AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road, Livonia, Michigan 48152-1094

Medalist II
Preferred Provider Option (PPO)
Iowa - Outline of Coverage

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!**

MAJOR MEDICAL EXPENSE COVERAGE – Policies of this category are designed to provide, to persons insured, coverage for major 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

Medalist II offers increased benefits when the Family Member uses a Network Provider. These benefit differences are illustrated under Network/ Non-Network. You pay the copayment as noted on the chart below. These copayments will not be applied toward the Calendar Year Deductible or Benefit Percentage.

Network Deductible: Both Network and Non-Network eligible charges 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 Non-Network eligible charges 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.

COVERED CHARGES

Calendar Year Deductible and Benefit Percentage apply to the following benefits, unless otherwise stated:

PLAN CHOICE	Plan 1		Plan 2		Plan 3	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Deductibles	Network charges apply to the Network deductible only. Non-Network charges apply to both the Network and Non-Network deductible.					
Individual Calendar Year Deductible	$500 $750 $1,000 $1,500 $2,500	$1,000 $1,500 $2,000 $3,000 $5,000	$1,000 $1,500 $2,500 $3,500 $5,000	$2,000 $3,000 $5,000 $7,000 $10,000	$1,500 $2,500 $3,500 $5,000	$3,000 $5,000 $7,000 $10,000
Family Calendar Year Deductible Common Family-met collectively by 2 or more persons	$1,000 $1,500 $2,000 $3,000 $5,000	$2,000 $3,000 $4,000 $6,000 $10,000	$2,000 $3,000 $5,000 $7,000 $10,000	$4,000 $6,000 $10,000 $14,000 $20,000	$3,000 $5,000 $7,000 $10,000	$6,000 $10,000 $14,000 $20,000
Benefit Percentages	Network charges apply to the Network Benefit Percentage maximum only. Non-Network charges apply to both the Network and Non-Network Benefit Percentage maximums.					
Individual Benefit Percentages	80% of $10,000	50% of $20,000	70% of $15,000	50% of $30,000	70% of $20,000	50% of $40,000
	80% of $15,000	50% of $30,000				
Family Benefit Percentages	80% of $20,000	50% of $40,000	70% of $30,000	50% of $60,000	70% of $40,000	50% of $80,000
	80% of $30,000	50% of $60,000				
Out-of-Pocket Maximum (Includes deductible) **Individual**	$2,500 $2,750 $3,000 $3,500 $4,500	$11,000 $11,500 $12,000 $13,000 $15,000	$5,500 $6,000 $7,000 $8,000 $9,500	$17,000 $18,000 $20,000 $22,000 $25,000	$7,500 $8,500 $9,500 $11,000	$23,000 $25,000 $27,000 $30,000
	$3,500 $3,750 $4,000 $4,500 $5,500	$16,000 $16,500 $17,000 $18,000 $20,000				

	Plan 1		Plan 2		Plan 3	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Out of Pocket Maximum (Includes deductible) **Common Family** - Met collectively by 2 or more persons	$5,000 $5,500 $6,000 $7,000 $9,000	$22,000 $23,000 $24,000 $26,000 $30,000	$11,000 $12,000 $14,000 $16,000 $19,000	$34,000 $36,000 $40,000 $44,000 $50,000	$15,000 $17,000 $19,000 $22,000	$46,000 $50,000 $54,000 $60,000
	$7,000 $7,500 $8,000 $9,000 $11,000	$32,000 $33,000 $34,000 $36,000 $40,000				
Lifetime Policy Maximum	$5 million					
Network Available	Midlands Choice					
ACCIDENT BENEFIT						
Accident	If a family member sustains an injury, we will waive the deductible and/or copayment 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 and/or copayment 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.					
	Plan 1		Plan 2		Plan 3	
PHYSICIAN SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
In Physician's Office & Urgent Care Centers • Visits for Sickness, Injury, Surgery or Follow-up • Consultations • Equipment & Supplies • Injections (except allergy injections) • X-rays • Lab tests (see Other Covered Services for lab work sent to an independent lab)	$30 copay per visit, then 100% up to $500 per person per calendar year. After $500 maximum, deductible & benefit percentage apply	Deductible and Benefit Percentage	$40 copay per visit, then 100% up to $500 per person per calendar year. After $500 maximum, deductible & benefit percentage apply	Deductible and Benefit Percentage	$50 copay per visit, then 100% up to $500 per person per calendar year. After $500 maximum, deductible & benefit percentage apply	Deductible and Benefit Percentage
Preventive Care $1,000 calendar year maximum per family member	$30 copay per visit, then 100%	Not covered	$40 copay per visit, then 100%	Not covered	$50 copay per visit, then 100%	Not covered
Outpatient Spinal Manipulation $500 calendar year maximum per family member **Allergy Testing, Serums & Injections** $500 calendar year maximum per family member	Deductible and Benefit Percentage	Deductible and Benefit Percentage	Deductible and Benefit Percentage	Deductible and Benefit Percentage	Not covered	
	Plan 1		Plan 2		Plan 3	
HOSPITAL SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
Inpatient Non-emergency admissions	Network: Network deductible and benefit percentage apply Non-Network: $500 copayment per admission, then non-network deductible & benefit percentage apply.					
Emergency admissions	Network & Non-Network: Network deductible and benefit percentage apply					
Outpatient Surgery	Network: Network deductible and benefit percentage apply Non-Network: $500 copayment, then Non-Network deductible & benefit percentage apply.					
Diagnostic Services • Pre-admission testing • X-rays • Nuclear medicine • Ultrasounds • MRIs • Mammograms • Laboratory tests	- Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
	Plan 1		Plan 2		Plan 3	
EMERGENCY ROOM SERVICES	Network	Non-Network	Network	Non-Network	Network	Non-Network
Emergency - Injury	Network & Non-Network: Network deductible and benefit percentage apply					
Emergency - Sickness	$50 copay per visit, then network deductible & benefit percentage apply. (Copay waived if admitted to hospital within 24 hours)		$100 copay per visit, then network deductible & benefit percentage apply. (Copay waived if admitted to hospital within 24 hours)		$150 copay per visit, then network deductible & benefit percentage apply. (Copay waived if admitted to hospital within 24 hours)	
Non-emergency Sickness	Not Covered		Not Covered		Not Covered	

OTHER COVERED SERVICES	Plan 1 Network	Plan 1 Non-Network	Plan 2 Network	Plan 2 Non-Network	Plan 3 Network	Plan 3 Non-Network
Ambulance	Network & Non-Network: Network deductible and benefit percentage apply					
Free-Standing Outpatient Surgery Center Facility charge	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Radiology or Diagnostic Services Outside of Hospital • X-rays • MRIs • Non-routine Mammograms • Nuclear medicine • Ultrasounds • Laboratory tests (including lab work sent by a physician to an independent laboratory)	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Outpatient Physical, Occupational & Speech Therapy Limited to 60 visits per calendar year (this is a combined total for all therapies)	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Durable Medical Equipment	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Home Health Care Limited to 20 visits per calendar year	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Hospice Care Up to $200 per day; lifetime maximum of $15,000 or 6 months, whichever comes first	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Nursing Facility $75 per day, 60 days per calendar year (room and board only)	Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage		Applicable Deductible and Benefit Percentage	
Mental Health (outpatient only) $1,000 maximum per person per calendar year	Subject to deductible and 50% benefit percentage				Not covered	
Organ Transplants Combined maximum lifetime benefit of $1 million	**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. **Non-designated Transplant Facility:** $700,000 maximum lifetime benefit					
Vision Exam Only Benefit	The following benefits are available only at Member Facilities: 1 eye exam per person every 12 months; $10 copay per eye exam 20% discount for eyeglasses 15% discount on physician's services when contact lenses are purchased					
PRESCRIPTION DRUG COVERAGE	**Plan 1**		**Plan 2**		**Plan 3**	
	$500 maximum benefit per person per calendar year for mental health drugs		$500 maximum benefit per person per calendar year for mental health drugs		$300 maximum benefit per person per calendar year	
Retail Pharmacy: Up to 31-day supply	Generic / Select Brand Name / Additional Brand Name Drugs & Diabetic Supplies				Generic Drugs Only	
Copay per prescription or refill	20% / 30% / 50% minimum $10 / $35 / $50		20% / 30% / 50% minimum $15 / $40 / $60		$15 copay per prescription or refill	
Mail Order Pharmacy: Up to 90-day supply	Generic / Select Brand Name / Additional Brand Name Drugs & Diabetic Supplies				Generic Drugs Only	
Copay per prescription or refill	$25 / $85 / $125		$35 / $100 / $150		$35 copay per prescription or refill	
Prescription Drug Benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-participating Pharmacy.						
OPTIONAL BENEFITS	**Plan 1 Network**	**Plan 1 Non-Network**	**Plan 2 Network**	**Plan 2 Non-Network**	**Plan 3 Network**	**Plan 3 Non-Network**
Dental Benefit $1,000 calendar year maximum	Type 1 procedures: 6-month waiting period, then 80% Type 2 procedures: 12-month waiting period, $100 calendar year deductible then 50%					
Maternity Benefit for Primary Insured or Insured Spouse Only 6-month waiting period from the effective date of the maternity coverage. To be covered, pregnancy must begin after the waiting period.	Applicable Deductible and Benefit Percentage					
$1,000 Prescription Drug Deductible per person 2 person maximum per family	Subject to Prescription Drug Deductible, then above Prescription Drug Coverage copays apply	Not covered	Subject to Prescription Drug Deductible, then above Prescription Drug Coverage copays apply	Not covered	Not available	

COVERED CHARGES

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 pay:
        (1) 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
        (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 surgery.
4) Anesthesia services: Anesthetics and their administration
5) In-hospital medical services:
    a. 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 the policy.
    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** – Nursing Facility room and board covered at $75 per day, 60 days per calendar year. Medical services and supplies furnished by the Nursing Facility.
    b. **Home Health Care** – Home Health Care covered at 20 visits per calendar year. 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 Office and Urgent Care Centers** - Covered Charges include: Physician's medical care; consultations; second opinions for surgery; office surgery; lab tests (not sent to an independent lab); x-rays; medical supplies; follow-up visits; and Injectable Prescription Drugs administered during an office visit, except chemotherapy.
    e. **Preventive Care** - Services are subject to a maximum benefit of $1,000 per calendar year. 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; and 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 towards the maximum benefit, however they will continue to be paid even if the maximum has been reached.
    f. **Physical, Occupational & Speech Therapy** - Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury only. Services are limited to a maximum of 60 visits per calendar year for all therapies combined.
    g. **Outpatient Spinal Manipulation (Not Covered on Plan 3)** - Services are subject to a maximum benefit of $500 per calendar year. Covered charges include: non-surgical care for dislocations or partial dislocations of the spine, x-rays, and lab tests.
    h. **Allergy Testing, Serums and Injections (Not Covered on Plan 3)** - Services are subject to a maximum benefit of $500 per calendar year.
    i. **Outpatient Mental Health Care (Not Covered on Plan 3)** - Care and services supervised or recommended by a Psychiatrist and provided on an outpatient basis. Covered Charges are subject to a maximum benefit of $1,000 per calendar year and a 50% benefit percentage. Covered Charges include: treatment of a mental or nervous disorder that is provided by a Psychiatrist, Clinical Psychologist, Psychiatric Social Worker, Registered Nurse or Licensed Clinical Social Worker; care, services or materials furnished by an Approved Psychiatric Facility.
7) Other Benefits:
    a. Injectable Prescription Drugs, except insulin. Insulin is covered under the Prescription Drug Program.
    b. Prosthetics, except myo-electric or microprocessor 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 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 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, 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.

g. 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.
h. Outpatient prescription drugs and medicines provided under the Prescription Drug Card Program, except drugs prescribed for medical conditions that have been excluded from coverage by amendment or rider to the policy. Drugs prescribed to treat anything listed in the General Exclusions section of the policy are not covered.
i. General anesthetics and Hospital or Ambulatory Surgical Center facility 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 5 years of age who has a dental condition or 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.
j. Contraceptive drugs and devices approved by the United States Food and Drug Administration for use as a contraceptive. Benefits are subject to the Outpatient Prescription Drug Program 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.
k. 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.
l. 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.
m. Self-management training and education for the treatment of all types of diabetes mellitus only under all of the following conditions:
   (1) The Family Member's physician certifies that such services are needed;
   (2) The self-mangement training and education program is certified by the Iowa department of public health, and provides the following:
      (a) 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 new onset of diabetes
         - poor glycemic control as evidenced by a glycosylated homglobin of nine and five-tenths or more in the 90 days before attending training
         - a change in treatment regimen from no diabetes medication to any diabetes medication, or from oral diabetes medication to insulin
         - high risk for complications based on poor glycemic control
         - high risk based on documented complications.
      (b) 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) Organ Transplants
   a. The Combined Maximum Lifetime Benefit is $1 million for charges incurred at a Designated and a Non-Designated Transplant Facility.
   b. Maximum Lifetime Benefit at a Designated Transplant Facility is $1 million. Maximum Lifetime Benefit at a Non-Designated Transplant Facility is $700,000.
   c. Covered Charges include Approved Transplant Procedures which means human to human transplants which include: heart transplants; combined heart and lung transplants; lung transplants; kidney transplants; kidney and pancreas transplants; liver transplants; bone marrow transplants; either allogeneic or autologous; and peripheral stem cell transplants.
   d. Covered Charges include Approved Transplant Services, which means Medically Necessary health services and supplies, which are related to transplantation and approved by Us prior to the delivery of any services. Such services include, but are not limited to, transplant facility or Hospital charges, Physician charges, Organ Procurement and Acquisition Expenses, tissue typing, and ancillary services.
   e. Covered Charges include Organ Procurement and Acquisition expenses, which include expenses directly related to: removal of the organ or bone marrow from the donor; preparation of the organ or bone marrow after removal from the donor for transplant for a period not to exceed 30 days; and transportation of the organ or bone marrow to the transplant facility. Such expenses do not include charges associated with attempts to save the life of the donor or to treat complications.
   f. Travel and Accommodation Expenses up to a maximum benefit of $10,000 are covered only if the transplant is performed at a Designated Transplant Facility, which include the following: transportation for the Family Member and one companion to accompany the Family Member to and from a Designated Transplant Facility; up to $150 per person per day for meals and lodging at or near the Designated Transplant Facility for the companion who accompanies the Family Member while the Family Member is receiving necessary Treatment at the Designated Transplant Facility; and up to $150 per person per day for meals and lodging at or near the Designated Transplant Facility for the Family Member while the Family Member is receiving necessary Outpatient Treatment at the Designated Transplant Facility as part of the transplant plan.
   g. Only Approved Transplant Procedures are covered. No benefits will be paid if the transplant procedure is not approved in advance.
9) Vision Exam Only
   a. Covered Charges include one vision examination per person every 12 months. The vision examination includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.
   b. The benefit will be the cost of the vision examination less the $10 copayment.
   c. The vision examination must be performed by a Member Doctor which means a doctor who is contracted by Vision Service Plan.
   d. If the Family Member is prescribed corrective eyewear by the Member Doctor for a covered vision examination the Family Member can obtain materials and services related to the ordering, fitting and adjusting of the corrective eyewear from the Member Doctor at the discount of 20% for eyeglasses and 15% for contact lenses.
10) Optional Maternity Coverage
   a. Available only to the primary insured or insured's spouse, 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 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, excluding the day of delivery, after vaginal delivery and 96 hours, excluding the day of delivery, after cesarean section.

11) Optional Dental Coverage
The dental deductible and benefit percentage are separate from the medical deductible and benefit percentage. The maximum benefit per person, per calendar year, 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

American Community will not pay any benefit for charges due to any of the following, nor can these charges be applied to the policy's Deductible, Copayments or Benefit Percentage:

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 Sickness or Injury that are 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 section of the policy.
12. Treatment given in a Hospital emergency room for 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 to a Family Member, when provided within 12 months of the Injury. The Injury must occur on or 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, except as provided under the Vision Exam Only Benefit;
    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, except as provided under the Outpatient Mental Health Care Rider.
26. Treatment of 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 that 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. Inoculations or prophylactic drugs for travel.
36. Growth Treatment, medication or hormones.

37. Services available in the community through educational or school programs.
38. Evaluation or Treatment of learning disabilities; attitudinal disorders; or disciplinary, social or Developmental conditions.
39. Care, services, procedures or supplies that are cognitive in nature.
40. 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.
41. Complications resulting from tests, examinations or other procedures, which are illegal or Experimental, Investigational, Unproven and/or for Research.
42. Foot care in connection with corns, calluses, toenails, flat feet, fallen arches, weak feet, or chronic foot strain; shoes, shoe accessories, and orthotics.
43. Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
44. Treatment of nail fungus.
45. Any expenses incurred outside of the United States for elective care, testing, procedures or services, except for Emergency care.
46. Treatment and testing of sleep disorders.
47. Expenses related to Treatment, diagnosis, or care provided over the Internet or via electronic mail.
48. 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.
49. 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.
50. Prescription Drugs provided while the Family Member is not Confined, except as provided under the Outpatient Prescription Drug Benefits section of the policy.
51. 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.

PRESCRIPTION DRUG PROGRAM EXCLUSIONS

We will pay no benefits for charges due to any of the following:
1. Prescription Drugs excluded from coverage or used to treat medical conditions that have been excluded from coverage by amendment or rider to this certificate;
2. Prescription Drugs used to treat anything listed in or excluded by the General Exclusion section of the policy;
3. Non federal legend drugs;
4. Contraceptive medications or devices, if you declined contraceptive coverage on your application for insurance;
5. Fertility agents and medications;
6. Injectable or any prescription directing parenteral administration or use, except insulin;
7. Oral and topical acne medications;
8. Substance abuse treatment agents;
9. Smoking deterrents;
10. All antiobesity preparations;
11. Amphetamines;
12. Legend vitamins and fluoride products;
13. Drugs to treat influenza or lessen its symptoms;
14. Therapeutic devices or appliances;
15. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
16. Immunization agents and vaccines;
17. Biologicals, blood or blood plasma;
18. Off-label use of prescription drugs except when insurance coverage is required by law;
19. Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual;
20. 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;
21. 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, 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;
22. 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;
23. 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;
24. Charges for the administration or injection of any drug;
25. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
26. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
27. Growth hormones or medications, unless related to tumor or surgical intervention;
28. Drugs for Treatment of onychomycosis (nail fungus);
29. Drugs for Treatment of impotency.

The following exclusions apply to Plan 3 only:

29. Brand Name Drugs;
30. Antidepressants;
31. Tranquilizers;
32. Miscellaneous psychotherapeutic agents;
33. Benzodiazepines;
34. Antimanic agents;
35. Drugs to treat Attention Deficit Hyperactivity Disorder.

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.

VISION EXCLUSIONS

No benefits are payable for:
1. Materials or services related to ordering, fitting, or adjusting any corrective eyewear. However, if the Family Member is prescribed corrective eyewear by the Member Doctor for a covered Vision Examination the Family Member can obtain materials and services related to the ordering, fitting and adjusting of the corrective eye-

wear from the Member Doctor at a discount of 20% for eyeglasses and 15% for contact lenses.

2. Services, examinations or material provided by a Non-Member Doctor.
3. Orthoptics or vision training.
4. Medical or surgical Treatment of the eyes.
5. Services or materials provided as a result of any Worker's Compensation Law or similar legislation, or obtained through or required by any government agency or program whether federal, state or any subdivision thereof.
6. Any Vision Examination required by an Employer as a condition of employment.
7. Any service or materials provided by any other vision care plan or benefit plan containing benefits for vision care.

ELIGIBILITY
The following persons are eligible to be Family Members:

1. You;
2. Your spouse; and
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 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 the policy 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 this policy 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. We may also change the premium in accordance with the Change of Residence provision.

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

RENEWAL CONDITIONS
The policy renews on a monthly basis as long as You pay 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 a 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 Renewal Date after Your marriage is dissolved; ((2) Your child's coverage ends on the earliest of the following: the first policy anniversary date after the child marries, the first policy anniversary date after the child ceases to be a resident of Iowa, or 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 if the Family Member enters a branch of the Military of any country and requests that it end; when the sum of benefits paid for that Family Member equals or exceeds the Maximum Lifetime Benefit; if the Family Member commits fraud or misrepresentation of material facts in applying for benefits under the policy; 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 you fail to pay a premium when due, or if 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 items (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 on the new policy will be measured from the Effective Date of the Family Member's coverage under this policy.

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 refund the premium paid and treat the policy as if it were never issued.

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. A Sickness that appeared or an injury sustained prior to the Effective Date of the Family Member's coverage, was fully disclosed on the application, and was not excluded from coverage by a rider is not a Pre-existing Condition.