

**READ YOUR POLICY CAREFULLY** – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**MEDICAL EXPENSE COVERAGE** – Policies of this category are designed to provide, to persons insured, coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out of hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

**COVERED CHARGES** – Next Generation HSA offers increased benefits when the Family Member uses a Network Provider. These benefit differences are illustrated under Network/Non-Network.

**Network Deductible:** Only Covered Charges payable at the Network benefit level will apply toward the Network Deductible. Once the Network Deductible is satisfied, network benefits are payable as long as you stay in network.

**Non-Network Deductible:** Only Covered Charges payable at the Non-Network benefit level will apply toward the Non-Network Deductible.

If a Family Member incurs Covered Charges from a Network provider, American Community will pay benefits according to the column headed Network. Benefits are based upon a negotiated reimbursement schedule. If a Family Member incurs Covered Charges from a Non-Network provider, American Community will pay benefits according to the column headed Non-Network. These benefits are based upon a Usual, Customary and Reasonable (UCR) reimbursement schedule. UCR means a charge which We determine does not exceed the amount usually accepted by providers in the general area where the charge is incurred.

The Deductible, Benefit Percentage and Out-of-Pocket Maximum are based on the Benefit Period as determined by the effective date of the policy. The Benefit Period is the 12 month period beginning on the effective date of the policy and reoccurring every 12 months thereafter.

All benefits are subject to the Benefit Period Deductible and Benefit Percentage unless otherwise indicated:

PLAN CHOICE	100% PLAN		80% PLAN	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
<b>BENEFIT PERIOD DEDUCTIBLES</b>				
<b>Single Coverage:</b> The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$1,150** \$1,500 \$2,100 \$2,700 \$3,500 \$5,000	\$2,300** \$3,000 \$4,200 \$5,400 \$7,000 \$10,000	\$1,150** \$1,500 \$2,100 \$2,700 \$3,500	\$2,300** \$3,000 \$4,200 \$5,400 \$7,000
<b>Family Coverage:</b>	\$2,300** \$3,000	\$4,600** \$6,000	\$2,300** \$3,000	\$4,600** \$6,000
<b>Common Family Deductible</b> The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$4,200 \$5,450 \$7,000 \$10,000	\$8,400 \$10,900 \$14,000 \$20,000	\$4,200 \$5,450 \$7,000	\$8,400 \$10,900 \$14,000
<b>Embedded Family Deductible*</b> The network and non-network deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$4,600** \$5,450 \$7,000 \$10,000	\$9,200** \$10,900 \$14,000 \$20,000	\$4,600** \$5,450 \$7,000	\$9,200** \$10,900 \$14,000

\*Embedded Deductible means reimbursement will begin on any individual meeting the single deductible (which is one-half the family deductible) or on the whole family when 2 or more individuals meet the family deductible.

\*\*These may be adjusted annually for changes in the U.S. Consumer Price Index (CPI).

<b>Lifetime Policy Maximum</b>	\$5 million
<b>Network Available</b>	Midlands Choice

	NETWORK COVERAGE	NON-NETWORK COVERAGE
<b>BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.</b>		
Individual Benefit Percentage/Out-of-Pocket Maximum After Deductible	100%/NA 80%/\$1,000	75%/\$4,000 50%/\$4,000
Family Benefit Percentage/Out-of-Pocket Maximum After Deductible	100%/NA 80%/\$2,000	75%/\$4,000 50%/\$8,000

<b>ACCIDENT BENEFIT</b>	
<b>Accident</b>	We will waive the 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 Deductible will be applied to any Covered Charges incurred after the 30-day limit has been met.

	NETWORK COVERAGE	NON-NETWORK COVERAGE
<b>PHYSICIAN SERVICES</b>		
<b>BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.</b>		
<b>In Physician's Office and Urgent Care Centers</b> • Office Visits • Office Surgery • Visits for Injury • X-rays • Laboratory Tests		
<b>In-Hospital Visits by a Physician</b>	100% or 80%	75% or 50%
<b>Outpatient Spinal Manipulation</b> \$500 benefit period maximum per family member		
<b>Allergy Testing, Serums and Injections</b> \$500 benefit period maximum per family member		
<b>Preventive Care</b> \$300 benefit period maximum per family member • Immunizations • PSA Testing • Routine Physical Exams • Colorectal Cancer Exam • Routine Mammograms • Pap Smear • Inoculations or Prophylactic Drugs for Travel • Bone Density	100% or 80%	Not Covered
<b>HOSPITAL SERVICES</b>		
<b>BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.</b>		
<b>Inpatient Services</b>		
<b>Outpatient Surgery</b>		
<b>Diagnostic Services</b> • Pre-admission testing • X-rays • Laboratory Tests • Nuclear medicine • MRIs • Mammograms • Ultrasounds	100% or 80%	75% or 50%
<b>Emergency Room Services</b>	Emergency sickness or injury subject to the <b>Network</b> deductible and <b>Network</b> benefit percentage of 100% or 80%. <b>Non-emergency sickness is not covered.</b>	
<b>OTHER COVERED SERVICES</b>		
<b>BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.</b>		
<b>Free-Standing Outpatient Surgery Center</b> Facility Charges		
<b>Radiology or Diagnostic Services Outside of the Hospital</b> • X-rays • Nuclear medicine • MRIs • Ultrasounds • Mammograms • Laboratory Tests (including lab work sent by a physician to an independent laboratory)		
<b>Outpatient Physical, Occupational and Speech Therapy</b> Limited to 60 visits per benefit period (this is a combined total for all therapies)	100% or 80%	75% or 50%
<b>Home Health Care</b> Limited to 20 visits per benefit period		
<b>Hospice</b> Up to \$200 per day, a lifetime maximum \$15,000 or 6 months, whichever comes first		
<b>Nursing Facility</b> Limited to \$75 per day, 60 days per benefit period		
<b>Prescription Drug Coverage</b> Includes the discount drug card for use at network retail pharmacies, up to a 30-day supply. The mail-order program also provides discounts for up to a 90-day supply of maintenance medications.	Discount Program, then 100% or 80%	75% or 50%
<b>Organ Transplants</b> Combined maximum lifetime benefit of \$1 million. Includes charges incurred at designated and non-designated transplant facilities. A designated transplant facility is a medically proven, exceptional success rate facility for organ transplants that has agreed to provide approved transplant services to our policyholders.	Designated Transplant Facility \$1 million maximum lifetime benefit with up to \$10,000 for travel and accommodation expenses for the insured person and one companion. Meals and lodging are limited to \$150 per person per day.  100% or 80%	Non-Designated Transplant Facility \$700,000 maximum lifetime benefit  75% or 50%
<b>OPTIONAL BENEFITS</b>		
<b>BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.</b>		
<b>Dental Benefit</b> Benefit period maximum benefit is \$1,000	Type I procedures: 6-month waiting period, then 80%  Type II procedures: 12-month waiting period, \$100 benefit period deductible, then 50%	
<b>Maternity Benefit for Insured and Spouse Only if Covered Under the Policy</b> 6-month waiting period from the effective date of the rider. To be covered, pregnancy must begin after the waiting period.	100% or 80%	75% or 50%

- 1) Daily hospital room and board:
  - a. Semi-private room and routine nursing care for Confinement in a Hospital
  - b. Room and board and nursing care in an Intensive Care Unit
- 2) Miscellaneous hospital services:
  - a. Medical services and supplies furnished by the hospital
  - b. Oxygen
  - c. Blood and blood derivatives
  - d. Treatment given in a Hospital emergency room for an Emergency Sickness or Injury. Benefits are payable at the Network benefit level.
- 3) Surgical services:
  - a. Surgeon's medical care or surgery. If two or more procedures are performed through the same incision, the most American Community will consider:
    - (1) for procedures performed by a Network Provider is the Preferred Provider Network allowance for the most expensive procedure and 50% of the Preferred Provider Network allowance for the remaining procedures; or
    - (2) 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.
  - b. Mastectomy, including 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.
  - c. Services of an assistant surgeon or technical surgical assistant, but no more than 20% of the amount allowed for the surgeon's fee.
- 4) Anesthesia services: Anesthetics and their administration
- 5) In-hospital medical services:
  - a. Prescription drugs and medicines provided while Confined
  - b. X-rays, lab tests and other diagnostic services
  - c. Radiation therapy, chemotherapy
  - d. Radiology and pathology
  - e. Physician's medical care
- 6) Out of hospital care:
  - a. **Nursing Facility Care** – Nursing Facility room and board covered at \$75 per day, 60 days per benefit period. Medical services and supplies furnished by the Nursing Facility.
  - b. **Home Health Care** – Home Health Care covered at 20 visits per benefit period. Covered charges include: home health services performed by a Registered Nurse or licensed therapist; physical and occupational therapy; speech therapy and audiology; respiratory and inhalation therapy; professional nutrition counseling.
  - c. **Hospice** – Hospice care covered at \$200 per day, subject to a lifetime maximum of \$15,000 or 6 months, whichever comes first. Covered charges include: home health aid services supervised by a Registered Nurse or licensed therapist; home health services performed by a Registered Nurse or licensed therapist; physical therapy; respiration and inhalation therapy; professional nutrition counseling; medical social services; family counseling due to the Family Member's terminal condition; respite care; bereavement support services for other Family Members during the three month period following the death of a Family Member, not to exceed a benefit of \$500.
  - d. Physician's medical care
  - e. X-rays, lab tests, and other diagnostic services
  - f. Second opinion for surgery
  - g. Treatment given in an outpatient section of a Hospital, Free Standing Outpatient Surgery Center, or similar facility.
  - h. Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury, covered at a combined maximum of 60 visits per benefit period for all therapies.
- 7) Other Benefits:
  - a. Allergy testing, serums and injections limited to \$500 per benefit period.
  - b. Prosthetics, except myo-electric prosthetics and dental prosthetics, for losses incurred while insured under the policy.
  - c. Casts, splints, trusses, braces (except dental), crutches, and surgical dressings.
  - d. 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 a dialysis treatment continues to be medically required. We will consider as eligible all charges for supplies, materials and repairs 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 a Family Member on or after the day such individual is entitled to benefits under Medicare, except as provided by law.
  - e. Rental up to the purchase price of Durable Medical Equipment for other than kidney dialysis.
  - f. Emergency ambulance service to the nearest Hospital capable of treating the Family Member's condition.
  - g. Medically Necessary Treatment of congenital defects and birth anomalies for dependent children who are Family Members. 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.
  - h. Approved Transplant Procedures up to \$1 million in a Designated Transplant Facility and \$700,000 in a Non-Designated Transplant Facility. The Combined Maximum Lifetime Transplant Benefit is \$1 million for charges incurred at a Designated and a Non-Designated Transplant Facility. To be eligible to receive the benefits available, transplants must be approved by American Community prior to the beginning of the evaluation. No benefits will be paid if the procedure is not approved in advance. Benefits will be paid for Approved Transplant Procedures, Approved Transplant Services, Organ Procurement and Acquisition Expenses, and Travel and Accommodation Expenses as defined in the policy.
  - i. Prescription drugs, except drugs prescribed for medical conditions that have been excluded from coverage by amendment or rider to this policy. Coverage includes prescription contraceptive drugs and devices approved by the Food and Drug Administration. Drugs prescribed to treat anything listed in the General Exclusions section of the policy are not covered.
  - j. Outpatient spinal manipulation including non-surgical care for dislocations or partial dislocations of the spine, x-rays and lab tests, up to \$500 per benefit period.
  - k. Administration of general anesthesia and Hospital or Ambulatory Surgical Center charges incurred when dental care is provided for the following Family Members, when determined to be necessary by a licensed dentist and the Family Member's treating Physician:
    - (1) A child under five (5) years of age who has a dental condition or a developmental disability for which patient management in the dental office has proven to be ineffective;
    - (2) A person who has one or more medical conditions that would create significant or undue medical risk if the necessary dental treatment is not rendered in a Hospital or Ambulatory Surgical Center.
  - l. Contraceptive drugs and devices approved by the United States Food and Drug Administration for use as a

contraceptive. Benefits are subject to the Prescription Drug Discount Card benefits and limitations included in the policy. Coverage does not include over-the-counter drugs and devices that do not require a prescription for purchase. Coverage does not apply if You have declined contraceptive coverage on Your application for insurance.

- m. Outpatient services for the purpose of preventing conception. Coverage does not include surgical services intended for abortion or sterilization, including but not limited to tubal ligation or vasectomy. Coverage does not apply if You have declined contraceptive coverage on Your application for insurance.
  - n. Equipment and supplies for the Treatment of all types of diabetes mellitus when prescribed by a licensed Physician, including blood glucose meter and glucose strips for home monitoring.
  - o. Self-management training and education for the Treatment of all types of diabetes mellitus only under all of the following conditions: (a) The Family Member's Physician certifies that such services are needed; (b) The self-management training and education program is certified by the Iowa department of public health, and provides the following:
    - (1) Initial training for up to 10 hours of initial outpatient diabetes self-management training within a continuous 12-month period for each Family Member that meets any of the following conditions:
      - (a) A new onset of diabetes
      - (b) Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the 90 days before attending training
      - (c) A change in treatment regimen from no diabetes medication to any diabetes medication, or from oral diabetes medication to insulin
      - (d) High risk for complications based on poor glycemic control
      - (e) High risk based on documented complications.
    - (2) A Family Member who receives the initial training is eligible for one (1) follow-up training session of up to one (1) hour each year.
- 8) Preventive Care Benefits up to a maximum of \$300 per benefit period. Covered charges include: routine physical exams, including x-ray and lab services; age appropriate immunizations; an annual prostate-specific antigen (PSA) blood test and digital rectal exam limited to males age 50 and over, males age 40 and over with a family history of prostate cancer or males at risk; an annual pap smear or cervical smear; inoculations or prophylactic drugs for travel; bone density test; colonoscopy; routine mammograms limited to one baseline mammogram between the ages of 35 and 39, or more frequent mammograms if recommended by the woman's physician; one mammogram per year after age 39, or more frequently if recommended by the patient's physician; and one mammogram per year for women at risk. Covered Charges for routine mammograms count toward the Preventive Care maximum. However, they will continue to be paid even after the Preventive Care maximum has been reached.
- 9) Optional Maternity Coverage
- a. Available to you or your spouse, if insured under the policy, with a 6-month waiting period from the effective date of the rider.
  - b. To be covered, the pregnancy must begin after the waiting period.
  - c. Benefits are subject to benefit period network and non-network deductibles and benefit percentage contained in the policy.
  - d. Covered charges include routine pre-natal care, routine delivery services, in-hospital care of well newborn, and inpatient care and associated charges incurred for 48 hours after vaginal delivery and 96 hours after cesarean section.

10) Optional Dental Coverage

The dental deductible and benefit percentage are separate from the medical deductible and benefit percentage. The maximum benefit per person, per benefit period, is \$1,000 (Type 1 & 2 combined)

Type 1:

- No deductible is required; charges for covered services are covered at 80% after a six-month waiting period.
- Benefits include office visits and examinations, cleanings, x-rays, diagnostics, space maintainers and pathology.

Type 2:

- Charges for covered services are subject to a \$100 calendar year deductible, then covered at 50% after a 12-month waiting period.
- Benefits include fillings, oral surgery, extractions, root canals, endodontics, periodontics, crowns, inlays, bridges and dentures.

**GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS**

We will pay no benefit for charges due to any of the following. These charges are not Covered Charges and cannot be used to satisfy the policy's Deductible, Benefit Percentage, or Out of Pocket Maximum.

1. Pre-existing Conditions for two (2) years starting on the Effective Date of a Family Member's coverage under the Policy.
2. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.
3. Suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
4. Injury received while committing or attempting to commit a felony.
5. War or any act of war, whether or not declared, or participation in a riot or insurrection.
6. 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 a Sickness or Injury that is covered by Workers' Compensation Insurance or similar laws.
7. Services performed by volunteers, a relative, a Family Member, a Family Member's employer, or a resident in the Family Member's household.
8. Services or supplies for personal comfort or convenience.
9. Travel or lodging expenses, except as provided under the Medical Benefits section of the policy.
10. Maintenance care, Custodial Care or homemaker services.
11. Preventive medical care, except as provided under the Medical Benefits or Preventive Care Benefits sections of the policy.
12. Treatment given in a Hospital emergency room for a Non-Emergency Sickness.
13. 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. The Injury must occur after the Effective Date of the Family Member's coverage under the policy.
14. Cosmetic Treatment, or complications of Cosmetic Treatment, except when required:
  - a. As the result of an Injury and when provided within 12 months of the Injury. The Injury must occur after the Effective Date of the Family Member's coverage under the policy or
  - b. Due to mastectomy as provided under the Medical Benefits section of the policy.
15. 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.
- 16. Hearing aids or their fitting, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury.
- 17. Vitamins, minerals, supplements, herbals, botanicals, food, special diets, specially grown or prepared foods or diets, even if prescribed to treat a Sickness.
- 18. 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.
- 19. Care of a well, newborn child, except when insurance coverage is required by law.
- 20. Sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
- 21. 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. Gender reassignment or charges due to complications of gender reassignment.
- 23. Treatment of acne.
- 24. Treatment of "quality of life" or "lifestyle" concerns including but not limited to eating disorders; weight loss programs, drugs or surgery (including complications of surgery); smoking cessation; expenses related to nicotine addiction, caffeine addiction and non-chemical addictions; exercise programs or equipment; hair loss; hair restoration or removal; sexual function, dysfunction, inadequacy or desire.
- 25. Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.
- 26. Treatment for Substance Abuse.
- 27. Physical, occupational or speech therapy for Developmental reasons.
- 28. Transplants, except as provided under the Medical Benefits section of the policy.
- 29. Examination, diagnosis, appliances or Treatment of malocclusion, misalignment, dysfunction, deformity or defect of the jaw or temporomandibular joint dysfunction.
- 30. Charges which a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
- 31. Charges for Treatment by a Physician, which is not within the scope of his or her license.
- 32. Performance of physical examinations or the verification of health status for a third party, that is not related to the provision of care, such as, requirements for employment, licenses, educational or recreational activities.
- 33. Court-ordered evaluation, Treatment or testing.
- 34. Genetic testing, counseling and services.
- 35. Growth Treatment, medication or hormones.
- 36. Services available in the community through educational or school programs.
- 37. Evaluation or Treatment of learning disabilities; Attention Deficient Hyperactivity Disorder; attitudinal disorders; or disciplinary, social or Developmental conditions.
- 38. Care, services, procedures or supplies that are cognitive in nature.
- 39. Tests, examinations or other procedures performed which are not Medically Necessary to the care and Treatment of a Sickness or Injury, or which are:
  - a. Illegal; or
  - b. Experimental, Investigational, Unproven and/or for Research.
- 40. Foot care in connection with corns, calluses, toenails, flat feet, fallen arches, weak feet, or chronic foot strain; shoes, shoe accessories, and orthotics.
- 41. Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.

- 42. Treatment of nail fungus.
- 43. Any expenses incurred outside of the United States for elective care, testing, procedures or services, except for Emergency care.
- 44. Treatment and testing of sleep disorders.
- 45. Expenses related to Treatment, diagnosis, or care provided over the Internet or via electronic mail.
- 46. 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.
- 47. Expenses related to an Injury sustained while the Family Member is participating in a professional sporting event for which they receive money or any other compensation.
- 48. Prescription Drugs used to prevent Sickness; and to prevent, treat or lessen the symptoms of influenza or respiratory virus.
- 49. Non federal legend drugs.
- 50. Amphetamines.
- 51. Prescription Drugs labeled "Caution – limited by Federal Law to investigational use" or experimental drugs, even though a charge is made to the individual.
- 52. Any Prescription Drug 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.
- 53. Charges for which benefits are not provided in the policy.

#### **MATERNITY EXCLUSIONS**

No benefits will be paid for any of the following:

- 1. Vitamins including pre-natal vitamins;
- 2. In vitro fertilization;
- 3. Drugs, tests, treatments or procedures to aid or assist conception.

#### **DENTAL EXCLUSIONS**

We will not pay benefits for charges due to any of the following, except as otherwise provided in the policy.

- 1. Type I procedures incurred during the first 6 months of coverage.
- 2. Type II procedures incurred during the first 12 months of coverage.
- 3. Orthodontic treatment.
- 4. Any treatment which is for cosmetic purposes or for the correction of congenital or developmental malformations.
- 5. Replacement of any prosthetic appliance, crown, or bridge within 5 years of its last placement.
- 6. Replacement of a lost or stolen appliance.
- 7. Appliances, restoration or procedures necessary to increase vertical dimension or restore occlusion or for purposes of splinting.
- 8. Any prosthetic dental appliances finally installed or delivered more than 90 days after coverage ends.

#### **ELIGIBILITY**

The following persons are eligible to be Family Members:

- 1. You;
- 2. Your spouse;
- 3. Your children and your spouse's children and adopted children, provided they are not married and less than 25 years old.

We consider a child in Your custody, pursuant to an interim court order of adoption by You, vesting temporary care of the child in You, as an adopted child, regardless of whether a final order granting adoption is ultimately issued.

#### **PREMIUMS**

First month premium is due upon application. Premiums may be paid in monthly, quarterly, semi-annual or annual modes. We can change the premium for this policy if We change the premium for all other policies in Your state which are issued using this form. In addition, We may also change the premium in accordance with the Change of Residence provision in the policy. The renewal premium is calculated from the table of rates We use for this form on the due date of the premium and takes into account the number of Family Members covered under the

policy, their classification on the premium Due Date as well as any age increases.

If We change the premium, we must mail You written notice at least 30 days before a premium is due.

#### **PREMIUM REFUND**

If you die while this policy is in force We will prorate the refund of premium paid from the date following the date of your death to the end of the period for which premium has been paid.

The premium will be paid as follows: (1) if You paid the premium, the refund will be issued to your surviving spouse. If there is no surviving spouse, the premium will be paid to your estate; (2) if a person other than you paid the premium, the refund will be issued to that person. Proof of payment of the premium must be provided to Us before the refund will be issued.

#### **RENEWAL CONDITIONS**

You may renew this policy each month by paying Your premium on or before the due date.

Renewability is guaranteed except in the event: (1) You failed to pay premiums in accordance with the terms of the policy or We have not received timely 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.

#### **END OF COVERAGE**

Coverage ends as follows:

1. Your spouse's coverage ends on the first Premium Due Date after Your marriage is dissolved.
2. Your child's coverage ends on the earliest of the following:
  - a. The first policy anniversary date after the child marries,
  - b. The first policy anniversary date after the child ceases to be a resident of Iowa, or
  - c. The first renewal date after the child attains age 26 or is no longer a full-time student if over age 26.
3. A Family Member's coverage ends:
  - a. If the Family Member enters a branch of the Military of any country and requests that it end. Upon written request We will refund the premium for that Family Member. The refund will be prorated.
  - b. When the sum of benefits paid for that Family Member equals or exceeds the Maximum Lifetime Benefit.
  - c. If the Family Member commits fraud or intentional misrepresentation of material facts in applying for benefits under this policy.
  - d. If the Family Member changes their residence and moves outside of the United States, is deported or is not able to re-enter the United States. Coverage will end on the date the Family Member leaves the United States.
4. All coverage ends for all Family Members if:
  - a. You fail to pay a premium when due, or
  - b. We end all policies in Your state which are issued using this form.

Insurance under the optional maternity benefit rider ends at the earliest of the following dates: the date the policy to which the optional rider is attached ends; the end of the period for which premium has been paid; or the monthly renewal date following the date American Community receives written notice from you requesting cancellation.

Insurance under the optional dental benefit rider ends at the same time as coverage under the policy to which the optional rider is attached ends.

#### **MENTALLY OR PHYSICALLY HANDICAPPED CHILD**

Your child's coverage will not end due to age while the child is mentally or physically incapable of earning their own living, is actually dependent on You for a majority of their support, and is covered by the policy on the date immediately preceding the day their coverage would have ended due to age. You must furnish Us proof of incapacity within 31 days of the date coverage ends due to age. Proof may be required at reasonable intervals thereafter. Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the 32nd day after we requested or you were required to provide proof of incapacity or dependence and it was not provided, and the child has attained the limiting age; (2) the date the child attains the limiting age, if we requested proof of disability and dependence at least 31 days from the date the child reaches the attainment of the limiting age, and you do not furnish us proof of disability and dependence within 31 days of request; (3) the date the child becomes capable of self-support; or (4) the date the child's coverage under the policy ends for any reason other than age.

#### **CONVERSION**

We will issue a new policy to insure a Family Member whose coverage ends for any reason described in item 1. and 2. in the End of Coverage provision. The premium will be based on the adult rate for the Family Member's age and sex. We must receive a written request and the first premium within 31 days after the coverage ends or in the case of divorce, within 60 days from the date of the judgement granting the divorce, whichever is later. The new policy will take effect when the coverage under this policy ends. The Time Limit on Certain Defenses and the Pre-existing Condition Exclusion on the new policy will be measured from the Effective Date of the Family Member's coverage under this policy. The new policy will be issued on this policy form.

#### **CANCELLATION**

During the first 10 days after You receive the policy, You may cancel it by returning it to American Community with a written request to cancel and We will promptly refund the premium paid.

After You have had the policy 10 days, You may cancel it with a written request to cancel and We will refund any prorated unearned premium. The cancellation will be effective on the date We receive Your request or the date You specify, whichever is later. The cancellation will be without prejudice to any claim originating prior to the cancellation date.

#### **PRE-EXISTING CONDITION**

A Sickness or Injury that was diagnosed by or treated by a licensed Physician within five (5) years prior to the Effective Date of coverage or produced symptoms within five (5) years prior to the Effective Date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or Treatment.



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