therapy;
 - e. Professional nutrition counseling;
 - f. Medical social services;
 - g. Family counseling due to the Family Member's terminal condition;
 - h. Respite care; and
 - i. Bereavement support services for other Family Members during the three-month period following the death of a Family Member, up to the maximum benefit shown on the Schedule.
41. The following home health care services:
 - a. Home health services performed by a Registered Nurse (R.N.), a licensed vocational nurse under the supervision of an R.N., a home health aide under the supervision of an R.N., or a licensed physical, occupational, respiratory, or speech therapist;
 - b. Physical and occupational therapy;
 - c. Speech therapy and audiology;
 - d. Respiratory and inhalation therapy; and
 - e. Professional nutrition counseling.
42. The following preventive care services:
 - a. Charges for routine physical exams and lab services not sent to an independent lab, subject to the Preventive Care maximum;
 - b. Charges for immunizations age six (6) and older, other than human papillomavirus, subject to the Preventive Care maximum;
 - c. Charges for an annual screening mammogram for females age 35 and over;
 - d. Charges for an annual examination for the detection of prostate cancer, including a prostate-specific antigen test used for the detection of prostate cancer, for a male who is:
 - (1) At least 50 years of age and is asymptomatic; or
 - (2) At least 40 years of age and has a family history of prostate cancer or another prostate risk factor;
 - e. Charges for a medically recognized screening examination for a Family Member who is 50 years of age or older for the detection of colorectal cancer, including:
 - (1) A fecal blood test performed annually and a flexible sigmoidoscopy performed every five (5) years; or
 - (2) A colonoscopy performed every 10 years;
 - f. Charges for an annual medically recognized diagnostic examination for the early detection of cervical cancer for Family Members 18 years of age or older. Coverage includes a conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the U.S. Food and Drug Administration (USFDA), alone or in combination with a test approved by the USFDA for the detection of the human papilloma virus;
 - g. Charges for immunizations for children under age six (6), including immunizations for diphtheria, haemophilus influenzae type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella and any other immunizations required by law. These benefits will not be subject to a deductible, coinsurance, or copayment;
 - h. Charges for a screening test for hearing loss from birth through the date the child is 30 days old, including necessary diagnostic follow-up care from birth through the date the child is 24 months old.;
 - i. Charges for human papillomavirus immunizations;
 - j. Charges for bone density tests;
 - k. Charges for lab work sent to an independent lab; and
 - l. All other preventive services not specifically listed.
43. Accidental death (including dismemberment and loss of sight) covers the primary insured up to a maximum benefit of \$10,000; spouse up to a maximum of \$2,500; and dependent child up to a maximum of \$1,000. Benefits are payable if the loss results from an accidental bodily injury which occurred while insured under the policy; was independent of disease or bodily infirmity; evidenced by a bruise or wound, except in the case of internal injuries shown by autopsy, asphyxiation or drowning; and the loss occurs within 90 days after the accident bodily injury. The full amount of insurance is payable for loss of life, both hands or feet; sight of both eyes; one hand and one foot; one hand and sight of one eye, one foot and sight of one eye. One-half the full amount of insurance is payable for loss of one hand, one foot, or sight of one eye. With respect to hands and feet, "loss" means permanent severance at or above the wrist or ankle joint. With respect to eyesight, "loss"

means the entire and permanent loss of sight. The full amount of insurance will be paid only once for any one accident, no matter how many of the above listed losses occur as a result of that accident.

44. Outpatient Prescription Drugs, if option selected, subject to exclusions.

Emergency Care Services and Benefits

Emergency Care is treatment provided in a hospital emergency facility or comparable facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- A. placing the person's health in serious jeopardy;
- B. serious impairment to bodily functions;
- C. serious dysfunction of a bodily organ or part;
- D. serious disfigurement; or
- E. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

If you cannot reasonably reach a Network Provider and until you can reasonably be expected to transfer to a Network Provider, We will pay for emergency care at the Network Provider level.

Out of Area Services and Benefits

If an emergency occurs during your temporary absence from the Service Area, benefits for medically necessary Emergency Care services will be paid at the Network Provider level until you can reasonably be expected to transfer to a Network Provider.

Your Financial Responsibility

You are responsible for paying the premium on a timely basis. You are also responsible for the co-payments, deductible, benefit percentage, charges in excess of the benefit limits included in the policy, charges which are not covered charges under the policy, and charges which are more than the Usual, Customary and Reasonable Charge for services performed by a Non-Network Provider.

Limitations and Exclusions

There is a 6-month Waiting Period for Certain Conditions for Treatment of the following when received on a non-Emergency basis: tonsils, adenoids, hemorrhoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, uterine prolapse.

1. Pre-existing Conditions for two (2) years starting on the Effective Date of the Family Member's coverage under the Policy.
This exclusion does not apply to the Family Member if:
The Family Member was continuously covered for an Aggregate Period of 18 months by Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of the Family Member's coverage under the Policy, excluding any Waiting Period.
This 2-year exclusion period will be reduced for the Family Member if all of the following are true:
 - a. The Family Member does not have an aggregate Creditable Coverage totaling 18 months; and
 - b. The Family Member has some Creditable Coverage that was in effect at any time during the 18 months preceding:
 - (1) The first day coverage is effective, if there is not a waiting period; or
 - (2) The day that the Family Member files a substantially complete application for coverage, if there is a Waiting Period.
2. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.
3. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
4. Charges for any loss caused by the Family Member's commission or attempt to commit a felony or caused by the Family Member's engagement in an illegal occupation.
5. Charges for losses which are due to participation in a war or any act of war, whether or not declared, or participation in a riot or insurrection.
6. Charges for any Sickness contracted or Injury received while a member of the Military, Navy or Air Force of any country or combination of countries, any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, and charges for Treatment of Sickness or Injury that are covered by workers' compensation insurance or similar laws.
7. Charges for services performed by volunteers, a relative, a Family Member, a Family Member's employer, or a resident in the Family Member's household, other than dental services.
8. Charges for services or supplies for personal comfort or convenience.

9. Charges for travel or lodging expenses.
10. Charges for maintenance care, Custodial Care or homemaker services.
11. Charges for treatment given in a Hospital emergency room for Non-Emergency Sickness.
12. Charges for dental services or supplies for Treatment of the teeth, gums or alveolar processes, unless:
 - a. The Dental Benefit Rider is included in the Policy; or
 - b. Required as a result of and rendered within 12 months of any Injury to sound, natural teeth, and provided that Treatment begins within 90 days following the Injury.
13. Cosmetic Treatment, or complications of Cosmetic Treatment, except when required:
 - a. As a result of an Injury and when provided within 12 months of the Injury; or
 - b. Due to mastectomy as provided under the Medical Benefits section of this Policy; or
 - c. Due to Reconstructive Surgery for Craniofacial Abnormalities as provided under the Medical Benefits section of this Policy.
14. Vision related surgery or services, including, but not limited to:
 - a. Eye refractions;
 - b. Examinations for eye refractions;
 - c. Eyeglasses or their fitting;
 - d. Contact lenses or their fitting;
 - e. Surgery to correct nearsightedness, farsightedness, astigmatism or vision conditions; and
 - f. Eye training, exercises or vision therapy.
15. Charges for any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring hearing loss or auditory comprehension, routing hearing tests and audiograms that are not performed in connection with a Sickness or Injury. This exclusion does not apply to Newborn Hearing Screening as covered under the Preventive Care Benefit.
16. Charges for vitamins, minerals, supplements, herbals, botanicals, food, special diets, specially grown or prepared foods or diets, even if prescribed to treat a Sickness except for clinically proven vitamin deficiency syndromes that cannot be corrected by dietary intake.
17. Charges for expenses related to an uncomplicated pregnancy including routine antepartum care, routine prenatal laboratory tests, routine ultrasounds, routine delivery services, routine postpartum care and routine maternity hospitalization.
18. Charges for care of a well, newborn child, except when insurance coverage is required by law.
19. Charges for contraceptive drugs, devices, methods or aids, unless the optional Outpatient Prescription Drug benefit is chosen.
20. Charges for sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
21. Charges for expenses related to the diagnosis and/or Treatment of infertility or fertilization procedures. Examples of fertilization procedures include, but are not limited to: ovulation induction procedures, invitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.
22. Charges for gender reassignment or charges due to complications of gender reassignment.
23. Charges for the diagnosis and/or Treatment of acne.
24. Charges for the diagnosis and/or Treatment of eating disorders.
25. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.
26. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and non-chemical addictions.
27. Charges for hair loss, hair restoration or removal.
28. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.
29. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, other than Organic Brain Disease, even if court ordered.
30. Charges for the diagnosis and/or Treatment of Substance Abuse.
31. Charges for physical, occupational or speech therapy for Developmental reasons. This exclusion does not apply to Treatment of Developmental delays as covered under the Medical Benefits section of this Policy.
32. Charges for transplants, except as provided under the Medical Benefits section of this Policy.
33. Charges for examination, diagnosis, appliances or Treatment of malocclusion, misalignment, dysfunction, deformity or defect of the jaw or temporomandibular joint dysfunction.
34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed, except for Medicaid or as otherwise required by law.
35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.
36. Charges for performance of physical examinations for a third party, that is not related to the provision of care, such as, requirements for employment, licenses, educational or recreational activities.
37. Charges for court-ordered evaluation, Treatment or testing which is not Medically Necessary.
38. Charges for genetic testing, counseling and services.
39. Charges for inoculations or prophylactic drugs for travel.

40. Charges for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote, or delay growth or to delay puberty to allow for increased growth. This exclusion does not apply to Treatment of Developmental delays as covered under the Medical Benefits section of this Policy.
41. Charges for services available in the community through educational or school programs.
42. Charges for evaluation or Treatment of learning disabilities; Attention Deficit Disorder; attitudinal disorders; or disciplinary, social or Developmental conditions. This exclusion does not apply to Treatment of Developmental delays as covered under the Medical Benefits section of this Policy.
43. Charges for tests, examinations or other procedures performed which are not Medically Necessary to the care and Treatment of a Sickness or Injury, or which are illegal or Experimental, Investigational, Unproven and/or for Research, including complications resulting from tests, examinations or other procedures, which are illegal or Experimental, Investigational, Unproven and/or for Research.
44. Charges for foot care in connection with corns, calluses, toenails, flat feet, fallen arches, weak feet, or chronic foot strain; shoes, shoe accessories, and orthotics.
45. Charges for treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
46. Charges for treatment of nail fungus.
47. Charges for any expenses incurred outside of the United States for elective care, testing, procedures or services, except for Emergency care.
48. Charges for diagnosis, Treatment, testing, and surgical intervention of sleep disorders, including complications resulting from diagnosis, treatment, testing or surgical intervention.
49. Charges for expenses related to Treatment, diagnosis, or care provided over the Internet or via electronic mail, except for Telehealth Services and Telemedicine Medical Services.
50. Charges for non-medical expenses even if recommended by a Physician. This includes, but is not limited to: work hardening or strengthening programs, travel expenses, hypnosis, self-help training, services or supplies at a health spa or similar facility, massage therapy, charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, information required to process Your claims, and similar expenses.
51. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Rider is attached to the Policy.
52. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.
53. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of this Policy.
54. Charges for services or supplies related to alternative and complementary medicine, including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, naturotherapy, thermograph, orthomolecular therapy, contact reflex analysis, bionenergal synchronization technique (BEST) and iridology-study of the iris.
55. Charges for myo-electric or microprocessor Prosthetics.
56. Charges for replacement of or maintenance, repair, modification or enhancement to a prosthetic. Charges for replacement due to outgrowing prosthetics as a result of the normal skeletal growth of a child will be covered.
57. Charges for replacement of or maintenance, repair, modification or enhancement to Durable Medical Equipment. Charges for replacement due to outgrowing Durable Medical Equipment as a result of the normal skeletal growth of a child will be covered.
58. Charges for Treatment required due to an Injury sustained while operating any motorized vehicle while the Family Member's blood alcohol level is at or above the legal limit, as defined by law. This exclusion applies whether or not any person is charged with any violation in connection with the Accident.
59. Charges for which benefits are not provided in this Policy.
60. No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:
 - a. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;
 - b. Insurrection, riot, or war;
 - c. The committing of, or the attempt to commit, an assault or felony;
 - d. Disease or disorder of the body or mind;
 - e. Medical or surgical Treatment or diagnosis, preventive care or complications of care;
 - f. The voluntary or involuntary:
 - i. Taking of drugs (except drugs taken as prescribed by a Physician) or poison; or
 - ii. Inhaling of gas or other inhalants;
 - g. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or
 - h. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of, a visible accidental wound).
61. The following drugs are excluded from the Outpatient Prescription Drug Benefit, if included in the policy:
 - a. Brand Name Drugs (this exclusion only applies to the Generic Only plan);
 - b. Prescription Drugs excluded from coverage or used to treat medical conditions that have been excluded from coverage by amendment or rider to this Policy;
 - c. Prescription Drugs used to treat anything listed in or excluded by the General Exclusion section of the Policy;
 - d. Non federal legend drugs;

- e. Contraceptive drugs and devices that are not approved by the United States Food and Drug Administration;
- f. Contraceptive devices that are surgically implanted;
- g. Fertility agents and medications;
- h. Injectable or any prescription directing parenteral administration or use, except insulin;
- i. Antidepressants, except for Treatment of Organic Brain Disease;
- j. Tranquilizers, except for Treatment of Organic Brain Disease;
- k. Miscellaneous psychotherapeutic agents, except for Treatment of Organic Brain Disease;
- l. Benzodiazepines, except for Treatment of Organic Brain Disease;
- m. Antimanic agents, except for Treatment of Organic Brain Disease;
- n. Drugs to treat Attention Deficit Hyperactivity Disorder;
- o. Substance abuse treatment agents;
- p. Oral and topical acne medications;
- q. Smoking deterrents;
- r. All antiobesity preparations;
- s. Amphetamines;
- t. Legend vitamins and fluoride products;
- u. Drugs to treat influenza or lessen its symptoms, except as otherwise provided in the policy;
- v. Therapeutic devices or appliances, except as otherwise provided in the policy;
- w. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
- x. Immunization agents and vaccines, except as otherwise provided in the policy;
- y. Biologicals, blood or blood plasma;
- z. Off-label use of prescription drugs except when the drug:
 - (1) Has been approved by the Food and Drug Administration for at least one indication; and
 - (2) Is recognized by the following for Treatment of the indication for which the drug is prescribed:
 - (a) A prescription drug reference compendium approved by the Commissioner for purposes of this section; or
 - (b) Substantially accepted peer-reviewed medical literature.
- aa. Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual;
- bb. Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member; except benefits paid by the Texas Department of Human Services;
- cc. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is 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;
- dd. Prescription Drugs that are prescribed in excess of the manufacturer's guidelines, clinically approved dispensing guidelines, current FDA approved product labeling, peer review journals, authoritative drug compendia (USP-Drug Information, the American Hospital Formulary Services, and Micromedex), and generally recognized standards of care, except where prohibited by state law;
- ee. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order;
- ff. Charges for the administration or injection of any drug;
- gg. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
- hh. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
 - ii. Growth hormone medication and its derivatives or other drugs used to stimulate, promote, or delay growth or to delay puberty to allow for increased growth. This exclusion does not apply to Treatment of Developmental delays as covered under the Medical Benefits section of this Policy;
- jj. Drugs for Treatment of onychomycosis (nail fungus);
- kk. Drugs for Treatment of impotency;
- ll. Drugs to treat rosacea;
- mm. Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose;
- nn. Allergy medications;
- oo. Drugs to treat a cough or cold or lessen its symptoms;
- pp. Drugs to treat a migraine or headache;
- qq. Drugs not listed on the Formulary; and
- rr. Proton Pump Inhibitors.

Authorization Program

The policy does not require authorizations before, during, or after services are rendered.

Continuity of Care

To verify if a physician or other health care provider is currently participating, you should contact customer service at 1-800-991-2642 or the provider directly, prior to making appointments.

If a provider has been terminated as a Network Provider for reasons other than medical incompetence or unprofessional conduct, We will continue to cover an existing course of treatment at the Network Provider benefit level if you have special circumstances in accordance with the dictates of medical prudence. The provider must identify the special circumstance, request that you be permitted to continue treatment under the provider's care, and agree not to seek payment from you of any amount for which you would not be responsible if the provider were still a Network Provider.

We will only continue this benefit for 90 days after the effective date of the provider's termination as a Network Provider. If you have been diagnosed with a terminal illness at the time of the provider's termination, We will continue the benefit for nine (9) months after the effective date of the termination.

Complaint Resolution Procedures

If your claim is denied in whole or in part, you will receive written notification of the denial. The notification will explain the reason for the denial.

Level 1 Review: You or your treating provider have the right to appeal any denial of a claim for benefits by submitting a written request for review to Us. Appeals must be filed within 180 days of the written notification of denial. When We receive the written appeal, We will review the claim and make a determination within 30 business days. We may take an additional 30 business days for circumstances beyond Our control. If an extension is needed, you or your treating provider will be notified within 30 business days of Our receipt of the appeal.

Level 2 Review: If the matter is not resolved to your satisfaction, you or your treating provider may request a second review by sending Us a written appeal within 60 business days. When We receive the written appeal, We will review the claim and make a determination within 30 business days. We may take an additional 30 business days for circumstances beyond Our control. If an extension is needed, you or the treating provider will be notified within 30 business days of Our receipt of the second appeal. You will be informed in writing of Our final decision.

External Review: If the matter involves a determination that the services provided are not Medically Necessary, and your appeal has been denied, you may seek a review of the second appeal determination by an independent review organization certified by the Texas Commissioner of Insurance. To initiate a review by an independent review organization, you must submit a written request to Us.

We will not take any retaliatory action, such as refusing to renew or canceling coverage, against you or a provider because the provider has, on your behalf, filed a complaint against or appealed a decision made by Us.

Network Providers

A directory of Network Providers is available through Our website, www.american-community.com. We will update this list of Network Providers at least annually. If you have any questions about Network Providers, you may contact Us at 1-800-991-2642.

Service Area

The Service Area is defined as any place that is within fifty (50) miles of a Network Provider and in the state of Texas.

Renewability & Eligibility

A. The policy is guaranteed renewable. That means that you have the right to keep the policy in force with the same benefits, except that We may discontinue or terminate the policy if:

- (1) You failed to pay premiums in accordance with the terms of the policy or We have not received timely premium payments;
- (2) You performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy; or
- (3) We decide to cease offering coverage in the individual market, or this particular type of policy, in accordance with applicable state laws.

B. You will become ineligible for coverage when premiums are not paid according to the due dates and grace periods described in the policy.

The policy will not terminate when a covered person becomes eligible for Medicare. However, the policy excludes any benefits that are paid to a covered person by Medicare.

Premium

- A. The monthly premium for the plan for which you have made application is \$_____. The annual premium for the plan for which you have made application is \$_____. Premiums may be paid monthly, quarterly, semi-annually, or annually. At least one (1) month's premium amount must be submitted with your original application.
- B. We can change the premium at renewal if We change the premium for all other policies in your state which are issued using this form. The renewal premium is calculated from a table of rates We use for the policy form on the renewal date. This calculation takes into account your classification on the renewal date. Premiums may also change at renewal based upon your age or your residence. If We change the premium, We must deliver to you written notice at least 30 days before a premium is due.
- C. A grace period of 31 days will be granted for the payment of each premium due after the first premium. During the grace period, the policy continues in force, subject to Our right to cancel the policy in accordance with the policy's cancellation provision.

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