Filing at a Glance

Company: American Community Mutual Insurance Company

Product Name: Olympic	SERFF Tr Num: AMCM-125834735	State: ArkansasLH
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed	State Tr Num: 40396
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: IND09	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Pat Robbins, Suzanne Crowley	Disposition Date: 10/29/2008
	Date Submitted: 09/29/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Exempt from filing in Michigan
Explanation for Combination/Other:	Market Type: Individual
Submission Type: Resubmission	Previous Filing Number: AMCM-125700684
Group Market Size:	Overall Rate Impact:
Group Market Type:	Filing Status Changed: 10/29/2008
	State Status Changed: 10/29/2008
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Enclosed for your review and approval are the following forms. These forms are being resubmitted in response to the disapproval we received on SERFF Filing Number AMCM-125700684 on 9/19/08. The changes that were made in response to the disapproval are listed under the affected policy forms.

*IND09 - Policy Form. This is a medical expense preferred provider option policy that will be marketed to individuals. In response to the objection that the difference in benefit levels between network and non-network providers cannot exceed 25%, the following changes were made to this form:

- Under the 100% plan, the non-network benefit percentage has been changed from 70% to 75%.
- Under the 80% plans, the non-network benefit percentage has been changed from 50% to 55%.
- Under the preventive care benefit, services provided by non-network providers are being covered.
- The Vision Exam Only benefit has been removed because it only provides benefits for services rendered at network providers.
- The Organ Transplant Benefit has been revised to provide a lifetime maximum benefit of $750,000 at non-designated transplant facilities.

In response to the objection regarding the definition of accident not being in compliance with Rule 18, Section 5D, the following changes were made:

- The definition of "Accident or Accidental"on page 4 was revised.
- The provisions of the Accidental Death Benefit on page 25 that were in conflict with Rule 18 were removed or revised.

Also the word "involuntary" was removed from exclusion 6 as requested.

In response to the objection regarding handicapped dependents, the following changes were made:

- All references to time limits for furnishing proof of incapacity were removed from the Mentally or Physically Handicapped Child provision on page 33.
- Also, on page 33, the reasons coverage for a handicapped child would end were updated.

*AR-RX-GENERIC09-AR - This is an outpatient prescrption drug rider that provides coverage of generic drugs only. This rider will be offered as an optional benefit with policy form IND09.

*AR-RX-TIER09-AR - This is an outpatient prescription drug rider that provides coverage of brand name and generic drugs. This rider will also be offered as an optional benefit with policy form IND09.

*650DR This is a dental benefit rider that will be offered as an optional benefit with policy form IND09.

*AR HA-1 1/09 Application for Individual Health Insurance Policies.

*MCCR-95 Minor Child Coverage Rider - This will be issued with the policy if the primary insured is a minor child.

*EXR-04-99 Exclusion Rider- This rider will be issued with the policy under certain conditions as determined by underwriting.

*13-52 (4-89) Endorsement that may be used to make changes to the policy after issue.

*33-41 R 499 Amendment for application that may be used during the underwriting process.

*GP-AR (1/09) Internal Grievance and External Review Procedures will be issued with every policy form.

*33-133 605 4/93 Application for Removal of Exclusion Rider that will allow a policyholder to request that an exclusion rider be removed from the policy.

*The following forms will be used during the underwriting process to obtain additional information about an applicant's medical condition(s), based on the responses to the medical questions on our regular application form:
· 33-AAQ 3/07 (Allergy/Asthma);
· 33-ADQ 3/07 (Alcohol & Drug);
· 33-APHQ 6/08 (Abnormal Pap/HPV);
· 33-ARQ 6/08 (Arthritis);
· 33-CATQ 6/08 (Cataracts);
· 33-CSQ 3/07 (Cesarean Section);
· 33-CTUQ 6/08 (Carpal/Ulnar Tunnel);
· 33-EAQ 6/08 (Otitis Media/Ear);
· 33-GHDUQ 6/08 (GERD, Hiatal/Diaphragmatic Hernia, Ulcer);
· 33-GIQ 6/08 (Gastrointestinal);
· 33-HCLQ 3/07 (High Cholesterol/Lipids);

· 33-HMQ 6/08 (Heart Murmur);
· 33-HYPQ 6/08 (Hypertension);
· 33-INFQ 6/08 (Infertility);
· 33-JNTQ 6/08 (Joint Injury);
· 33-KUQ (Kidney/Urinary);
· 33-MHQ 6/08 (Mental Health);
· 33-MIQ 6/08 (Migraine/Headache);
· 33-SEQ 6/08 (Seizure/Epilepsy);
· 33-SPQ 6/08 (Spinal);
· 33-TCQ (Tumor/Cyst); and
· 33-THQ 6/08 (Thyroid).

Form AR OLYMPIC OOC 1/09 is the Outline of Coverage that will be used with policy form IND09. A copy of this form is attached under the Supporting Documention tab. The Outline of Coverage was revised to include the changes that were made to form IND09.

These are new forms and they do not replace any forms currently in use in your state. These forms are exempt from filing in our domiciliary state of Michigan.

Any bracketed material represents variable information. No such items will be contradictory to any applicable state or federal law. Included with this filing is the Statement of Variability for all forms listed above.

The rates and actuarial memorandum are also enclosed for your approval. Included in the acturial memorandum is certification that this product qualifies for the mental health parity exemption. Exhibit A attached with the actuarial memorandum contains the documentation that the increased cost would exceed 1.5% of the total premium in accordance with Arkansas Code 23-99-505.

In response to the objection regarding trend factor increases, the rates were revised to remove the trend factors. The actuarial memorandum was revised to reflect the changes made to form IND09 regarding the non-network benefit percentage changes.

Company and Contact

Filing Contact Information

Patricia Robbins, Sr. Compliance Specialist
39201 Seven Mile Road
Livonia, MI 48152

probbins@american-community.com
(734) 591-4708 [Phone]
(734) 591-4628[FAX]

Filing Company Information

American Community Mutual Insurance Company	CoCode: 60305	State of Domicile: Michigan
39201 Seven Mile Road	Group Code:	Company Type:
Livonia, MI 48152	Group Name:	State ID Number:
(800) 991-2642 ext. [Phone]	FEIN Number: 38-1290976	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	Policy = $50.00 Rates = $50.00 ACMIC USE ONLY acct#6200030
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Community Mutual Insurance Company	$100.00	09/29/2008	22803566

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/29/2008	10/29/2008
Approved-Closed	Rosalind Minor	10/09/2008	10/09/2008
Approved-Closed	Rosalind Minor	10/07/2008	10/07/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	10/01/2008	10/01/2008	Pat Robbins	10/03/2008	10/03/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Policy	Form	Pat Robbins	10/29/2008	10/29/2008
Outline of Coverage	Supporting Document	Pat Robbins	10/29/2008	10/29/2008
Outline of Coverage	Supporting Document	Pat Robbins	10/08/2008	10/08/2008

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/29/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Letter from Actuary	Approved-Closed	No
Form *(revised)*	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form	Generic Prescription Drug Rider	Approved-Closed	Yes
Form	Prescription Drug Rider	Approved-Closed	Yes
Form	Dental Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Minor Child Coverage Rider	Approved-Closed	Yes
Form	Exclusion Rider	Approved-Closed	Yes
Form	Amendment of Application	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Internal Grievance & External Review Procedures	Approved-Closed	Yes
Form	Application for Removal of Exclusion Rider	Approved-Closed	Yes
Form	Allergy/Asthma	Approved-Closed	Yes
Form	Alcohol & Drug	Approved-Closed	Yes
Form	Abnormal Pap/HPV	Approved-Closed	Yes
Form	Arthritis	Approved-Closed	Yes
Form	Cataracts(s)	Approved-Closed	Yes
Form	Cesarean Section	Approved-Closed	Yes
Form	Carpal/Ulnar Tunnel	Approved-Closed	Yes
Form	Ear/Otitis	Approved-Closed	Yes

Form	GERD, Hiatal/Diaphragmatic Hernia, Ulcer	Approved-Closed	Yes
Form	Gastrointestinal	Approved-Closed	Yes
Form	High Cholesterol/Lipids	Approved-Closed	Yes
Form	Heart Murmur	Approved-Closed	Yes
Form	Hypertension	Approved-Closed	Yes
Form	Infertility	Approved-Closed	Yes
Form	Joint Injury	Approved-Closed	Yes
Form	Kidney/Urinary	Approved-Closed	Yes
Form	Mental Health	Approved-Closed	Yes
Form	Migraine/Headache	Approved-Closed	Yes
Form	Seizure/Epilepsy	Approved-Closed	Yes
Form	Spinal	Approved-Closed	Yes
Form	Tumor/Cyst	Approved-Closed	Yes
Form	Thyroid	Approved-Closed	Yes
Rate *(revised)*	Rate Sheet	Approved-Closed	Yes
Rate	Rate Sheet	Replaced	No

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/09/2008
Implementation Date:
Status: Approved-Closed
Comment: The outline of coverage is replaced and approved effective on this date. The rest of the filing will maintain the original approval date.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Letter from Actuary	Approved-Closed	No
Form *(revised)*	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form	Generic Prescription Drug Rider	Approved-Closed	Yes
Form	Prescription Drug Rider	Approved-Closed	Yes
Form	Dental Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Minor Child Coverage Rider	Approved-Closed	Yes
Form	Exclusion Rider	Approved-Closed	Yes
Form	Amendment of Application	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Internal Grievance & External Review Procedures	Approved-Closed	Yes
Form	Application for Removal of Exclusion Rider	Approved-Closed	Yes
Form	Allergy/Asthma	Approved-Closed	Yes
Form	Alcohol & Drug	Approved-Closed	Yes
Form	Abnormal Pap/HPV	Approved-Closed	Yes
Form	Arthritis	Approved-Closed	Yes
Form	Cataracts(s)	Approved-Closed	Yes
Form	Cesarean Section	Approved-Closed	Yes
Form	Carpal/Ulnar Tunnel	Approved-Closed	Yes
Form	Ear/Otitis	Approved-Closed	Yes

Form	GERD, Hiatal/Diaphragmatic Hernia, Ulcer	Approved-Closed	Yes
Form	Gastrointestinal	Approved-Closed	Yes
Form	High Cholesterol/Lipids	Approved-Closed	Yes
Form	Heart Murmur	Approved-Closed	Yes
Form	Hypertension	Approved-Closed	Yes
Form	Infertility	Approved-Closed	Yes
Form	Joint Injury	Approved-Closed	Yes
Form	Kidney/Urinary	Approved-Closed	Yes
Form	Mental Health	Approved-Closed	Yes
Form	Migraine/Headache	Approved-Closed	Yes
Form	Seizure/Epilepsy	Approved-Closed	Yes
Form	Spinal	Approved-Closed	Yes
Form	Tumor/Cyst	Approved-Closed	Yes
Form	Thyroid	Approved-Closed	Yes
Rate *(revised)*	Rate Sheet	Approved-Closed	Yes
Rate	Rate Sheet	Replaced	No

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/07/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document *(revised)*	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Letter from Actuary	Approved-Closed	No
Form *(revised)*	Policy	Approved-Closed	Yes
Form	Policy	Replaced	Yes
Form	Generic Prescription Drug Rider	Approved-Closed	Yes
Form	Prescription Drug Rider	Approved-Closed	Yes
Form	Dental Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Minor Child Coverage Rider	Approved-Closed	Yes
Form	Exclusion Rider	Approved-Closed	Yes
Form	Amendment of Application	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Internal Grievance & External Review Procedures	Approved-Closed	Yes
Form	Application for Removal of Exclusion Rider	Approved-Closed	Yes
Form	Allergy/Asthma	Approved-Closed	Yes
Form	Alcohol & Drug	Approved-Closed	Yes
Form	Abnormal Pap/HPV	Approved-Closed	Yes
Form	Arthritis	Approved-Closed	Yes
Form	Cataracts(s)	Approved-Closed	Yes
Form	Cesarean Section	Approved-Closed	Yes
Form	Carpal/Ulnar Tunnel	Approved-Closed	Yes
Form	Ear/Otitis	Approved-Closed	Yes

Form	GERD, Hiatal/Diaphragmatic Hernia, Ulcer	Approved-Closed	Yes
Form	Gastrointestinal	Approved-Closed	Yes
Form	High Cholesterol/Lipids	Approved-Closed	Yes
Form	Heart Murmur	Approved-Closed	Yes
Form	Hypertension	Approved-Closed	Yes
Form	Infertility	Approved-Closed	Yes
Form	Joint Injury	Approved-Closed	Yes
Form	Kidney/Urinary	Approved-Closed	Yes
Form	Mental Health	Approved-Closed	Yes
Form	Migraine/Headache	Approved-Closed	Yes
Form	Seizure/Epilepsy	Approved-Closed	Yes
Form	Spinal	Approved-Closed	Yes
Form	Tumor/Cyst	Approved-Closed	Yes
Form	Thyroid	Approved-Closed	Yes
Rate *(revised)*	Rate Sheet	Approved-Closed	Yes
Rate	Rate Sheet	Replaced	No

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/01/2008
Submitted Date	10/01/2008
Respond By Date	

Dear Patricia Robbins,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment: I spoke with one of your actuaries this morning to discuss the trend increases. On the original filing, I commented that our Department does not allow automatic trend increases.

Since the disapproval of the filing, we have discussed further the use of trend increases based on inflation. We will accept your orgininal actuarial memorandum containing the trend increases with the understanding that you inform the consumer that these policies do contain a trend increase.

Please attach the original actuarial memorandum.

Objection 2

- Policy (Form)

Comment: Thank you for updating the schedule pages to be in compliance with our Bulletin 9-85.

The benefit percentage is in compliance, but I see a problem with the deductibles. For example:
$5,000 deductible In-Network with a $10,000 deductible out-of-network. A calendar year deductible per family of $10,000 In-Network and a $20,000 out-of-network. Also, the Out-of Pocket maximum per person per calendar years is $5,000 In-Network and $12,500 out-of-network. These amounts are greater than a 25% differential. Please review the schedule again and make the necessary adjustments.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/03/2008
Submitted Date	10/03/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Thank you for your time and assistance resolving these objections.

Per your telephone conversation with our actuaries, attached under supporting documention is a letter from our Chief Actuary, Jeff Erickson explaining and certifying that the difference between the network and non-network benefits for this product do not exceed 25%. In light of this explanation, there have been no further changes made to the policy schedule pages.

Related Objection 1

Applies To:

- Policy (Form)

Comment:

Thank you for updating the schedule pages to be in compliance with our Bulletin 9-85.

The benefit percentage is in compliance, but I see a problem with the deductibles. For example: $5,000 deductible In-Network with a $10,000 deductible out-of-network. A calendar year deductible per family of $10,000 In-Network and a $20,000 out-of-network. Also, the Out-of Pocket maximum per person per calendar years is $5,000 In-Network and $12,500 out-of-network. These amounts are greater than a 25% differential. Please review the schedule again and make the necessary adjustments.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Letter from Actuary

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: Attached is the revised rate sheet which now includes the new business inflationary trend increase factors. The actuarial memorandum included in this filing is accurate and does not require any changes.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

I spoke with one of your actuaries this morning to discuss the trend increases. On the original filing, I commented that our Department does not allow automatic trend increases.

Since the disapproval of the filing, we have discussed further the use of trend increases based on inflation. We will accept your orgininal actuarial memorandum containing the trend increases with the understanding that you inform the consumer that these policies do contain a trend increase.

Please attach the original actuarial memorandum.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Rate Sheet	IND09, AR-RX-GENERICO9-AR, AR-RX-TIER09-AR, 650DR	New	*Previous State Filing Number* *Percent Rate Change Request* 0	

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Previous Version

Rate Sheet	*IND09, AR-RX-GENERICO9-AR, AR-RX-TIER09-AR, 650DR*	*New*	*Previous State Filing Number*
			Percent Rate Change Request
			0

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Sincerely,

Pat Robbins, Suzanne Crowley

Amendment Letter

Amendment Date:

Submitted Date: 10/29/2008

Comments:

Thank you for re-opening this filing and allowing us to fix the missing coverage for dental anesthesia. The covered charge for this mandated benefit has been added to policy form IND09 at the bottom of page 20 as item number 37. Attached is an updated version of this form.

Also attached is a revised copy of the outline of coverage form AR IND OOC 1/09. The dental anesthesia benefit has been added at the bottom of the first column on page 9 and continues at the top of the second column on page 9.

I certify that these are the only changes that have been made to these forms since they were approved and that these forms have not been put into use.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
IND09	Policy/Contract/Fraternal Certificate	Policy	Initial				41	IND09 (Arkansas) without comments 10.29.08.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment: Page 9 has been updated to include benefits for dental anesthesia

AR IND09 OOC 1-09(Rev 10.29.08).pdf

Amendment Letter

Amendment Date:

Submitted Date: 10/08/2008

Comments:

Due to a change in the name of this product, the outline of coverage has been updated. The form number has been changed to reflect the product form number instead of the product name. Since we have not yet determined a new name for this product, we have bracketed the name of the product [Olympic] throughout the document to allow us to update it at a later time.

Thank you for your assistance with this change.

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Outline of Coverage

Comment:

AR IND09 OOC 1-09 bracketed.pdf

Form Schedule

Lead Form Number: IND09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	IND09	Policy/Contract/Fraternal Certificate	Policy	Initial		41	IND09 (Arkansas) without comments 10.29.08.pdf
Approved-Closed	AR-RX-GENERIC09-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Generic Prescription Drug Rider	Initial		41	AR-RX-GENERIC09-AR (Filed).pdf
Approved-Closed	AR-RX-TIER09-AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Prescription Drug Rider	Initial		41	AR-RX-TIER09-AR(Filed).pdf
Approved-Closed	650DR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page,	Dental Benefit Rider	Initial		41	650DR Dental Rider (Generic).pdf

		Endorsement or Rider			
Approved-Closed	AR HA-1 1/09	Application/Enrollment Form	Application	Initial	40	AR HA-1 1-09 (Application).pdf
Approved-Closed	MCCR-95	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Minor Child Coverage Rider	Initial	52	MCCR-95 (Minor Child Rider).pdf
Approved-Closed	EXR 04/99	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Exclusion Rider	Initial	40	EXR-04-99 (Exclusion Rider).pdf
Approved-Closed	33-41 R 4/99	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment of Application	Initial	42	33-41 R 499 (amendment of application).pdf
Approved-Closed	13-52 (4/89)	Policy/Contract/Fraternal Certificate:	Endorsement	Initial	55	13-52 (4-89) - Endorsement.pdf

		Amendment, Insert Page, Endorsement or Rider				
Approved-Closed	GP-AR (1/09)	Other	Internal Grievance & External Review Procedures	Initial	40	GP-AR(1-09) - Internal Grievance & External Review Procedures.pdf
Approved-Closed	33-133 605 4/93	Application/Enrollment Form	Application for Removal of Exclusion Rider	Initial	40	33-133 605 4-93 (App for Removal of Exclusion Rider).pdf
Approved-Closed	33-AAQ 3/07	Application/Enrollment Form	Allergy/Asthma	Initial	40	33-AAQ 3-07 Allergy & Asthma (bracketed).pdf
Approved-Closed	33-ADQ 3/07	Application/Enrollment Form	Alcohol & Drug	Initial	40	33-ADQ 3-07 Alcohol and Drug(bracketed).pdf
Approved-Closed	33-APHQ 6/08	Application/Enrollment Form	Abnormal Pap/HPV	Initial	67	33-APHQ 6-08 Abnormal PAP_HPV.pdf
Approved-Closed	33-ARQ 6/08	Application/Enrollment Form	Arthritis	Initial	65	33-ARQ 6-08 Arthritis .pdf
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AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

POLICY STATEMENT

We issue this policy to You for the premium payment and the statements made in Your application. We will pay for certain medical expenses incurred as a result of a Family Member's Injury or Sickness. The benefits depend strictly upon the terms in this policy. These terms, along with the application and any riders or endorsements form the policy. Your insurance begins at 12:01 a.m. on the Effective Date. Your insurance will end at 12:00 midnight at the end of the period for which premium has been paid. The time is determined at Your place of residence.

YOU MAY EXAMINE YOUR POLICY FOR 10 DAYS

Please read Your policy carefully. If You are not satisfied with the policy for any reason, return it to Our Home Office within 10 days after You receive it. If You do, We will refund any premium paid and treat the policy as if it was never issued.

RENEWAL CONDITIONS AND RATES

This policy renews on a monthly basis as long as You pay Your premium on or before the Due Date. The Renewal Date is shown on page 3 of the policy. 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 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.

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. The renewal premium is calculated from a table of rates We use for this policy form on the Due Date of the premium. This calculation takes into account the number of Family Members covered under this policy and their classification on the premium Due Date. Premiums may also change as a Family Member's age increases. If We change the premium, We must mail You written notice at least 30 days before a premium is due.

CANCELLATION AFTER THE FIRST 10 DAYS

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

OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY

MAJOR MEDICAL EXPENSE POLICY - PREFERRED PROVIDER OPTION

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

CONSUMER INFORMATION NOTICE

Policyholder Service Office of Company:	American Community Mutual Insurance Company
Address:	[39201 Seven Mile Road, Livonia, Michigan 48152]
Telephone Number:	[(800) 991-2642]
Name of Agent:	[Robert Agent]
Address:	[123 North Main, Livonia, Michigan 48152]
Telephone Number:	[(734) 555-1212]

If we at American Community Mutual Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
[1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640]

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POLICY SCHEDULE

[BENEFIT PERIOD [January 1st through December 31st]]

[Calendar Year] Deductible per Person
Network . . . . . [$5,000/$7,500/$10,000]
Non-Network . . . . . [$10,000/$15,000/$20,000]

Benefit Percentage per Person [per Calendar Year]
Network . . . . . [100%]*
Non-Network . . . . . [75% of the 1st $10,000; then 100% thereafter]*

Out of Pocket Maximum per Person [per Calendar Year]
Network . . . . . [$5,000/$7,500/$10,000]
Non-Network . . . . . [$12,500/$17,500/$22,500]

[Calendar Year] Deductible per Family
Network . . . . . [$10,000/$15,000/$20,000]
Non-Network . . . . . [$20,000/$30,000/$40,000]

Benefit Percentage per Family [per Calendar Year]
Network . . . . . [100%]*
Non-Network . . . . . [75% of the 1st $20,000; then 100% thereafter]*

Out of Pocket Maximum per Family [per Calendar Year]
Network . . . . . [10,000/$15,000/$20,000]
Non-Network . . . . . [$25,000/$35,000/$45,000]

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

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* **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	[Doe, John C.]
POLICY NUMBER:	[2001023]
EFFECTIVE DATE:	[February 9, 2009]
RENEWAL DATE:	[9th] of each month
TOTAL AMOUNT OF PREMIUM:	[$xxx.xx]
[PREMIUM FOR PRESCRIPTION DRUGS:	[$xxx.xx]
[PREMIUM FOR DENTAL:	[$xxx.xx]
PREMIUM PERIOD:	[Monthly/Quarterly/Semi-Annually/Annually]
AGE AT ISSUE:	[35]

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . **[**$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . **[**80% of the 1st $10,000; then 100% thereafter**]***
Non-Network . . . . . **[**55% of the 1st $10,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$3,000/$3,500/$4,500/$5,500/$7,000/$9,500**]**
Non-Network . . . . **[**$6,500/$7,500/$9,500/$11,500/$14,500/$19,500**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**
Non-Network . . . . . **[**$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]**

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . **[**80% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . **[**55% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$6,000/$7,000/$9,000/$11,000/$14,000/$19,000**]**
Non-Network . . . . . **[**$13,000/$15,000/$19,000/$23,000/$29,000/$39,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**80% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . . **[**55% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . **[**$5,000/$5,500/$6,500/$7,500/$9,000/$11,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$14,000/$16,000/$19,000/$24,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**
Non-Network . . . . . **[**$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]**

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**80% of the 1st $40,000; then 100% thereafter**]***
Non-Network . . . . . **[**55% of the 1st $40,000; then 100% thereafter**]***

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$10,000/$11,000/$13,000/$15,000/$18,000/$23,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$28,000/$32,000/$38,000/$48,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$500/$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $10,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$4,500/$5,000/$5,500/$6,500/$7,500/$9,000/$11,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$13,000/$15,000/$17,000/$20,000/$25,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**
Non-Network . . . . . **[**$2,000/$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]**

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $40,000; then 100% thereafter**]***

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$9,000/$10,000/$11,000/$13,000/$15,000/$18,000/$23,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$26,000/$30,000/$34,000/$40,000/$50,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$500/$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$8,500/$9,000/$9,500/$10,500/$11,500/$13,000/$15,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$13,000/$15,000/$17,000/$20,000/$25,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**
Non-Network . . . . **[**$2,000/$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]**

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $40,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $40,000; then 100% thereafter**]***

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$17,000/$18,000/$19,000/$21,000/$23,000/$26,000/$31,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$26,000/$30,000/$34,000/$40,000/$50,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

MAXIMUM BENEFITS PER FAMILY MEMBER:

Maximum Lifetime Benefit. . . . . **[**$5,000,000**]**

Accidental Death Benefit - Primary Insured. . . . . **[**$10,000**]**
Spouse . . . . . **[**$2,500**]**
Child . . . . . **[**$1,000**]**

Combined Maximum Lifetime Transplant Benefit. . . . . **[**$1,000,000**]**
Designated Transplant Facility Maximum . . . . . **[**$1,000,000**]**
Non-Designated Transplant Facility Maximum . . . . . **[**$750,000**]**

Skilled Nursing Facility. . . . . **[**60 days**]** per **[**Calendar Year**]**

Home Health Care. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Hospice. . . . . up to **[**$200 per day**]**
Lifetime Maximum . . . . . **[**$10,000 or 6 months, whichever comes first**]**

Outpatient Physical Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Outpatient Speech Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Outpatient Occupational Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Preventive Care. . . . . **[**$1,000**]** per **[**Calendar Year**]**

Outpatient Spinal Manipulation. . . . . **[**$500**]** per **[**Calendar Year**]**

Allergy Testing and Serums.. . . . . **[**$500**]** per **[**Calendar Year**]**

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

OPTIONAL BENEFITS:

Dental Benefits. . . . . **[**Included/Not Included**]**
[See Dental Benefit Rider for Benefits & Schedule**]**

Outpatient Prescription Drug Rider . . . . . **[**Included/Not Included**]**
[See Outpatient Prescription Drug Rider for Benefits & Schedule**]**

POLICY SCHEDULE

PHYSICIAN'S SERVICES		
	Network	**Non-Network**
Office Visits: Visits for Sickness, Injury, or Follow-up, including lab tests and x-rays (See Non-Hospital Services for lab work sent to an independent lab)	[Subject to Network Deductible & Benefit Percentage] [[$30/$40] Copayment per visit, then 100%]	Subject to Non-Network Deductible & Benefit Percentage
Urgent Care Centers Visits: Office Visits for Sickness, Injury, or Follow-up, including lab tests and x-rays (See Non-Hospital Services for lab work sent to an independent lab)	[Subject to Network Deductible & Benefit Percentage] [[$60/$80] Copayment per visit, then 100%]	Subject to Non-Network Deductible & Benefit Percentage
Surgery, Equipment, Supplies, Injections (other than allergy injections):	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
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	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Chemotherapy, Infusion Therapy and Sclerotherapy (vein surgery or treatment):	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Allergy Injections:	[Subject to Network Deductible & Benefit Percentage][100%]	Subject to Non-Network Deductible & Benefit Percentage
Allergy Testing and Serums: $500 maximum benefit per Family Member per [Calendar Year]	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage

POLICY SCHEDULE

PHYSICIAN'S SERVICES

	Network	Non-Network
Preventive Care:		
Preventive Care Maximum: **[**$1,000**]** per Family Member per **[**Calendar Year**]**		
The following services are subject to the Preventive Care Maximum:		
Routine physical exams Age 19 & older Immunizations other than human papillomavirus Age 19 & older Routine mammograms PSA testing & exams Pap smears Lab work performed in the office	**[**Subject to Network Deductible & Benefit Percentage**]** **[[**$30/$40**]** Copayment per visit, then 100%**]**	Subject to Non-Network Deductible & Benefit Percentage
The following services are <u>not</u> subject to the Preventive Care Maximum:		
Immunizations other than human papillomavirus Birth through age 18	100%	100%
Well Child Care Birth through age 18	**[**Subject to Network Deductible & Benefit Percentage**]** **[[**$30/$40**]** Copayment per visit, then 100%**]**	Subject to Non-Network Deductible & Benefit Percentage
Human papillomavirus immunizations Bone density tests Colorectal cancer exams Lab work sent to an independent lab All other preventive care services	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Outpatient Spinal Manipulation:		
$500 maximum benefit per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
In-Hospital Services:		
Surgery; consultations; radiology; anesthesiology; pathology; physical, occupational and speech therapy	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Accident Benefit:		
Applies to any Covered Charges incurred due to an Injury when Treatment is received within **[**30 days**]** after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit.

POLICY SCHEDULE

HOSPITAL SERVICES

	Network	Non-Network
Inpatient:		
Non-Emergency Admissions	Subject to Network Deductible & Benefit Percentage	[$500] Copayment per Confinement, then subject to Non-Network Deductible & Benefit Percentage
Emergency Admissions	Subject to Network Deductible & Benefit Percentage	Subject to **Network** Deductible & Benefit Percentage
Emergency Room Services:		
Emergency Injury (Copayment waived if Admitted to Hospital within 24 hours)	[$250][$150] Copayment per visit, then subject to Network Deductible & Benefit Percentage	[$250][$150] Copayment per visit, then subject to **Network** Deductible & Benefit Percentage
Emergency Sickness (Copayment waived if Admitted to Hospital within 24 hours)	[$250][$150] Copayment per visit, then subject to Network Deductible & Benefit Percentage	[$250][$150] Copayment per visit, then subject to **Network** Deductible & Benefit Percentage
Non-Emergency Injury or Sickness	Not Covered	Not Covered
Diagnostic Services:		
Pre-admission testing, x-rays, lab tests, MRI, nuclear medicine, non-routine mammograms, and ultrasounds	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Outpatient Surgery:	Subject to Network Deductible & Benefit Percentage	[$500] Copayment per surgery, then subject to the Non-Network Deductible & Benefit Percentage
Accident Benefit:		
Applies to any Covered Charges incurred due to an Injury when Treatment is received within [30 days] after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.

POLICY SCHEDULE

NON-HOSPITAL SERVICES		
	Network	**Non-Network**
Air Ambulance:	Subject to Network Deductible, then **[**80%**]**	Subject to **Network** Deductible, then **[**80%**]**
Ambulance other than Air Ambulance:	Subject to Network Deductible & Benefit Percentage	Subject to **Network** Deductible & Benefit Percentage
Facility Charges for Outpatient Surgery:		
For procedures performed in a Free-Standing Outpatient Surgery Center or other non-hospital facility:	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Diagnostic Services:		
Nuclear medicine; non-routine mammograms; M.R.I.; cat scans; ultrasounds; x-rays; lab tests (including lab work sent by a physician to an independent lab).	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Skilled Nursing Facility:		
[60 days**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Hospice:		
Up to **[**$200 per day**]** Lifetime Maximum per Family Member of **[**$10,000 or 6 months, whichever comes first**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Home Health Care:		
[20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Physical Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Occupational Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Speech Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage

POLICY SCHEDULE

NON-HOSPITAL SERVICES		
Durable Medical Equipment:	Subject to Network Deductible, then [50%]	Subject to Non-Network Deductible, then [50%]
Accident Benefit: Applies to any Covered Charges incurred due to an Injury when Treatment is received within [30 days] after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.

POLICY SCHEDULE

ORGAN TRANSPLANT BENEFITS		
	Designated Transplant Facility	**Non-Designated Transplant Facility**
Maximum Benefit per Family Member	**[**$1,000,000***]**	**[**$750,000***]**
Transplant Facility Charges	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Organ Procurement & Acquisition Expenses	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Charges by the Transplant Network	Subject to Network Deductible & Benefit Percentage	Not Applicable

*** The Combined Maximum Lifetime Transplant Benefit is [$1,000,000]. This includes all charges incurred at a Designated Transplant Facility and a Non-Designated Transplant Facility.**

DEFINITIONS

This section defines many of the terms used in this policy. Defined terms are capitalized and have the meanings set forth in this section.

Accident or Accidental means an event that meets all of the following requirements:

1. Causes harm to the physical structure of the body;
2. Is the direct cause of a loss, independent of any disease, bodily infirmity or any other cause;
3. Happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.

Approved Transplant Procedures are human to human transplants which include:

1. Heart transplants;
2. Combined heart and lung transplants;
3. Lung transplants;
4. Kidney transplants;
5. Kidney and pancreas transplants;
6. Liver transplants;
7. Bone marrow transplants, either allogeneic or autologous; and
8. Peripheral stem cell transplants.

Approved Transplant Services 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.

Benefit Percentage means the percentage of Covered Charges that are payable by Us after the Deductible has been met. The Benefit Percentage is shown on the Schedule.

Benefit Percentage Maximum means the amount of Covered Charges a Family Member will have to pay in a **[**Calendar Year**]** after the Deductible has been met. The Benefit Percentage Maximum is shown on the Schedule.

[Benefit Period means the 12 month period beginning on the Effective Date of this policy and re-occurring every 12 months thereafter. The Benefit Period is shown on the Schedule.**]**

Clean Claim means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim

1. For payment of expenses incurred during a period of time for which premiums are delinquent, or
2. For which We need additional information in order to resolve one or more of the following issues:
   a. Information in order to determine if a policy limitation or exclusion is applicable to the claim;
   b. Medical information in order to determine the price for a medical procedure without a Current Procedural Terminology (CPT) Code or a Health Care Financing Administration Common Procedure (HCPC) Code;
   c. Information in order to determine if the Family Member who received the claimed services is eligible under the terms of the policy;
   d. Information in order to determine if the claim is covered by another health carrier, workers' compensation, a government supported program, or a liable third party;
   e. Information in order to determine the obligation of each health carrier or government program under coordination of benefits rules;
   f. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim; or
   g. Payment of premiums that were delinquent at the time the claimed services were rendered.

Cognitive means of or pertaining to thinking skills including but not limited to language use, memory, judgment, reasoning, intellect, social skills, and calculation skills; the mental process by which knowledge is acquired.

Combined Maximum Lifetime Transplant Benefit means the maximum amount that We will pay for a person covered under the policy for all covered transplants combined. The amount is shown on the Schedule. This amount is included in and part of the Maximum Lifetime Benefit.

Complications to a Pregnancy means Hospital Confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemmorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; or miscarriage. It also includes an emergency cesarean section required because of fetal or maternal distress during labor; severe pre-eclampsia; arrest of descent or dilatation; or obstruction of the birth canal by fibroids or ovarian tumors; necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A cesarean section delivery is not considered to be an emergency cesarean section if it is merely for the convenience of the patient and/or Physician or solely due to a previous cesarean section.

Complications of Pregnancy also includes treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, human papilloma virus, abnormal PAP, syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy.

Confined or Confinement means admitted as a resident bed patient to a Hospital or Skilled Nursing Facility.

Copayment means the amount a Family Member must pay for a provider's services or for purchase of medications or other medical supplies each time a service or medication is obtained. Copayments are not considered as part of any related Covered Charges and do not satisfy any Deductible or Benefit Percentage. Copayments may apply in addition to the Deductible and Benefit Percentage for certain Covered Charges.

Cosmetic means surgery or any other Treatment directed at changing the normal or abnormal physical appearance of any body structure in the absence of functional impairment of that body part.

Covered Charge means a medical expense of a Family Member due to Sickness or Injury, which subject to limitations expressed with the Covered Charge, on the Schedule, or in the Exclusions:

1. Is due to Medically Necessary care or Treatment;
2. Is incurred while this policy is in effect with regard to the Family Member;
3. Is incurred on the advice of a licensed Physician;
4. Is not more than the Usual, Customary, and Reasonable Charge for Non-Network services;
5. Is not more than the charge which would have been made had no insurance been in force; and
6. Is not excluded from coverage by the terms of this policy.

A medical expense will be deemed to have been incurred on the date the service is performed or the date the purchase occurs.

Custodial Care means care that is provided to assist the patient with activities of daily living. These types of services include help in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, supervision of medication that can usually be self-administered or administered by a non-licensed person, organizing appointments or activities, transporting to or from appointments or activities, or acting as a coordinator or liaison for care or services.

Deductible means a set amount of Covered Charges that must be paid each **[**Calendar Year**]** by or for the Family Member and which is not Our obligation. The Network and Non-Network **[**Calendar Year**]** Deductibles per Family Member and per Family are shown on the Schedule.

Designated Transplant Facility means a facility, affiliated with a national organ transplant network, which has entered into an agreement to render the required type of Approved Transplant Procedures to persons insured by Us. Selection of the Designated Transplant Facility to be used for a particular transplant will be determined by the Family Member's attending Physician in consultation with the transplant network's staff and Us. The Designated Transplant Facility chosen may or may not be located within the Family Member's geographic area.

Developmental means the progression of skills or abilities that demonstrate increasing Cognitive, intellectual, social, educational and physical competence in an individual who has never attained these levels.

Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs the primary purpose of which is weight reduction. The training is to enable diabetic patients to understand the diabetic management process and daily management of diabetic therapy as method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

Due Date means the day of the month on which the premium payment is due.

Durable Medical Equipment means basic equipment which is approved for use for a particular condition and:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of Sickness or Injury; and
4. Is appropriate for use in the patient's home.

Effective Date means the day the insurance coverage begins under this policy.

Emergency means a medical condition which is sudden in its onset and manifests itself by symptoms of sufficient severity that a reasonably prudent person, with average knowledge of medicine would conclude that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the person's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Executive Officer means the President, a Vice President, the Secretary, or the Treasurer of American Community Mutual Insurance Company.

Experimental, Investigational, Unproven and/or for Research means that the procedure, test, Prescription Drug, Treatment, or complications as a result thereof, at the time We make a determination regarding coverage is:

1. Not generally accepted in the medical community in the United States as effective in treating the condition, Sickness, or diagnosis for which their use is proposed;
2. Not proven by scientific evidence to be effective in treating the condition, Sickness, or diagnosis for which their use is proposed;
3. Part of a research protocol or clinical trial; or
4. Not approved by the federal Food and Drug Administration.

Family Member means You and any persons You listed in Your application whom We accepted for insurance. You may add persons to this policy by following the policy provision entitled Family Members. The provision entitled End of Coverage tells when a Family Member's insurance ends.

Free Standing Outpatient Surgery Center means a facility which:

1. Operates according to the law;
2. Has facilities for surgery on its premises;
3. Is solely for outpatient or same day surgery; and
4. Is separate from Hospital facilities.

Home Health Agency means an agency designed to provide those services listed in the Home Health Care Covered Charges within the patient's home and is licensed by the state to provide home health care.

Home Office means Our main office in **[**Livonia, Michigan**]**.

Hospice means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

Hospital means an institution that is either accredited by the Joint Commission on Accreditation of Health Care Organizations as a general acute care Hospital under the Hospital Accreditation Program or that:

1. Operates according to the law;
2. Is primarily for Treatment of sick and injured people as Inpatients and is open at all times;
3. Is supervised by a staff of one or more licensed Physicians, and has a 24 hour nursing service;
4. Has facilities for surgery on its premises; and
5. Is licensed by the state as an acute care Hospital.

A facility will not be considered a Hospital if it is primarily for:

1. Aged persons;
2. Care of alcoholics or substance abusers;
3. Custodial Care, rest, convalescent or transitional care;
4. Educational or Developmental services or care; or
5. A residential facility.

Hospital Admission means admitted to a Hospital as a resident bed patient for Treatment or surgery.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry.

Injury means Accidental bodily damage or loss.

Inpatient means Confined in a Hospital or Skilled Nursing Facility.

Intensive Care Unit means a section within a Hospital which:

1. Is solely for the care of critically ill patients;
2. Has special supplies and equipment for such care ready for immediate use;
3. Is under constant observation by registered nurses (R.N.) or other highly trained personnel; and
4. Is separate from other Hospital facilities.

A facility will not be considered an Intensive Care Unit if it is mainly for normal recovery care after an operation.

Low Protein Modified Food Product means a food product that is specifically formulated to have less then one (1) gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

Maximum Lifetime Benefit per Family Member means the maximum amount that We will pay for a person covered under the policy for all Sicknesses and Injuries combined. The amount is shown on the Schedule. This maximum applies even if the Family Member's coverage lapses and is later reinstated.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary means medical, surgical, or other health care services, supplies, Treatments, procedures, drug therapies, or devices which are necessary to treat the Family Member's condition. Determination of medical necessity is done on a case by case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a Physician has performed or prescribed a procedure or Treatment or the fact that it may be the only available Treatment for a particular Injury or Sickness does not, alone, mean that it is Medically Necessary. In addition, the service must be:

1. Consistent with the diagnosis of and prescribed course of Treatment for the Family Member's condition;
2. Required for reasons other than the convenience of the Family Member or their Physician, and not required solely for custodial, comfort, maintenance, or quality of life reasons;
3. Performed in the most cost efficient type of setting appropriate for the condition;
4. Rendered at the frequency which is accepted by the medical community;
5. Likely to be effective in treating the Family Member's condition;
6. Not for Cosmetic purposes; and
7. Not Experimental, Investigational, Unproven and/or for Research.

Medicare means Title XVIII of the Social Security Act, as amended.

Mental or Nervous Disorder means a clinically significant behavioral or psychological condition or syndrome causing distress, disability or functional impairment, regardless of the cause. Mental or Nervous Disorder includes: psychosis, depression, schizophrenia, bipolar affective disorder and other psychiatric illnesses listed in the current DSM, the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. For purposes of this policy, the term Mental or Nervous Disorder does not include learning disabilities, attitudinal disorders, disciplinary problems or Substance Abuse.

Network means the Preferred Provider Network named by Us.

Network Provider means a Hospital, Physician, or other provider or supplier of health care services that has signed an agreement with the Network named by Us.

Non-Designated Transplant Facility means a facility which has not entered into a special transplant agreement with Us to provide Approved Transplant Procedures to persons insured by Us.

Non-Emergency means a medical condition that is not an Emergency.

Non-Network Provider means a Hospital, Physician, or other provider or supplier of health care services that has not signed an agreement with the Network named by Us.

Office Visit means a meeting between a Family Member and a Physician in the Physician's office or an Urgent Care Center. During this visit the Physician performs evaluation and management services as defined in the most recent edition of Current Procedural Terminology.

Organ Procurement and Acquisition Expenses shall include expenses directly related to:

1. Removal of the organ or bone marrow from the donor;
2. Preparation of the organ or bone marrow after removal from the donor for transplant for a period not to exceed 30 days; and
3. Transportation of the organ or bone marrow to the transplant facility.

If any benefits remain and are available under this Policy after the recipient's expenses have been paid, medical expenses of a live donor will be reimbursed.

Other Valid Coverage means coverage, whether or not issued on an excess basis, for medical expenses by or under:

1. Blue Cross or Blue Shield;
2. A union;
3. Membership in an association;
4. Group insurance;
5. Automobile medical payments insurance;
6. Personal injury protection under no fault automobile insurance;
7. A union welfare plan;
8. An employer or employee benefit plan;
9. A Hospital or medical service organization;
10. Any other insurance, welfare, or prepayment plan;
11. An expense incurred hospital, surgical, medical, or sick care insurance policy or certificate;
12. A hospital or medical service subscriber contract, medical practice or other prepayment plan; or
13. Other expense incurred plan or program.

Other Valid Coverage does not mean Medicaid, hospital indemnity plans, specified disease only policies, or limited occurrence policies that provide only for intensive care or coronary care at a Hospital, first aid outpatient medical expense resulting from accidents, or specified accidents such as travel accidents.

Outpatient means a person who receives Treatment at a Hospital, Physician's office, or clinic but is not hospitalized.

Physician means a medical doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license issued by the jurisdiction in which such person's services are rendered. Such jurisdiction must be in the United States of America. The Physician may not be the insured or related by blood or marriage to the insured.

Pre-existing Condition means a medical condition, for which, prior to the Effective Date of coverage:

1. The Family Member received medical advice or Treatment from a Physician within 60 months before the Effective Date of coverage;
2. Medical advice or Treatment was recommended by a Physician within 60 months before the Effective Date of coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or Treatment within 60 months before the Effective Date of the Family Member's coverage under this policy.

[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.**]**

Preferred Provider Network means that group of providers of medical services including, but not limited to, Hospitals, Physicians, laboratories, pharmacies, and providers of Hospice, home health care services and medical equipment that are approved for the Network by the Preferred Provider Network Administrator. The Preferred Provider Network Administrator will provide the Family Member with a list of Network Providers of medical services.

Preferred Provider Network Administrator is the entity that is:

1. Named by Us; and
2. Responsible for managing the Network.

Prescription Drug means a drug or medicine, which can be obtained only by prescription and, except for insulin bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription."

Preventive Care means health care provided to a Family Member in order to promote or maintain the individual's good health and prevent health problems.

Prosthetic means an external or implanted device that substitutes for or supplements a missing or defective part of the body.

Rehabilitation means the use of physical, occupational or speech therapy to restore physical function after a Sickness or Injury that is provided with the expectation that the condition will improve in a reasonable and predictable period of time and the services:

1. Can only be performed safely and effectively by a qualified therapist;
2. Must be related directly to the Sickness or Injury;
3. Must be ordered by a Physician;
4. Must be consistent with accepted standards of medical practice; and
5. Must be proven effective in treating the condition.

Renewal Date means the date shown on the Schedule.

Schedule means the Policy Schedule on pages [3 - 3(g)].

Sickness means illness, disease, or Complications to a Pregnancy.

Skilled Nursing Facility means an institution which:

1. Is licensed as a Skilled Nursing Facility by the state;
2. Operates according to the law;
3. Is approved for payment of Medicare benefits (or is qualified for approval);
4. Is mainly engaged in providing, in addition to room and board, skilled nursing care on a 24 hour basis by or under the supervision of a registered nurse (R.N.);
5. Provides medical care under the supervision of a licensed Physician; and
6. Keeps a medical record of each patient.

A facility will not be considered a Skilled Nursing Facility if it is primarily for:

1. Aged persons;
2. Care of alcoholics or substance abusers;
3. Custodial Care, rest, convalescent or transitional care;
4. Educational or Developmental services or care; or
5. A long-term care or residential facility.

Speech Therapist means someone who:

1. Has a master's degree in speech pathology;
2. Has completed an internship; and
3. Is licensed by the state in which he or she performs his or her services, if that state requires licensing.

Substance Abuse means the taking or use of alcohol or other drugs at dosages that place a Family Member's social, economic, psychological, and physical welfare in potential hazard; or to the extent that a Family Member loses the power of self-control as a result of the use of alcohol or drugs; or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Treatment means medical or surgical management of a Sickness or Injury, including seeking medical advice, consultation, diagnosis, surgery, testing, therapy, or the use of Prescription Drugs.

Treatment Plan means the Family Member's Physician's written or oral plan, which includes but is not limited to:

1. The anticipated date of Confinement;
2. The facility to be used;
3. The Family Member's medical indications requiring Confinement;
4. The recommended procedures, Treatment or surgery; and
5. The procedure code or diagnostic code applicable to the Family Member's Sickness or Injury.

Urgent Care Center means a freestanding facility, center, or other entity that operates primarily to provide specialty medical treatment of an unforeseen, unexpected Sickness or Injury on an urgently needed or prompt basis.

Usual, Customary, and Reasonable Charge (Applicable only to Non-Network services or supplies) means a charge which does not exceed the amount usually accepted by providers in the general area where the charge is incurred.

Waiting Period means the length of time an eligible Family Member must be covered under this policy before benefits are payable.

We, Us, Our means American Community Mutual Insurance Company.

You, Your, Yours means the Primary Insured named on the Schedule.

BENEFIT PROVISIONS

We will pay Covered Charges as defined and limited in the policy. During a **[**Calendar Year**]**, Covered Charges may be subject to Copayments, the Deductible, and/or the Benefit Percentage as shown on the Schedule. Covered Charges must be incurred while coverage under the policy is in force, and are subject to the terms, conditions, limitations, exclusions, and maximum benefit amounts stated in the policy. If a Family Member incurs Covered Charges from a Network Provider, We will pay benefits for those Covered Charges according to the Schedule column headed Network. If a Family Member incurs Covered Charges from a Non-Network Provider, We will pay benefits for those Covered Charges according to the Schedule column headed Non-Network.

Copayment. Some benefits are subject to a Copayment, which is the amount a Family Member must pay for a provider's services or for the purchase of medications or other medical supplies each time a service or medication is obtained. Copayments are not considered as part of any related Covered Charges and do not satisfy any Deductible or Benefit Percentage for a Family Member. Copayments may apply in addition to the Deductible and Benefit Percentage for certain Covered Charges.

Deductible. This is a set amount of Covered Charges that must be paid by or for the Family Member and which is not Our obligation. Benefits that are subject to the Deductible, will be payable for a Family Member when the earlier of the following occurs:

1. The Family Member's Covered Charges in a **[**Calendar Year**]** exceed the **[**Calendar Year**]** Deductible per Person shown on the Schedule; or
2. The combined Covered Charges for all Family Members in a **[**Calendar Year**]** exceed the **[**Calendar Year**]** Deductible per Family shown on the Schedule.

Family Members must meet a new Deductible each **[**Calendar Year.**]**

Benefit Percentage. Once the Deductible has been met, We pay a percentage of the Family Member's Covered Charges that exceed the **[**Calendar Year**]** Deductible. These percentages are shown on the Schedule. The Family Member is responsible for their percentage of the Covered Charges up to the Out of Pocket Maximum shown on the Schedule. Unless otherwise provided under the policy and subject to any applicable Copayments or maximums, benefits will be paid at 100% for a Family Member when the earlier of the following occurs during a **[**Calendar Year**]**:

1. The Family Member's out of pocket expenses in a **[**Calendar Year**]** reach the Out of Pocket Maximum per Person per **[**Calendar Year**]** shown on the Schedule; or
2. The combined out of pocket expenses for all Family Member's in a **[**Calendar Year**]** reach the Out of Pocket Maximum per Family per **[**Calendar Year**]** shown on the Schedule.

Out of Pocket Maximum: The Out of Pocket Maximum per Person is the sum of the **[**Calendar Year**]** Deductible per Person and Benefit Percentage per Person per **[**Calendar Year**]** shown on the Schedule.

The Out of Pocket Maximum per Family is the sum of the **[**Calendar Year**]** Deductible per Family and Benefit Percentage per Family per **[**Calendar Year**]** shown on the Schedule.

In addition to the **[**Calendar Year**]** Deductible and Benefit Percentage, the Family Member is responsible for the following, which are not included in the Out of Pocket Maximum:

1. Copayments;
2. Charges in excess of the benefit limits included in this policy;

3. Medical expenses which are not eligible to be Covered Charges under this policy;
4. Medical expenses which are more than the Usual, Customary and Reasonable Charge for services performed by a Non-Network Provider;
5. Medical expenses which are incurred during any Waiting Period included in this policy;
6. Charges for Durable Medical Equipment that are payable after the Deductible has been met; and
7. Charges for an air ambulance that are payable after the Deductible has been met.

Maximum Lifetime Benefit. The most We will pay under this policy during the lifetime of any one Family Member is the Maximum Lifetime Benefit shown on the Schedule. The Maximum Lifetime Benefit applies even if the Family Member's coverage lapses and is later reinstated.

Accident Benefit. If a Family Member sustains an Injury, We will waive the Deductible and pay the Covered Charges related to the Injury at the Benefit Percentage shown on the Schedule for services incurred within **[**30 days**]** of the Injury subject to the maximum shown on the Schedule. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit has been met.

Common Accident Benefit: 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.

Medicare Coordination: Benefits which We will pay are limited to those Covered Charges which are within the policy limits and which are in excess of those Covered Charges which qualify for reimbursement under Medicare.

THE DEDUCTIBLES, COPAYMENTS, BENEFIT PERCENTAGES, OUT OF POCKET MAXIMUMS, AND MAXIMUM BENEFITS ARE SHOWN ON THE SCHEDULE.

PRIOR NOTIFICATION REQUIREMENTS

FOLLOWING THESE PROCEDURES DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. WE WILL PAY BENEFITS ACCORDING TO THE TERMS OF THE POLICY.

Prior Notification means contacting Us by telephone at **[**800-991-2642**]** and providing Us with information regarding the Hospital Admission.

PRIOR NOTIFICATION IS REQUIRED FOR THE FOLLOWING HOSPITAL ADMISSIONS:

A. Non-Emergency Hospital Admission

The provider, Doctor, or Family Member must contact Us prior to any Non-Emergency Hospital Admission.

B. Emergency Hospital Admission

The provider, Doctor, or Family Member must contact Us within 48 hours following any Emergency Hospital Admission.

MEDICAL BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy.

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 shown on the Schedule.

4. Medical services and supplies furnished by the Hospital.

5. Treatment given in a Hospital emergency room for an Emergency 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 allowance for the most expensive procedure and 50% of the Preferred Provider Network allowance 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.

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 to 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 a Family Member on or after the day such individual is entitled to benefits under Medicare, except as provided by law.

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. Coverage also includes reconstructive surgery of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

25. Approved Transplant Procedures up to the Combined Maximum Lifetime Transplant Benefit shown on the Schedule. To be eligible to receive the benefits available, transplants must be approved by Us 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, and Organ Procurement and Acquisition Expenses as defined in the policy and subject to the maximum benefits shown on the Schedule.

26. 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. Hospital Inpatient post-mastectomy care of not less than 48 hours, however, the attending Physician after consulting with the Family Member may approve a shortened length of Hospital Inpatient stay.

27. Allergy testing and serums, subject to the maximum benefit shown on the Schedule.

28. Allergy injections.

29. 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.

30. The following care and Treatment of Your newborn child, provided the child is covered under the policy from the moment of birth as described under the Addition of a Newborn Child provision contained in this policy:

    a. Testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants that may be mandated by Arkansas law in the future.

    b. Treatment related to a premature birth.

    c. Routine nursery care and pediatric charges for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

31. Medically Necessary Treatment of loss or impairment of speech or hearing, including communicative disorders generally treated by a speech pathologist or audiologist. Coverage does not include hearing instruments or devices.

32. Medical Foods and Low Protein Modified Food Products that are prescribed as Medically Necessary for the therapeutic treatment of a Family Member inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism. To be covered under the policy, the food products must be administered under the direction of a licensed Physician and the cost of the food products must exceed the income tax credit of $2,400 per year per person as allowed by Arkansas law.

33. Medically Necessary diagnosis and Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorders. Treatment includes both surgical and non-surgical procedures whether prescribed or administered by a Physician or a dentist.

34. Contraceptive drugs and devices approved by the United States Food and Drug Administration are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the terms, conditions and limitations contained on the Prescription Drug Program Benefit Rider included in the policy.

35. Contraceptive devices that are surgically implanted and are approved by the United State Food and Drug Administration are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the Benefit Provisions section of the policy and are not covered under the Outpatient Prescription Drug Benefit Rider.

36. Treatment of Type 1, Type 2, and gestational diabetes, if determined to be Medically Necessary and prescribed by a licensed Physician, including:

    a. Diabetes equipment, supplies and appliances; and
    b. Diabetes Self-Management Training.

    Covered Charges include the following equipment, supplies and appliances:

    a. Blood glucose monitors and blood glucose monitors for the legally blind;
    b. Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
    c. Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
    d. Insulin;
    e. Injection aids;
    f. Syringes, including pen-like insulin injection devices and pen needles;
    g. Insulin pumps and appurtenances which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
    h. Oral agents for controlling the blood sugar level, which are Prescription Drugs;
    i. Podiatric appliances for prevention of complication associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and
    j. Glucagon emergency kits and Injectable glucagon.

    Diabetes Self-Management Training must be provided by an appropriately licensed health care professional in accordance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Covered Charges is limited to:

    a. One training session per lifetime;
    b. Additional training sessions that are Medically Necessary because of a significant change in the Family Member's symptoms or condition and are order in writing by a Physician.

37. General anesthetics and Hospital or ambulatory surgical treatment center facility charges incurred when dental care is provided for the following Family Members:

    a. A child age 6 or under;
    b. A person with a diagnosed serious mental or physical condition; or
    c. A person with a diagnosed significant behavioral problem as determined by an Arkansas licensed attending physician.

HOSPICE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy, subject to the Hospice maximum benefit shown on the Schedule.

We will pay Hospice Benefits for a Family Member, provided:

1. All Hospice care services, whether provided in a Hospice facility or at the Family Member's home, are coordinated by a Hospice. (A copy of the Hospice program's Treatment Plan may also be required.)

2. The Family Member:

   a. Is terminally ill;
   b. Has a life expectancy of six months or less; and
   c. Would otherwise have been Confined in a Hospital or Skilled Nursing Facility.

3. The attending Physician certifies:

   a. The Family Member's illness, including a prognosis for life expectancy; and
   b. Hospice care is Medically Necessary.

4. The attending Physician reviews the care given at least once a month.

Covered Charges include the following:

1. Home health aide services under the supervision of a registered nurse or licensed therapist;

2. Home health services performed by a licensed registered nurse or licensed therapist;

3. Physical therapy;

4. Respiratory and inhalation therapy;

5. Professional nutrition counseling;

6. Medical social services;

7. Family counseling due to the Family Member's terminal condition; and

8. Respite care.

HOME HEALTH CARE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy, subject to the Home Health Care maximum benefit shown on the Schedule.

We will pay Home Health Care Benefits for a Family Member, provided:

1. This service is necessary as an alternative to care in a Hospital or Skilled Nursing Facility. Confinement in a Hospital or Skilled Nursing Facility is not required before the start of home health care.

2. The service requires the use of a licensed registered nurse, licensed physical, occupational, speech or respiratory therapist when the Family Member is confined to home due to their medical condition.

3. The Family Member is under the direct care of a Physician.

4. The Treatment Plan for home health care is established in writing by the attending Physician prior to the start of the Treatment.

5. The Family Member is examined by the attending Physician at least once each 60 days.

6. The attending Physician certifies that Confinement in a Hospital or Skilled Nursing Facility would be required in the absence of home health services.

7. The Treatment Plan is coordinated by a Home Health Agency.

8. The cost of the home health service is less than the cost of the same service provided in a Hospital.

Covered Charges include the following:

1. Home health services performed by a licensed registered nurse or licensed therapist;

2. Physical and occupational therapy;

3. Speech therapy and audiology;

4. Respiratory and inhalation therapy; and

5. Professional nutrition counseling.

PREVENTIVE CARE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of the policy.

The following requirements included in the definition of a Covered Charge do not apply to the Preventive Care Covered Charges:

1. The medical expense is due to Sickness or Injury; or
2. The medical expense is due to Medically Necessary care or Treatment.

Covered Charges subject to the Preventive Care Maximum shown on the Schedule include the following services:

1. Routine physical exams including lab services not sent to an independent lab, for a Family Member age 19 and older;

2. Immunizations, other than the human papillomavirus immunization for a Family Member age 19 and older;

3. An annual Prostate-Specific Antigen (PSA) blood test and Digital Rectal Examination upon the recommendation of a licensed Physician for:

   a. All males age 50 and over; and
   b. Males age 40 and over with a family history of prostate cancer or men at risk;

4. An annual cervical smear or pap smear;

5. Routine Mammograms, limited to:

   a. One mammogram between the ages of 35 and 39;
   b. One mammogram per year after age 39;
   c. One mammogram per year for women at risk.

Covered Charges <u>not</u> subject to the Preventive Care Maximum shown on the Schedule include the following services:

1. Colorectal cancer screening for a Family Member who is:
   a. Age 50 or older;
   b. Less that age 50 who is at high risk for colorectal cancer according to the American Cancer Society guidelines for colorectal cancer screening; or
   c. Experiencing symptoms of colorectal cancer as determined by a Physician.

   Covered Charges for colorectal cancer screening include the following:
   a. An annual fecal occult blood test, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
   b. A double-contract barium enema every 5 years; or
   c. A colonoscopy every 10 years; and
   d. Any additional medically recognized screening tests required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

2. Well child care benefits for a Family Member from birth through 18 years of age.

   Covered Charges for well child care must be rendered by or under the supervision of a single Physician during the course of one visit and include the following:

   a. A medical history;
   b. A complete physical exam;
   c. A developmental assessment;
   d. Anticipatory guidance;
   e. *Age appropriate immunizations, other than the human papillomavirus immunization; and
   f. Appropriate laboratory test(s).

   ***Age appropriate immunizations are not subject to the Deductible, Benefit Percentage or Preventive Care maximum benefit. Immunizations will be covered at 100%.**

3. Human papillomavirus immunizations;

4. Bone density tests;

5. Lab work sent to an independent lab; and

6. All other preventive services not specifically shown elsewhere in the policy.

ACCIDENTAL DEATH
(Including Dismemberment and Loss of Sight)

A. Accidental Death Benefits

Benefits will be paid if a Family Member incurs any of the losses listed in item C. below, if and only if:

1. The loss:

   a. Results from an accidental bodily injury which occurred while the Family Member was insured;
   b. Was independent of all other causes; and

2. The loss occurs within 90 days after the accidental bodily injury. However, benefits will be paid if use of extraordinary life support systems delays the loss for more than 90 days from the date of the accidental bodily injury.

B. Exclusions

No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

1. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;

2. Insurrection, riot, or war;

3. The committing of, or the attempt to commit, an assault or felony;

4. Disease or disorder of the body or mind;

5. Medical or surgical Treatment or diagnosis, preventive care or complications of care;

6. The voluntary:

   a. Taking of drugs (except drugs taken as prescribed by a Physician) or poison; or
   b. Inhaling of gas or other inhalants;

7. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or

8. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of, an accidental wound).

C. Table of Losses

In the Event of Loss of:	**The Amount Payable will be:**
Life	The Full Amount of Insurance
Both Hands or Both Feet	The Full Amount of Insurance
Sight of Both Eyes	The Full Amount of Insurance
One Hand and One Foot	The Full Amount of Insurance
One Hand and Sight of One Eye	The Full Amount of Insurance
One Foot and Sight of One Eye	The Full Amount of Insurance
One Hand	One-Half The Full Amount of Insurance
One Foot	One-Half The Full Amount of Insurance
Sight of One Eye	One-Half The Full Amount of Insurance

With respect to hands or 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.

NOTE: IN ANY EVENT, 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 THE RESULT OF THAT ACCIDENT.

THE AMOUNT OF INSURANCE IS SHOWN ON THE SCHEDULE.

PRE-EXISTING CONDITION LIMITATION

We will pay no benefits for charges due to a Pre-Existing Condition for 3 years starting on the Effective Date of a Family Member's coverage under the policy.

GENERAL EXCLUSIONS

We will pay no benefit for charges, including the diagnosis and/or Treatment, due to any of the following. These charges are not Covered Charges and cannot be used to satisfy this policy's Deductible, Co-payments, or Benefit Percentage.

1. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.

2. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.

3. Charges for an Injury received while committing or attempting to commit a felony.

4. Charges caused by or contributed to by war or any act of war, whether or not declared, or participation in a riot or insurrection.

5. Charges for any Sickness contracted or Injury sustained while a member of the Military, Navy, or Air Force of any country or combination of countries.

6. Charges for any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, except for Medicaid.

7. Charges for Treatment of Sickness or Injury covered by workers' compensation insurance or similar laws.

8. 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.

9. Charges for services or supplies for personal comfort or convenience.

10. Charges for travel or lodging expenses.

11. Charges for maintenance care, Custodial Care or homemaker services.

12. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.

13. Charges for dental services, supplies, or Prosthetics 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.

14. Charges for 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.
    b. Due to mastectomy as provided under the Medical Benefits section of this policy.
    c. Due to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.

15. Charges for 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. 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, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury, except as provided under the Medical Benefits section of this policy.

17. 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.

18. 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.

19. Charges for care of a well, newborn child, except as provided under the Medical Benefits or Preventive Care Benefits section of this policy.

20. Charges for contraceptives, contraceptive methods or aids, unless the Schedule shows that the Outpatient Prescription Drug Benefit Rider is included in the policy.

21. Charges for emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.

22. 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, in vitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.

23. Charges for gender reassignment or charges due to complications of gender reassignment.

24. Charges for the diagnosis and/or Treatment of acne.

25. Charges for the diagnosis and/or Treatment of eating disorders.

26. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.

27. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and non-chemical addictions.

28. Charges for hair loss, hair restoration or removal.

29. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.

30. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.

31. Charges for the diagnosis and/or Treatment of Substance Abuse.

32. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.

33. Charges for transplants, except as provided under the Medical Benefits section of this policy.

34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.

35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.

36. Charges for the 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.

37. Charges for court-ordered evaluation, Treatment or testing.

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.

41. Charges for services available in the community through educational or school programs.

42. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.

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, except podiatric appliances for prevention of complications associated with diabetes, as provided under the Medical Benefits section of this policy.

45. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.

46. Charges for the 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 telephone or electronic mail.

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 Treatment of an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to the following:

    a. Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
    b. Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.

52. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.

53. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.

54. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of this policy.

55. 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, reike therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

56. Charges for myo-electric or microprocessor Prosthetics.

57. 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.

58. 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.

59. **[**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.**]**

[60**]**. Charges for which benefits are not provided in this policy.

GENERAL PROVISIONS

Family Members

Eligibility. The following persons are eligible to be Family Members:

1. You;
2. Your spouse;
3. Your and Your spouse's children and adopted children, provided they are:
   a. Not married,
   b. Dependent on You for at least 50% of their support, and
   c. Less than **[**22**]** 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.

Addition of Family Members. To add a person as a Family Member, You must apply to Us on Our form and pay the required premium. All persons must be insurable under Our usual underwriting standards.

Addition of a Newborn Child. Your child born after the Effective Date is covered under the policy from the moment of birth provided more than one Family Member is insured under this policy when the birth occurs and We are given notice of the child's birth within 90 days of the birth or before the next premium due date, whichever is later. If You are the only Family Member covered under the policy when the birth occurs, the newborn child is subject to Our usual underwriting standards and the exclusion of any Pre-existing Conditions as provided in the policy.

Any additional premium required to cover the newborn child will be charged as of the Effective Date of the coverage for the newborn child.

Addition of an Adopted Child. A minor child adopted by You after the Effective Date is covered under the policy as of the date of the filing of the petition for adoption provided, more than one Family Member is insured under this policy when the petition for adoption is filed and You apply for coverage of the adopted child within 60 days after the date the petition for adoption is filed. If the adopted child is a newborn, coverage begins from the moment of birth provided more than one Family Member is insured under this policy when the birth occurs and the petition for adoption and application for coverage are both filed within 60 days after the date of birth. If You are the only Family Member covered under the policy the adopted child will be subject to Our usual underwriting standards and the exclusion of any Pre-existing Conditions as provided in the policy. Coverage for an adopted child will terminate upon the dismissal or denial of the petition for adoption.

Any additional premium required to cover the adopted child will be charged as of the Effective Date of the coverage for the adopted child.

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 first Renewal Date after the earliest of the following:

   a. The date the child marries,
   b. The date the child ceases to be dependent on You for at least 50% of their support, or
   c. The date the child attains age **[**23**]**.

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 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.

Mentally or Physically Handicapped Child. Your child's coverage will not end due to age while the child is:

1. Mentally or physically incapable of earning their own living;
2. Actually dependent on You for a majority of their support; and
3. Covered by the policy on the date immediately preceding the day their coverage would have ended due to age.

We may ask for proof of incapacity and dependency annually.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates:

1. The date the child becomes capable of self-support;
2. The date the child's coverage under the policy ends for any reason other than age;
3. The date the policy ends; or
4. The date a Covered Charge is incurred if, as part of the required proof of loss, We ask for proof of the child's status and You fail to provide proof that as of the date the expense was incurred the child remains:
    a. Mentally or physically incapable of earning their own living; and
    b. Actually dependent on You for a majority of their support.

Change of Residence. If You change Your residence and move into a different county in the same state or into a different state, You will keep this policy. We may adjust Your premium on the next Renewal Date based upon Your new geographic location.

Survivorship. If You die while this policy is in force, We will refund the unearned portion of Your premium. The refund will be prorated. If Your spouse is a Family Member then We will deem the policy to be issued to Your spouse. If Your spouse is not a Family Member and other Family Members are covered by this policy, We will issue a rider naming Your spouse or the Family Member's legal guardian as owner of the policy.

Continuity of Care. If on the Effective Date a Family Member is receiving Treatment from a Non-Network Provider for an acute condition, We will cover the current episode of Treatment for the acute condition at the Network benefit level until the current episode of Treatment ends or until the end of 90 days, whichever occurs first.

If a provider's participation in the Network has been terminated, We will continue to cover a current episode of Treatment for an acute medical condition at the Network benefit level until the current episode of Treatment ends or until the end of 90 days, whichever occurs first.

The Family Member should contact us at **[**800-991-2642**]** to request to continue services as described above.

Conversion. We will issue a new policy to insure a Family Member whose coverage ends for any reason described in sections 1 and 2 of the End of Coverage provision. The new policy will be issued on this policy form. The premium will be based on the table of rates for the Family Member's age and sex.

We must receive a written request and the first premium:

1. Within 31 days after the coverage ends; or
2. In the case of dissolution of marriage, within 60 days from the date of the judgment granting the dissolution, 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.

COORDINATION OF BENEFITS

COB may limit benefits when a Family Member is entitled to benefits from more than one source. It does this by relating the Family Member's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of a Family Member's Allowable Expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out below, so that from all sources, a Family Member will not be paid for more than 100% of his or her Allowable Expenses.

Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Following is a list of the sources (plans) with which this policy coordinates:

1. Group or blanket insurance and group subscriber contracts.

2. Employer or employee benefit organization insurance or workmen's compensation insurance.

3. Union welfare plans.

4. Group or group-type coverage through health maintenance organizations (HMOs) and other prepayment group practice plans.

5. Group-type contracts which are contracts not available to the general public and which can be obtained and maintained only because of membership in or connection with a particular organization or group.

6. The amount by which group or group-type hospital indemnity benefits exceed $30 per day.

7. Student insurance. (COB will not apply to accident-only coverage for grammar, high school, college or post high school students for which the parent pays the entire Premium and which is sponsored by or provided through a school.)

8. The medical benefits coverage in group, group-type, individual automobile "no fault" and traditional automobile "fault" type contracts.

Any plan that does not have this COB provision, or one like it, pays first. Plans providing individual or group no-fault auto insurance coverage and plans providing automobile medical payments insurance coverage pay first for medical, hospital, nursing, dental, surgical, ambulance, and prosthetic services incurred within 24 months after the automobile accident, up to an aggregate of $2,000 per person. For plans having a COB provision, or one like it, these rules apply to determine which benefit plan pays first and the order in which the other plans follow:

1. The plan that covers a Family Member as an employee/insured will be considered before the plan that covers the Family Member as a dependent. The plan that covers a Family Member as an employee will be considered before the plan that covers the Family Member as a member/insured.

2. For dependents who are covered under two or more plans, other than children whose parents are divorced or otherwise separated, the plan of the parent with the earlier birthday will be considered before the other parent's plan. If the birthdays fall on the same day, the plan that has covered the parent longer will be considered before the other plan. If the other plan does not have a birthday anniversary rule as described above, but instead has a rule based on the gender of the parent, and as a result the plans do not agree on the order of benefits, the rule in the other plan utilizing the gender rule will determine the order of benefits.

3. For dependent children whose parents are divorced or legally separated, the following rules apply:

   a. When the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a dependent of the parent without custody.

   b. When the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be considered before the benefits of a plan which covers that child as a dependent of his or her step-parent; and the benefits of a plan which covers that child as a dependent of the parent without custody will be considered last.

   c. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, (a) and (b) above will not apply; instead, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a dependent child.

4. In the case the above rules still produce a conflict, the plan which has covered the Family Member the longest will be considered first.

In determining total expenses, each item of expense will be considered by Us under this COB provision if it is payable in whole or in part by at least one of the sources whose benefits are being coordinated.

Benefits will be coordinated on a **[**Calendar Year**]** basis. This is called the "Claim Determination Period".

In order to make this COB provision work:

1. The Family Member, if requested, is required to furnish Us complete information concerning all sources and all benefits paid or payable from those sources.

2 As permitted by law, We may, without the Family Member's consent:

   a. Obtain information from all plans which might be involved.

   b. Release to such other plans any information it has.

   c. Reimburse such other plans, to the extent necessary, if We determine that benefits have been paid by another plan which should have been paid by Us. Such reimbursement will count as a valid payment under this plan.

d. Obtain reimbursement from any such other plan(s), and/or from the Family Member, if We have paid benefits which should have been paid by any such other plan(s). Such reimbursement is a valid payment under the other plan(s).

e. Obtain repayment of whatever amount is appropriate for the proper working of this provision, if payment from all sources exceeds 100% of total expenses, and if We determine that the 100% of Allowable Expenses was exceeded as a result of Our payment.

THIRD PARTY REIMBURSEMENT

This provision applies when a third party or its insurer is liable as a result of the negligence or intentional act of the third party for a loss for which medical or dental benefits are payable under this policy to or on behalf of a Family Member. If a third party or its insurer is liable for past, present or future medical or dental charges, the following rules will apply.

A. If the third party makes payment before Us, benefits provided under this policy will be reduced to the extent of the third party's payment.

B. If the third party does not make payment before Us:

1. We will pay any benefits due under this policy;

2. When payment is later made by the third party, We are entitled to be repaid first; the Family Member or legal representative is obligated to return to Us the payment less reasonable prorated expenses, such as lawyer's fees and court costs, incurred by the Family Member in seeking the third party payment.

3. The Family Member's obligation to repay Us will be binding upon the Family Member or legal representative regardless of whether:

   a. The payment, received from the third party or its insurer, is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement;

   b. The third party or its insurer admits liability;

   c. The medical or dental expenses are itemized in the third party payment; or

   d. The Family Member has been paid by the third party for all loss sustained or alleged.

SUBROGATION

This provision applies when a third party or its insurer is liable as a result of the negligence or intentional act of the third party for a loss for which medical or dental benefits are payable under this policy to or on behalf of a Family Member. If a third party or its insurer is liable for past, present or future medical or dental charges, the following rules will apply.

Before payment is made by the third party, We have the right of subrogation to attempt to recover the amount of Our payment, including the right to file or intervene in a lawsuit. We will give the Family Member or representative prior written notice of Our intent to file suit. The Family Member must cooperate in full with Our effort to seek recovery from the third party. The Family Member must do nothing to hinder Our attempt to recover from the third party or to resolve the claim with the third party unless We give prior written consent. Our recovery from the third party will be limited to the lesser of:

1. The amount We paid in benefits under this policy as a result of the medical or dental charges; or

2. The amount recovered from the third party.

Our recovery will apply whether or not payment has been made by the third party for all of the Family Member's losses.

STANDARD PROVISIONS

Entire contract; Changes. The policy, Your signed application and any attached riders, endorsements, or amendments form the entire contract. We can change benefits and/or policy terms, as of the Renewal Date specified by Us, provided:

1. We give You 30-days written notice in advance; and

2. The changes are made on a uniform basis for all policies issued in this state under this policy form.

No change in this policy is allowed until approved by one of Our Executive Officers. Any change must be written and attached to this policy for the change to be effective. No agent may authorize a change in this policy or waive any of its provisions.

Payment of Premiums. A premium must be paid on or before its Due Date. You must pay Your premiums to Our Home Office. If You do not pay a premium when due, the policy will end.

Returned Check Fee. If any premium payment made directly by check or by EFT (electronic funds transfer), is returned for non-sufficient funds, a nonrefundable service fee will be applied. This fee will be due with Your next premium payment.

Grace Period. A grace period of 31 days, measured from the premium Due Date, will be allowed for payment of all premium due, other than the initial premium. The policy will remain in force during the grace period, unless You give Us written notice that the policy is to be terminated earlier. If We pay any claims incurred during the grace period and premium has not been paid, We will deduct the premium for the grace period from the claims. However, if We deduct the premium from any claims incurred during the grace period, it will not keep Your policy in force past the end of the grace period.

Reinstatement. If the renewal premium and any applicable returned check fee(s) are not paid before the Grace Period ends, the policy will end in accordance with the Grace Period provision. Once per year, We will accept premium postmarked within **[**29 days**]** after the Grace Period ends. This acceptance of the premium will reinstate the policy.

The reinstated policy will cover only loss that results from an Injury that occurs after the reinstatement date or a Sickness that occurs more than 10 days after that date. In all other respects, Your rights and Ours will remain the same, subject to any provisions noted or attached to the reinstated policy.

Time Limit on Certain Defenses.

1. After 3 years from the Effective Date of this policy no statements, except fraudulent statements, made by a Family Member in the application can be used to void this policy or deny a claim which starts after the end of the 3 years.

2. No claim, for a Sickness or Injury commencing after 3 years from the Effective Date, will be reduced or denied on the ground that the Sickness or Injury not excluded from coverage by name or specific description had existed prior to the Effective Date of this policy.

Notice of Claim. Written notice of claim must be given within 20 days after the occurrence of any loss covered by this policy or as soon as reasonably possible. The notice must be given to Our Home Office. Your name and policy number should be in the notice.

Proof of Loss. You must send written proof of loss to Us within 90 days of the date the loss occurred. We will not deny Your claim for being late if You give Us the proof of loss as soon as it is possible to do so. No proof of loss will be accepted later than 1 year after the time the proof is otherwise required, unless You were not legally capable.

Time Payment of Claims. We will pay any benefits due:

1. Immediately upon receipt of proof of loss; or
2. In accordance with the Payment of Clean Claims provision below, whichever is more favorable to the Family Member.

Payment of Clean Claims. We will pay or deny each Clean Claim as follows:

1. If the claim is filed electronically, within 30 days after the claim is received by Us.
2. If the claim is filed on paper, within 45 days after the date the claim is received by Us.

If the claim is not a Clean Claim, We will suspend the claim and notify the provider within 30 days after receipt of the claim of any deficiencies in the submitted claim and describe any information necessary to establish the claim as a Clean Claim.

If We fail to pay or deny a Clean Claim, or We fail to notify the provider of any deficiencies as set forth above, and We subsequently pay the claim, We will pay to the provider that submitted the claim, interest on the Covered Charges. Interest will accrue beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period).

We will reopen and pay or deny a previously suspended claim within 30 days after We receive all the information We requested. If We fail to pay or deny the claim, and We subsequently pay the claim, We will pay to the provider that submitted the claim, interest on the Covered Charges. If We are not already required to pay interest as described above, interest will accrue beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period).

The interest will be calculated as follows:

The amount of the claim payment, times 12% per annum, times the number of days in the delinquent payment period, divided by 365.

Assignment. You authorize us to make payments directly to Network Providers who have provided Covered Charges to You or a Family Member. Regardless of whether You make an assignment, We reserve the right to make payment directly to You for Covered Charges provided by Non-Network Providers. When We pay You, You must pay the Non-Network Provider and We are not legally obligated to pay any additional amounts. You cannot assign Your right to receive payment to anyone else.

Payment of Claims for other than Loss of Life. After receiving proof of loss, We will pay any benefits due under the policy in accordance with the above Assignment provision. Any accrued benefits not paid at Your death will be paid at Our option to Your designated beneficiary or to Your estate. If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to **[**$1,000**]** to someone related to You by blood or marriage whom We consider to be entitled to the benefits. Such payment made in good faith legally discharges Us to the extent of the payment.

Payment of Claims for Loss of Life. Benefits for the loss of life of the Primary Insured will be payable in accordance with the beneficiary designation. If no such designation is in effect at the time of payment, such benefit will be paid to the Primary Insured's estate.

Benefits for the loss of life of a Family Member other than the Primary Insured will be paid to the Primary Insured. If the Primary Insured dies before the Family Member, benefits will be paid to the Family Member's estate.

Change of Beneficiary. You have the right to change the named beneficiary. The consent of the beneficiary will not be a requisite to any change of beneficiary or beneficiaries.

Physical Examination and Autopsy. We have the right to have You examined at Our cost as often as reasonably required while a claim is pending. We may require an autopsy, unless prohibited by law.

Premium Adjustments. If the Family Member's age has been misstated, his or her rate will be adjusted to the rate for his or her correct age.

Legal Actions. No legal action may be brought to recover on this policy:

1. Within 60 days after written proof of loss has been given as required, or
2. After 3 years from the time written proof of loss is required to be given.

Notices. Every notice or other document required or permitted under this policy or certificate shall be deemed to be sufficiently delivered, given, served, sent, provided and received for all purposes at such time as it is deposited in the United States mail or given to a reputable mail courier with postage properly affixed.

Conformity with Law. Any provision of this policy which, on its Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of those laws.

Signed for American Community Mutual Insurance Company at Livonia, Michigan.

[President & CEO**]**

NOTICE TO INSURED
OF ANNUAL MEETING AND ELECTION

We are a mutual insurance company. We have no stockholders. An annual meeting and election of Directors is held each year at **[**9:00 A.M. on the last Thursday in April at our home office in Livonia, Michigan.**]**

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER
GENERIC DRUGS ONLY

This Rider is a part of the policy to which it is attached. It is subject to all terms and conditions of the policy not inconsistent with it. We issue this Rider to You in return for Your application and premium payment.

The following benefit is added to Your policy:

RIDER SCHEDULE

	Prescription Drug Card*	**Mail Order**
Generic Drugs	**[**20%**]** Copayment per Prescription or refill (minimum **[**$15**]**)	**[**20%**]** Copayment per Prescription or refill (minimum **[**$45**]**)
Maximum Drug Supply	**[**30**]** days	**[**90**]** days

*****Prescription Drug Card Benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased from a Non-Participating Pharmacy.

THE PRESCRIPTION DRUG COPAYMENTS DO NOT APPLY TO THE **[**CALENDAR YEAR**]** DEDUCTIBLE, BENEFIT PERCENTAGE MAXIMUM OR OUT OF POCKET MAXIMUM PER FAMILY MEMBER.

DEFINITIONS

For purposes of this Rider only, the following terms are defined as follows:

Brand Name Drug means a Prescription Drug that is marketed under a proprietary, trademark-protected name.

[Formulary means a list of covered Prescription Drugs that reflect current medical standards of drug therapy and drugs covered under the policy.**]**

Generic Drug means a Prescription Drug that contains the same active ingredients in the same dosage form as the Brand Name Drug. The Generic Drug is therapeutically equivalent to the Brand Name Drug, but sold under its chemical or "Generic" name instead.

Maintenance Drug means a Generic Drug needed for more than 31 days to treat an ongoing and/or chronic medical condition.

Non-Participating Pharmacy means a pharmacy which has not entered into an agreement to provide Prescription Drugs under this rider to Family Members insured by Us.

Participating Pharmacy means a pharmacy which has entered into an agreement with the Prescription Drug Administrator to provide Prescription Drugs under this rider to Family Members insured by Us.

Plan Cost means the maximum reimbursement amount paid to Participating Pharmacies.

Prescription Drug means a drug or medicine, which can be obtained only by prescription and, except for insulin bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription".

Prescription Drug Administrator is the entity that is:

1. Named by Us;
2. Responsible for managing the Participating Pharmacies; and
3. Responsible for processing Prescription Drug claims.

BENEFITS

Benefits are subject to all policy provisions and will be paid in accordance with the Benefit Provisions section of the policy to which this rider is attached, subject to the Copayment and Maximum Drug Supply shown on the Rider Schedule.

Covered Charges are charges for Generic Drugs that are dispensed by a Participating Pharmacy or through the mail order pharmacy only**[** and listed on the Formulary**]**.

Prescription Drug Card Program. This program applies to Participating Pharmacies only. The Prescription Drug Card must be presented at the time the prescription is filled at the Participating Pharmacy. **No benefits are payable if a Participating Pharmacy is not used. If the Prescription Drug Card is not presented at the time the prescription is filled at the Participating Pharmacy, the maximum amount that will be reimbursed is the Plan Cost.**

Mail Order Drug Program: This program applies to Maintenance Drugs which must be obtained through the mail order pharmacy. However, an initial supply of Maintenance Drugs may be obtained from a Participating Pharmacy. The initial supply dispensed is subject to the Prescription Drug Card Copayment and Maximum Drug Supply shown on the Rider Schedule.

EXCLUSIONS

In addition to the Exclusions in the policy to which this rider is attached:

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 Deductible, Benefit Percentage Maximum, or Out of Pocket Maximum shown on the Schedule page of the policy to which this rider is attached.

1. Brand Name Drugs;
2. Prescription Drugs used to treat medical conditions that have been excluded from coverage by amendment or rider to this policy;
3. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy to which this rider is attached;
4. Non-federal legend drugs;
5. Contraceptive medications or devices that are not approved by the United States Food and Drug Administration for use as a contraceptive;

6. Contraceptive devices that are surgically implanted;
7. Fertility agents and medications;
8. Injectable or any prescription directing parenteral administration or use, except insulin;
9. Emergency contraception kits or any drugs that are intended to induce abortion;
10. Antidepressants;
11. Tranquilizers;
12. Miscellaneous psychotherapeutic agents;
13. Benzodiazepines;
14. Anti-manic agents;
15. Drugs to treat Attention Deficit Hyperactivity Disorder;
16. Substance abuse treatment agents;
17. Oral and topical acne medications;
18. Smoking deterrents;
19. All anti-obesity preparations;
20. Amphetamines;
21. Legend vitamins and fluoride products;
22. Drugs to treat influenza or lessen its symptoms;
23. Therapeutic devices or appliances;
24. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
25. Immunization agents and vaccines;
26. Biologicals, blood or blood plasma;
27. Off-label use of prescription drugs except when insurance coverage is required by law;
28. Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual;
29. 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;
30. 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;
31. 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;
32. 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;
33. Charges for the administration or injection of any drug;
34. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
35. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
36. 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;
37. Drugs for Treatment of onychomycosis (nail fungus);
38. Drugs for Treatment of impotency;

[39.**] [**Drugs to treat rosacea**]**;

[40.**] [**Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose**]**;

[41.**] [**Allergy medications**]**;

[42.**] [**Drugs to treat a cough or cold or lessen its symptoms;**]**

[43.**] [**Drugs to treat a migraine or headache;**]**

[44.**] [**Drugs not listed on the Formulary; and**]**

[45.**] [**Proton Pump Inhibitors**]**.

END OF COVERAGE. A Family Member's insurance under this rider ends at the earliest of the following dates:

1. The date the policy to which this rider is attached ends;
2. The end of the period for which premium has been paid; or
3. The Renewal Date following the date We receive written notice from You requesting cancellation.

Signed for at American Community Mutual Insurance Company at Livonia, Michigan

[President & CEO]

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER

This Rider is a part of the policy to which it is attached. It is subject to all terms and conditions of the policy not inconsistent with it. We issue this Rider to You in return for Your application and premium payment. The following benefit is added to Your policy:

RIDER SCHEDULE

Prescription Drug Deductible per Person. . . . . **[**$250**]** per **[**Calendar Year**]**
Prescription Drug Deductible per Family . . . . . **[**$500**]** per **[**Calendar Year**]**

Out of Pocket Maximum for Specialty Drugs per Person. . . . . **[**$2,500**]** per **[**Calendar Year**]**
Out of Pocket Maximum for Specialty Drugs per Family. . . . . **[**$5,000**]** per **[**Calendar Year**]**

	Prescription Drug Card*	**Mail Order**
Generic Drugs and Diabetic Supplies	**[**20%**]** Copayment per Prescription or refill (minimum **[**$15**]**)	**[**20%**]** Copayment per Prescription or refill (minimum **[**$45**]**)
Select Brand Name Drugs and Diabetic Supplies	Subject to Prescription Drug Deductible, then **[**30%**]** Copayment per Prescription or refill (minimum **[**$30**]**)	Subject to Prescription Drug Deductible, then **[**30%**]** Copayment per Prescription or refill (minimum **[**$90**]**)
Additional Brand Name Drugs and Diabetic Supplies	Subject to Prescription Drug Deductible, then **[**50%**]** Copayment per Prescription or refill (minimum **[**$60**]**)	Subject to Prescription Drug Deductible, then **[**50%**]** Copayment per Prescription or refill (minimum **[**$180**]**)
Maximum Drug Supply	**[**30**]** days	**[**90**]** days

Specialty Drugs*	Subject to Prescription Drug Deductible, then **[**25%**]** Copayment per Prescription or refill (maximum **[**$250**]**) up to the Out of Pocket Maximum shown above, then 100%
Maximum Specialty Drug Supply	**[**30**]** days

***** Prescription Drug Card Benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased from a Non-Participating Pharmacy. Specialty Drug Benefits only apply at a Participating Specialty Pharmacy. Not benefits are payable if a Specialty Drug is purchased at any other pharmacy.

THE PRESCRIPTION DRUG DEDUCTIBLE AND COPAYMENTS DO NOT APPLY TO THE **[**CALENDAR YEAR**]** DEDUCTIBLE, BENEFIT PERCENTAGE MAXIMUM OR OUT OF POCKET MAXIMUM PER FAMILY MEMBER.

American Community Mutual Insurance Company
39201 Seven Mile Road, Livonia, Michigan 48152

DEFINITIONS

For purposes of this Rider only, the following terms are defined as follows:

Additional Brand Name Drug means a Prescription Drug that is not a Generic Drug and is not included on the Select Brand Name Drug list.

Brand Name Drug means a Prescription Drug that is marketed under a proprietary, trademark-protected name, which includes Additional Brand Name Drugs and Select Brand Name Drugs.

Diabetic Supplies means:

1. Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
2. Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
3. Insulin;
4. Injection aids;
5. Syringes, including pen-like insulin injection devices and pen needles;
6. Oral agents for controlling the blood sugar level, which are Prescription Drugs; and
7. Glucagon emergency kits and injectable glucagon.

[Formulary means a list of covered Prescription Drugs that reflect current medical standards of drug therapy and drugs covered under the policy.**]**

Generic Drug means a Prescription Drug that contains the same active ingredients in the same dosage form as the Additional Brand Name Drug or the Select Brand Name Drug. The Generic Drug is therapeutically equivalent to the Additional Brand Name Drug or Select Brand Name Drug, but sold under its chemical or "Generic" name instead.

Maintenance Drug means a Prescription Drug needed for more than 31 days to treat an ongoing and/or chronic medical condition.

Non-Participating Pharmacy means a pharmacy which has not entered into an agreement to provide Prescription Drugs under this rider to Family Members insured by Us.

Participating Pharmacy means a pharmacy which has entered into an agreement with the Prescription Drug Administrator to provide Prescription Drugs under this rider to Family Members insured by Us.

Participating Specialty Pharmacy means a pharmacy which has entered into an agreement with the Prescription Drug Administrator to provide Specialty Drugs under this rider to Family Members insured by Us.

Plan Cost means the maximum reimbursement amount paid to Participating Pharmacies.

Prescription Drug means a drug or medicine, which can be obtained only by prescription and, except for insulin bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription".

Prescription Drug Administrator is the entity that is:

1. Named by Us;
2. Responsible for managing the Participating Pharmacies; and
3. Responsible for processing Prescription Drug claims.

Select Brand Name Drug means a list of commonly prescribed Prescription Drugs designated by the Prescription Drug Administrator that are selected based on their clinical and cost effectiveness.

Specialty Drug means a covered Prescription Drug identified on a specialty drug list that requires special handling, administration, or monitoring. These drugs treat complex, chronic and costly conditions.

BENEFITS

Benefits are subject to all policy provisions and will be paid in accordance with the Benefit Provisions section of the policy to which this rider is attached, subject to the Copayment, Maximum Drug Supply, and Prescription Drug Deductible shown on the Rider Schedule.

If an Additional Brand Name Drug or Select Brand Name Drug is chosen when a Generic Drug is available, then You are responsible for the Generic Drug Copayment plus the difference between the cost of the Additional Brand Name Drug or Select Brand Name Drug and the cost of the Generic Drug and any Deductible.

The Pharmacist may ask Your permission to contact the Physician for approval to select quality medications from the Select Brand Name Drug List. You and Your Physician must agree that a medication from the Select Brand Name Drug List is an appropriate alternative to the original prescription.

Prescription Drug Card Program. This program applies to Participating Pharmacies only, and includes coverage of Prescription Drugs, except Specialty Drugs, and Diabetics Supplies**[**, listed on the Formulary**]**. The Prescription Drug Card must be presented at the time the prescription is filled at the Participating Pharmacy. **No benefits are payable if a Participating Pharmacy is not used. If the Prescription Drug Card is not presented at the time the prescription is filled at the Participating Pharmacy, the maximum amount that will be reimbursed is the Plan Cost.**

Mail Order Drug Program: This program applies to the mail order pharmacy only, and includes coverage of Maintenance Drugs, except Specialty Drugs, and Diabetic Supplies **[**listed on the Formulary**]**. Maintenance Drugs must be obtained through the mail order pharmacy. However, an initial supply of Maintenance Drugs may be obtained from a Participating Pharmacy. The initial supply dispensed is subject to the Prescription Drug Card Copayment, Maximum Drug Supply, and Prescription Drug Deductible shown on the Rider Schedule.

Specialty Drug Program: This program applies to Participating Specialty Pharmacies only, and includes coverage of Specialty Drugs, which must be obtained from a Participating Specialty Drug Pharmacy. The Prescription Drug administrator must be contacted prior to filing a prescription for a Specialty Drug. The Prescription Drug Administrator will work with You to have your prescription filled by a Participating Specialty Pharmacy.

No benefits are payable if a Participating Specialty Pharmacy is not used.

EXCLUSIONS

In addition to the Exclusions in the policy to which this rider is attached:

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 Deductible, Benefit Percentage Maximum, or Out of Pocket Maximum shown on the Schedule of the policy to which this rider is attached.

1. Prescription Drugs used to treat medical conditions that have been excluded from coverage by amendment or rider to this policy;
2. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy to which this rider is attached;
3. Non-federal legend drugs;
4. Contraceptive medications or devices that are not approved by the United States Food and Drug Administration for use as a contraceptive;
5. Contraceptive devices that are surgically implanted;
6. Fertility agents and medications;
7. Emergency contraception kits or any drugs that are intended to induce abortion;
8. Antidepressants;
9. Tranquilizers;
10. Miscellaneous psychotherapeutic agents;
11. Benzodiazepines;
12. Anti-manic agents;
13. Drugs to treat Attention Deficit Hyperactivity Disorder;
14. Substance abuse treatment agents;
15. Oral and topical acne medications;
16. Smoking deterrents;
17. All anti-obesity preparations;
18. Amphetamines;
19. Legend vitamins and fluoride products;
20. Drugs to treat influenza or lessen its symptoms;
21. Therapeutic devices or appliances;
22. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
23. Immunization agents and vaccines;
24. Biologicals, blood or blood plasma;
25. Off-label use of prescription drugs except when insurance coverage is required by law;
26. Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs, even though a charge is made to the individual;
27. 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;
28. 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;
29. 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;
30. 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;
31. Charges for the administration or injection of any drug;

32. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
33. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
34. 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;
35. Drugs for Treatment of onychomycosis (nail fungus);
36. Drugs for Treatment of impotency;

[37.**] [**Drugs to treat rosacea**]**;
[38.**] [**Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose**]**;
[39.**] [**Allergy medications**]**;
[40.**] [**Drugs to treat a cough or cold or lessen its symptoms;**]**
[41.**] [**Drugs to treat a migraine or headache;**]**
[42.**] [**Drugs not listed on the Formulary; and**]**
[43.**] [**Proton Pump Inhibitors**]**.

END OF COVERAGE. A Family Member's insurance under this rider ends at the earliest of the following dates:

1. The date the policy to which this rider is attached ends;
2. The end of the period for which premium has been paid; or
3. The Renewal Date following the date We receive written notice from You requesting cancellation.

Signed for at American Community Mutual Insurance Company at Livonia, Michigan

[President & CEO**]**

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY

39201 Seven Mile Road, Livonia, Michigan 48152-1094

DENTAL BENEFIT RIDER

This Rider is a part of the policy to which it is attached. It is subject to all the terms and conditions of the policy not inconsistent with it.

We issue this Rider to you in return for your application and premium payment.

RIDER SCHEDULE

[Benefit Period/Calendar Year] Maximum Benefit ..... [$1,000]

Type I Procedure Benefits
- Waiting Period ..... [6 months]
- Deductible Amount ..... [$ 0]
- Percentage of Expenses Covered ..... [80%]

Type II Procedure Benefits
- Waiting Period ..... [12 months]
- Deductible Amount ..... [$ 100]
- Percentage of Expenses Covered ..... [50%]

Orthodontics ..... Not Included

Rider Effective Date ..... [Month xx, yyyy]

[Benefit Period/Calendar Year] Maximum Benefit means the total amount of Benefit, for Type I and Type II procedures combined, which we will pay per Family Member in a [Benefit Period/Calendar Year].

Waiting Period is the length of time a Family Member must be covered under this Rider before the Family Member is eligible to receive a benefit for the type of procedure. The Waiting Period for a Family Member starts when this Rider is effective for the Family Member. The number of months in the Waiting Periods for Type I and Type II Procedures are shown on the Rider Schedule.

BENEFIT PROVISIONS

Benefit. We will pay a Dental Benefit if a Family Member incurs Covered Dental Charges. The Covered Dental Charges must be incurred after the Rider Effective Date and after the Waiting Period for the type of procedure performed.

Dental Benefit. The Dental Benefit is Percentage of Expenses Covered for the procedure performed which exceeds the Deductible Amount.

Any dental claim which is payable as a Covered Charge in the policy will be paid under the Policy Benefit Provisions first; then the dental claim will be calculated under this Rider. The amount paid will be that amount, if any, which exceeds the amount paid under the other benefits.

Covered Dental Charges. Covered Dental Charges are the Reasonable and Customary charges for the procedures shown in Covered Dental Procedures. These procedures must be performed by a licensed physician, dentist, or dental hygienist.

There are two types of procedures.

Type I procedures include:	Visits and examinations; prophylaxis; x-rays; space maintainers; and topical fluoride for children only.
Type II procedures include:	Filings; oral surgery; extractions; root canals; endodontics; periodontics; inlays and crowns; bridges; and dentures.

When Expenses Are Incurred. We consider Covered Dental Charges incurred on the day the procedure is performed, if a procedure is not completed in one day, we consider the day the procedure is completed as the incurred date for any charges in connection with such procedure. For an appliance or modification of an appliance, we consider the procedure performed when the impression is made. For a crown, bridge, or gold restoration we consider the procedure performed when the tooth or teeth are prepared. For root canal therapy we consider the procedure performed when the pulp chamber is opened.

Pre-estimate of Dental Benefits. If a proposed course of treatment will result in charges of more than $100, the dentist should complete a Treatment Plan and submit it to us prior to the performance of the procedure. We will supply the Treatment Plan form. On the form the dentist will itemize the dental services he or she recommends and show the estimated charge for each service. The Treatment Plan must be accompanied by supporting pre-treatment x-rays. We will review the Treatment Plan and return it to the dentist indicating the estimated benefits.

A Treatment Plan is not required for emergency care.

COVERED DENTAL PROCEDURES

TYPE I PROCEDURES

VISITS, EXAMINATIONS, AND CLEANING

Procedure No.	Description of Service
9430	Office visit during regular office hours includes treatment and observation of injuries to teeth and supporting structure other than for routine operative procedures.
9440	Professional visit after hours. Payment will be made on basis of services rendered or visit, whichever is greater.
9310	Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist.
1120	Prophylaxis for children under age 14 limited to one treatment every six months.
1110	Prophylaxis for individuals age 14 or over; treatments to include scaling and polishing limited to one treatment every six months.
1221	Topical application of stannous fluoride, including prophylaxis, per treatment limited to one treatment per year for children under age 18.
9110	Emergency palliative treatment, per visit.

X-RAY AND PATHOLOGY. Except for injuries; eligible charge includes examination and diagnosis.

Procedure No.	Description of Service
0220	Single film.
0230	Additional films up to 12 each.
0210	Entire denture series consisting of at least 14 films, including bitewings if necessary limited to once every three years.
0240	Intra-oral, occlusal view, maxillary or mandibular, each.
0250	Superior or inferior maxillary, extra-oral, one film.
0251	Superior or inferior maxillary, extra-oral, two films.
0272	Bitewing films, two including examination, once every six months.
0274	Bitewing films, four including examination, once every six months.
0330	Panoramic survey, maxillary and mandibular, single film, considered an entire denture series.
0440	Biopsy and examination of oral tissue (soft).
0490	Microscopic examination.

SPACE MAINTAINERS. Includes all adjustments within six months after installation.

Procedure No.	Description of Service
1510	Fixed, unilateral, band type.
1511	Fixed, lingual or palatal arch, band type.
1530	Removable acrylic with round wire rest only.
8210	Removable inhibiting appliance to correct thumb sucking.
8220	Fixed or cemented inhibiting appliance to correct thumb sucking.

TYPE II PROCEDURES

RESTORATIVE DENTISTRY. Multiple restorations in one surface will be considered as a single restoration.

Procedure No.	Description of Service
Amalgam Restorations - Primary Teeth	
2110	Cavities involving one surface.
2120	Cavities involving two surfaces.
2130	Cavities involving three or more surfaces.
Amalgam Restorations - Permanent Teeth	
2140	Cavities involving one surface.
2150	Cavities involving two surfaces.
2160	Cavities involving three or more surfaces.
2170	Pins, in addition to restoration.
Synthetic Restorations	
2210	Silicate cement filing.
2310	Acrylic or plastic filing.
2330	Composite resin filing.

ORAL SURGERY. Includes local anesthesia and routine postoperative care.

Procedure No.	Description of Service
Extractions	
7110	Uncomplicated (single)
7120	Each additional tooth.
7210	Surgical removal of erupted tooth.
7252	Postoperative visit (sutures and complications) after multiple extractions and impaction.
Impacted Teeth	
7220	Removal of tooth (soft tissue)
7230	Removal of tooth (partially bony)
7240	Removal of tooth (completely bony)
Alveolar or Gingival Reconstructions	
7320	Alveolectomy (edentulous) per quadrant.
7310	Alveolectomy (in addition to removal of teeth) per quadrant.
7340	Stoma plasty with ridge extension, per arch.
7470	Removal of exostosis, maxilla or mandible.
7471	Removal of mandibular tori, per quadrant.
7970	Excision of hyperplastic tissue, per arch.
7971	Excision of pericoronal gingiva.
Cysts and Neoplasms	
7510	Incision and drainage of abscess.
7490	Radical resection of mandible with bone gait.
7430	Removal of cyst or tumor up to 1.25 centimeters.
7431	Removal of cyst or tumor over 1.25 centimeters.
Other Surgical Procedures.	
7980	Sialolithotomy; removal of salivary calculus.
7983	Closure of salivary fistula.
7984	Dilation of salivary duct.
7270	Tooth replantation.
7540	Removal of foreign body from bone (independent procedure).
7260	Closure of oral fistula of maxillary sinus.
7261	Maxillary sinusotomy for removal of tooth fragment or foreign body.
7550	Sequestrectomy for osteomyelitis.
7840	Condylectomy of temporomandibular joint.
7850	Meniscectomy of temporomandibular joint.
7960	Frenulectomy.
7530	Removal of foreign body from soft tissue.
7910	Suture of soft tissue injury.
7280	Crown exposure for orthodontia.

ANESTHESIA.

9220	General, in conjunction with surgical procedures only.

STUDY MODELS.

0470	Diagnostic casts.

RECEMENTATION.

2910 Inlay.
2920 Crown.
6930 Bridge.

PERIODONTICS.

4210 Gingivectomy, including post-surgical visits, per quadrant.
4212 Gingivectomy, treatment per tooth, fewer than six teeth.
4220 Gingival curettage, root planning, per quadrant, not prophylaxis.
4260 Osseous surgery, including post-surgical visits.
4270 Muco gingival surgery, pedicle soft tissue graft.
4330 Correction of occlusion related to periodontal problems, per quadrant.

ENDODONTICS.

3110 Pulp capping.
3220 Vital pulpotomy, in addition to restoration.
3130 Remineralization. Calcium Hydroxide, temporary restoration, as a separate procedure only.

Root Canals including necessary x-rays and cultures but excluding final restoration.
3310 Single rooted canal therapy.
3320 Bi-rooted canal therapy.
3330 Tri-rooted canal therapy.
3410 Apicoectomy, separate procedure.
3420 Apicoectomy, performed in conjunction with root canal therapy.

RESTORATIVE. Gold restorations and crowns are covered only when necessary as a result of decay or accidental injury.

Inlays
2510 One surface.
2520 Two surfaces.
2530 Three or more surfaces.
2540 Only, in addition to inlay allowance.

Crowns
2710 Acrylic.
2720 Acrylic with metal.
2740 Porcelain.
2750 Porcelain with metal.
2790 Gold, full cast.
2810 Gold, 3/4 cast.
2830 Stainless steal, when tooth cannot be restored with a filing material.
2890 Gold dowel pin.

PROSTHODONTICS. Bridge Abutments, See inlays and Crowns

Pontics
6210 Cast Gold, sanitary.
6220 Slotted facing.
6230 Slotted Pontic.
6240 Porcelain fused to gold.
6250 Plastic processed to gold.

REMOVABLE BRIDGE. Unilateral

5280 One Piece casting chrome cobalt alloy clasp attachment, all types, per unit.

Repairs: Crowns and Bridges
6970 Repairs, Eligible charge based upon extent and type of damage and nature of materials involved.

DENTURES AND PARTIALS. Eligible charge for dentures, partial dentures and relining includes adjustments within six months after installation. Specialized techniques and characterizations are not eligible.

5110 Complete maxillary denture.
5120 Complete mandibular denture.
5220 Partial acrylic upper or lower with chrome cobalt alloy clasps acrylic base.
5230 Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles.
5610 Broken dentures, no teeth involved.
5620 Replacing missing or broken teeth, each tooth.
5820 Stayplate to replace anterior teeth only.
6940 Simple stress breakers, extra per unit.
5410 Adjustment to denture more than six months after installation.
5740 Office reline, cold cure, acrylic.
5760 Laboratory reline, processed.
5850 Special tissue conditioning. Limit, two treatments per arch, per treatment.
5720 Denture duplication, jump case, per denture.
5611 Partial denture repairs, metal. Eligible charge based upon extent and type of damage and nature of materials involved.

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth.
5650 First tooth.
5660 First tooth with clasp.
5661 Each additional tooth and clasp.

EXCLUSIONS

We will not pay benefits for charges due to any of the following. These charges may not be used to satisfy a Family Member's Deductible Amount for this Rider or the Policy.

1. Type I procedures incurred during the first 6 months that you or a Family Member are covered under this Rider.
2. Type II procedures incurred during the first 12 months that you or a Family Member are covered under this Rider.
3. Orthodontic treatment.
4. Any treatment which is for cosmetic purposes or for the correction of congenital or developmental malformations. Facings on crowns or pontics, posterior to the second bicuspid, shall always be considered cosmetic.
5. The replacement of any prosthetic appliance, crown, or bridge within 5 years after the date of its last placement, unless the replacement is required as a result of accidental bodily injuries sustained by a Family Member while covered under this Rider.
6. The replacement of 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 a Family Member's insurance under this Rider ends.
9. Any other charges excluded from coverage by terms of the policy to which this Rider is attached.

End of Coverage. A Family Member's insurance under this Rider ends at the same time as coverage under the policy to which this Rider is attached ends.

Signed for American Community Mutual Insurance Company at Livonia, Michigan

[President]

Arkansas
Application for Individual Health Insurance Policies

Please complete application in blue or black ink.

Agent #: ___ ___ ___ ___ ___

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®
39201 Seven Mile Road Livonia, Michigan 48152-1094
(800) 991-2642 (734) 591-9000
www.american-community.com

Thank you for applying to American Community Mutual Insurance Company (*herein referred to as American Community or AC*). Please take the time to carefully complete this application. Your answers will become part of the underwriting process and the insurance contract.

A. TYPE OF APPLICATION

☐ New Application ☐ Change to a new policy with AC. Current Policy #_____

☐ Add Dependents to Policy # _____ Key Insured _____

(Please indicate information only on the dependents to be added to the policy.)

[• Was an American Community Short Term application submitted with this application? ☐ Yes ☐ No]

B. PERSONS APPLYING FOR INSURANCE

1. **List all Family Members applying for insurance.** Children must be at least 15 days old and under [22] years old. Include maiden names of females in parentheses. [To qualify as a full time (FT) student (for children between the ages of 18 and 22), a child must be enrolled in a minimum of 12 credit hours at a college, university, or trade school.]
   ☐ Check here if there are more than 3 dependent children. Attach a separate page listing the additional children.

Full Name First-Middle-Last (Include Maiden Name if used within past 5 yrs.)	Relationship to Applicant	Sex M/F	Date of Birth	Height FT. IN.	Weight LBS.	Social Security Number	✓ if FT Student
	Key Applicant						
	Spouse						
	Child						
	Child						
	Child						

2. Home Address

Street		
City	State	Zip
County		

3. Billing Address if other than Home Address

Name		
Street		
City	State	Zip

4. If any proposed applicant does not live at the above address, please explain: _____

5. Contact Numbers

Daytime Ph. #
Evening Ph. #
Spouse's Ph. #
E-mail Address

6. Occupation(s) If self-employed, please identify or describe your occupation.

Key Applicant Occupation:
Spouse Occupation:

You may be contacted for a telephone interview.
Please indicate the best time (between 8:00 a.m. and 5:00 p.m. Eastern Standard Time) for an interview: _____

C. EXISTING COVERAGE AND REPLACEMENT

Are any Applicants covered by other health insurance now? ☐ Yes - Complete section below ☐ No

Will this coverage be replaced by this policy if issued? ☐ Yes ☐ No - **Desired effective date:**_____

If health insurance is being replaced, replacement form [RAS-AR (2009)] must be signed and submitted with this application.

Applicant(s) Name(s)	Insurance Company Name	Group or Individual	Certificate or Policy Number	Effective Date	Termination Date

D. BENEFITS REQUESTED

Please complete, sign and attach the [Arkansas Product Selection Form] identifying the Health Plan selected.

E. PREMIUM PAYMENT INFORMATION

Estimated monthly premium quoted by agent $ _____

INITIAL PREMIUM PAYMENT OPTIONS: (make checks payable to American Community Mutual Insurance Company)

☐ Credit Card ☐ Check $ _____ ☐ EFT (Only if EFT is chosen as the billing option)

INITIAL PREMIUM SHORTAGE OPTIONS:

☐ Credit Card ☐ Bill Me ☐ EFT (Only if EFT is chosen as the billing option)

Please complete Credit Card and/or EFT information if you have selected them as a Premium Payment Option.

CREDIT CARD
(for initial payment only)

☐ **MasterCard**

☐ **Visa**

Card Holder Name: _____

Card Number: _____ Expiration Date: _____

Signature: X _____ Date signed: _____

Signature: X _____ Date signed: _____

BILLING FREQUENCY:

☐ Monthly ☐ Quarterly* ☐ Semi-Annually* ☐ Annually*

BILLING OPTIONS:

☐ Bill Me** ☐ EFT (Electronic Fund Transfer)

☐ New List Bill** (List Bill Agreement Required) ☐ List Bill #_____

Employer name for List Bill _____

*Not available if EFT or List Bill is chosen as billing option.

**Administrative Charge: Once approved, an additional Billing Fee of $10 will be applied to each premium statement (fee is waived for EFT). List Bills include a $10 Monthly Billing Fee.

ELECTRONIC FUNDS TRANSFER (EFT)

☐ Checking

☐ Savings

(If allowed by bank)

Name of Financial Institution: _____

Address: _____ City: _____ State: _____Zip Code:_____

Account Holder's Name: _____

Transit Routing Number: _____Account Number: _____

Authorization Agreement For Electronic Funds Transfer for Premium Payment

I authorize American Community Mutual Insurance Company (Company) to initiate monthly electronic withdrawals, in the amount of the then-current monthly premium rate, from the account and financial institution (Bank) named above. This authority remains in effect until Company and Bank receive written notification from me of its termination in such time and manner as to give Company and Bank a reasonable opportunity to act on it. Company reserves the right to void this agreement at any time without prior notice.

Signature: X _____ Date Signed: _____

Signature: X _____ Date Signed: _____

Returned Check Fee: If any premium payment made directly by check or by Electronic Funds Transfer (EFT) is returned for non-sufficient funds, a nonrefundable service fee will be charged.

F. QUESTIONS APPLY TO EACH PERSON APPLYING FOR COVERAGE (APPLICANTS)

Please answer all questions.

	Yes	No
1. Are you, your spouse, significant other, or any dependent or adopted child now pregnant or is there an adoption pending? **If yes, Do Not Submit Application.**	☐	☐
2. Are you a U.S. Citizen?	☐	☐
3. Has any applicant lived outside the United States within the past 12 months or does any applicant plan to travel outside the United States in the next 12 months? If yes, who? _____ Where?_____ When? (give date range) _____	☐	☐
4. Has any applicant smoked cigarettes, cigars, pipes or used any form of tobacco, including chewing tobacco or nicotine products? If yes, who? _____ Form of tobacco used: _____ Number of years used:_____ How often did or do you use tobacco products? (ex. 10 cigarettes per day.) _____	☐	☐

	Yes	No
If quit, please provide date of last use:_____ Why did you quit?_____		
5. Does any applicant engage in scuba or sky diving, organized racing, flying or other hazardous activities? If yes, who? _____ What activity?_____	☐	☐
6. Did or does any applicant consume, on average, more than 2 alcoholic beverages *(one beverage equals one 12 oz. beer or one 4 oz. wine or 1 oz. of liquor)* per day in the past 5 years? If yes, please complete the Alcohol/Drug Questionnaire.	☐	☐
7. Has any applicant's driver's license been suspended or revoked in the last 5 years? If yes, please provide their name and driver's license number. Name:_____ Driver's license number: _____ If yes, and alcohol or drugs were related to suspension/revocation, please complete Alcohol/Drug Questionnaire.	☐	☐

(continued on next page)

(Section F continued)

Within the last 10 years, has any applicant had symptoms of; or a diagnosis of; or received treatment, including but not limited to medications for; or had testing for; or consulted with a physician or medical professional concerning ongoing monitoring or follow-up for any of the following:

Answer each question individually (please do not draw a continuous line through your answers) and document details of any "Yes" answers on page 4.

		Yes	No
8.	Abdominal Pain	☐	☐
9.	Abnormal test results	☐	☐
10.	Adrenal Gland Disorders	☐	☐
11.	Alcohol Abuse	☐	☐
12.	Allergies	☐	☐
13.	Alzheimer's	☐	☐
14.	Anemia	☐	☐
15.	Aneurysm	☐	☐
16.	Anxiety	☐	☐
17.	Arthritis/gout	☐	☐
18.	Artificial limb or prosthesis	☐	☐
19.	Asthma	☐	☐
20.	Autism	☐	☐
21.	Autoimmune Disorders	☐	☐
22.	Back or spine Disorder	☐	☐
23.	Bladder Disorders	☐	☐
24.	Blood Disorders	☐	☐
25.	Breast Disorder	☐	☐
26.	Bronchitis	☐	☐
27.	Cancer	☐	☐
28.	Carpal Tunnel Syndrome	☐	☐
29.	Cerebral Palsy	☐	☐
30.	Cesarean Section	☐	☐
31.	Chest Pain	☐	☐
32.	Chronic fatigue syndrome	☐	☐
33.	Chronic infections	☐	☐
34.	Chronic Obstructive Pulmonary Disease (COPD)	☐	☐
35.	Colitis	☐	☐
36.	Colon polyps	☐	☐
37.	Convulsions	☐	☐
38.	Crohn's Disease	☐	☐
39.	Cyst	☐	☐
40.	Depression	☐	☐
41.	Diabetes or High Blood Sugar	☐	☐
42.	Digestive Disorders	☐	☐
43.	Drug Abuse	☐	☐
44.	Ear Infections	☐	☐
45.	Eating Disorders	☐	☐
46.	Edema	☐	☐
47.	Elevated cholesterol (>250)	☐	☐
48.	Elevated Triglycerides (>300)	☐	☐
49.	Emphysema	☐	☐
50.	Epilepsy	☐	☐
51.	Eye Disorders	☐	☐
52.	Female Disorders	☐	☐
53.	Fibromyalgia	☐	☐
54.	Foot Disorder	☐	☐
55.	Gallbladder Disorder	☐	☐
56.	Gastric bypass	☐	☐
57.	Gastric reflux	☐	☐
58.	Headaches	☐	☐
59.	Hearing Impairment	☐	☐
60.	Heart attack	☐	☐
61.	Heart Disorders	☐	☐
62.	Heart murmur	☐	☐
63.	Hemophilia	☐	☐
64.	Hemorrhoids	☐	☐
65.	Hernia	☐	☐
66.	High Blood Pressure (provide last 3 pressures and dates)	☐	☐
67.	Hodgkin's Disease	☐	☐
68.	Infertility	☐	☐
69.	Intestinal Disorder	☐	☐
70.	Irregular heartbeat	☐	☐
71.	Irritable bowel syndrome	☐	☐
72.	Joint Disorders/ Replacement	☐	☐
73.	Kidney Disorders	☐	☐
74.	Knee Disorder/injury	☐	☐
75.	Leukemia	☐	☐
76.	Liver Disorder	☐	☐
77.	Lou Gehrig's Disease	☐	☐
78.	Lupus	☐	☐
79.	Lyme Disease	☐	☐
80.	Lymphadenopathy	☐	☐
81.	Lymphoma	☐	☐
82.	Male Genital Disorder	☐	☐
83.	Mental And Nervous Disorders	☐	☐
84.	Migraines	☐	☐
85.	Miscarriage	☐	☐
86.	Multiple sclerosis	☐	☐
87.	Muscular Disorders	☐	☐
88.	Muscular dystrophy	☐	☐
89.	Nervous System Disorders	☐	☐
90.	Numbness or tingling	☐	☐
91.	Osteoporosis or Osteopenia	☐	☐
92.	Pancreas Disorders	☐	☐
93.	Paralysis	☐	☐
94.	Phlebitis	☐	☐
95.	Pneumonia	☐	☐
96.	Polyp	☐	☐
97.	Pregnancy Complications	☐	☐
98.	Prostate Disorders	☐	☐
99.	Rectal bleeding	☐	☐
100.	Reproductive System Disorders	☐	☐
101.	Respiratory Disorders	☐	☐
102.	Seizures	☐	☐
103.	Shoulder Disorder/Injury	☐	☐
104.	Sinus infections	☐	☐
105.	Skin condition	☐	☐
106.	Sleep Disorders	☐	☐
107.	Speech Impairment	☐	☐
108.	Stroke	☐	☐
109.	Substance Abuse	☐	☐
110.	Thyroid Disorder	☐	☐
111.	TemporoMandibular Joint (TMJ)	☐	☐
112.	Tonsils	☐	☐
113.	Transient Ischemic Attack (TIA)	☐	☐
114.	Tremors	☐	☐
115.	Tumor	☐	☐
116.	Ulcer	☐	☐
117.	Varicose veins	☐	☐
118.	Vertigo or Dizziness	☐	☐

Has anyone applying for coverage (Document details of any "Yes" answers on page 4)

		Yes	No
119.	Been diagnosed or treated for any medical symptom or condition not listed above?	☐	☐
120.	Had any diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed?	☐	☐
121.	Had any symptoms or conditions for which a prudent person would seek medical advice or treatment?	☐	☐
122.	Taken, or currently take, any medication?	☐	☐
123.	Had Breast Implants or Internal Fixation (plates, screws, pins, shunts, stents, etc.)?	☐	☐
124.	Had a routine medical exam or routine PAP Smear or well child exam?	☐	☐
125.	Been tested positive for, been diagnosed as having, or been treated for:		
	a. Human Immunodeficiency Virus (HIV)?	☐	☐
	b. Hepatitis?	☐	☐
	c. Sexually transmitted disease?	☐	☐

[Note: Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of this policy, if approved, only if such sickness, injury, or condition is fully disclosed on this application and is not excluded from coverage by a rider or policy exclusion.]

If any questions or conditions in section F are checked "Yes", please explain below (use additional paper, if necessary).
Please indicate all details of the symptoms, injury, ailment or condition. Include items such as specific location of condition, diagnosis, type of treatment, testing, and/or hospitalization.

Question Number	Patient/Applicant	Condition, Injury, Symptom, or Diagnosis			Was recovery complete?	Treatment or advice given, surgery performed, diagnostic test results and medications prescribed	Name, address and phone number of doctors and hospitals
		Condition	Date began	Date last treated			

PLEASE INCLUDE ANY DOCTOR/FACILITY LISTED ABOVE ON THE AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION. FAILURE TO LIST COMPLETE ADDRESSES AND PHONE NUMBERS OF DOCTORS/FACILITIES CAN RESULT IN DELAYED UNDERWRITING.

Additional Information:

G. CONSENT, TERMS AND CONDITIONS

1. I represent that I have read this Application and understand each of the questions, and that the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation on this Application will void my policy at the discretion of American Community. I further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. I understand that this application will be medically underwritten. I agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. I represent that neither I, nor my spouse, is receiving any form of reimbursement or compensation for this coverage from any employer.
4. I understand and agree that no agent or broker has the authority: (i) to bind American Community by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information American Community requests; (iii) approve coverage; (iv) make or alter any contract on behalf of American Community; or (v) waive or alter any of American Community's other rights or requirements.
5. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics, mode of living or type of risk of any persons proposed for insurance to give to American Community, its legal representatives or its reinsurers, any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records and criminal history.
6. I consent to any physician, hospital, clinic, pharmacy, or other medical or medically related facility and insurance company, health information repository, its agents, business associates, or legal representatives to give to American Community, its legal representatives or its reinsurers any information or records or knowledge of the health, except for psychotherapy notes, of any persons proposed for insurance to carry out treatment, payment and health care operations.
7. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. I know that I, or my authorized representative, may request and are entitled to receive a copy of the consent.
8. I am signing this application on my own behalf and on behalf of all listed dependents. I understand that my statements and answers in this application must continue to be true as of the date I receive the policy. I understand that if my or my dependent's health or any of the answers or statements change prior to the underwriting decision date, I must inform American Community in writing. I understand that failure to do so may result in my application being denied or rescission of my or my dependent's coverage under the policy.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not: a.) provide interim coverage, b.) guarantee coverage, or c.) guarantee issue of a policy.
10. I acknowledge receipt of the Outline of Coverage for the health insurance plan selected on the Product Selection Form attached to this application.
11. I understand that the existence of other insurance may reduce the benefits under this plan.
12. I understand that this application is void if not approved within 90 days after the date the application was signed.

X_____	_____	X_____	_____
Signature Key Applicant (or if minor Child, Parent or Guardian)	Date	**Spouse's Signature** (or signature of dependent age 18 or over for child only policies)	Date

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Do not cancel any current health insurance coverage until you receive an approval letter and an insurance policy from American Community. You will be notified of the effective date of your policy.

PROXY

The undersigned hereby appoints the President of American Community Mutual Insurance Company, with full power of substitution as the undersigned's proxy with full power, to vote and act on their behalf on all issues at all meetings of the members of the Company and any adjournments thereof. If the proxy named herein, or his named substitute, is for any reason unable to act, the Board of Directors of the Company may fill the place of such proxy by appointing another. The proxy named herein shall only vote for those persons to serve as directors who have been nominated by the Board of Directors of the Company. If such persons are unable or unwilling to serve, then the proxies named herein may select other nominees and vote for such other nominees to serve as directors. In addition, all other matters properly brought before the meeting of the members the proxy will vote in accord with the recommendation of the Board of Directors, if any, and, if none, according to his judgment. This proxy will continue in force for the period of time the undersigned is the named insured of a policy issued and in effect by the Company. The proxy may be revoked by the undersigned at any time by filing with the Secretary of the Company a written revocation, a duly executed proxy bearing a later date or by attending and voting in person at any meeting of the members.

Signature: X _____ **Date:** _____

AGENT INFORMATION: Name: _____ Number: _____

Phone # _____ Fax # _____ **Signature: X** _____

H. AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION:

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service as well as those entities listed below, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsures, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of the health of the undersigned for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

1. _____
Key Applicant's Name — Physician/Facility, Address and Phone Number

2. _____
Spouse's Name — Physician/Facility, Address and Phone Number

3. _____
Child's Name — Physician/Facility, Address and Phone Number

4. _____
Child's Name — Physician/Facility, Address and Phone Number

5. _____
Child's Name — Physician/Facility, Address and Phone Number

This authorization is valid for 24 months from the date below. A photographic copy of this authorization shall be as valid as the original for 24 months from the date below.

I understand and acknowledge that:

1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state specific authorization form.

1. **X** _____
Signature of key applicant* — Date — Social Security Number — Date of Birth

2. **X** _____
Signature of spouse* — Date — Social Security Number — Date of Birth

3. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

4. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

5. **X** _____
Signature of dependent (age 18 and over)* — Date — Child's name — Child's Social Security Number — Date of Birth

*If under the age of 18, the parent or guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

Applicant MUST keep a copy of this authorization form and send a signed copy in with the application.

NOTICE OF YOUR PRIVACY RIGHTS

We know that your trust in us is very important. We are committed to protecting your privacy rights. Please read this document carefully. It discloses your privacy rights.

Obtaining Information About You - We may obtain information from your application, a telephone interview with you, claims history with us, policies you have or had with us, account balances and premium payment history, and other sources, such as health care providers (medical information), and consumer reporting agencies (credit reports). Your address, birthday, telephone number, social security number are examples of such information. You may have to share such information with us, our affiliates, agencies or others working with us.

Our Use of Personal Information - We will share such information only with companies associated with us. We, or your agent or broker may use your information to offer you products or help you choose a product.

We may, as permitted by the law and without your prior approval, give information about you to persons who do business for us, your agent or broker, other insurance companies, or other persons handling your business, insurance company support organizations, regulatory or law enforcement authorities; and our affiliated companies. Information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

Your Rights

➲ The right to access, inspect and copy the personal information pertaining to you that we maintain in our files about you.
➲ The right to request that we correct or amend any personal information that we have about you.

To exercise these rights, please send a written request to the attention of the Privacy Coordinator.

How We Protect Your Personal Information - We protect the information we share with companies working for us through an agreement. The agreement obligates those companies to keep your information confidential.

Only our employees who work to service your business see your personal information. We have trained our employees to closely follow our privacy rules for your protection. Your privacy rights will continue if you cease to be our customer.

THE REMAINDER OF THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required to maintain the privacy of your personal medical information and provide you with this notice as to our legal duties and privacy practices. We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make any new provisions effective to all of the medical information that we maintain about you. If we revise this notice, we will provide you with a revised notice by mailing the revised notice to the address you have supplied us.

STATEMENT OF YOUR RIGHTS

You have the right to know how we use or disclose your personal medical information. There are certain uses and disclosures of your personal medical information that we are permitted or required to make by law without your permission. In addition, you have:

➲ The right to request that we place additional restrictions on our uses and disclosures of your personal medical information, but we are not obligated to agree to any such restrictions.
➲ The right to access, inspect and copy the protected information pertaining to you that we maintain in our files, and the right to request that we correct or amend any personal medical information that we have about you.
➲ The right to receive an accounting of the disclosures of your personal medical information that we make for purposes other than activities related to your treatment, or our payment functions or other health care operations.
➲ The right to request that you receive communications of personal medical information in a confidential manner.
➲ The right to obtain a paper copy of this notice from us on request.

To exercise these rights please send a written request to the attention of the Privacy Coordinator.

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED MEDICAL INFORMATION

Payment Functions. We may use or disclose your protected medical information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. For example, payment functions may include (but are not limited to) reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

Health Care Operations. We may also use or disclose your protected medical information without your permission to carry out certain insurance-related activities. For example, these activities include using your protected information for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of another contract of health insurance, placing a contract for reinsurance of risk relating to claims for health care, and performing audit functions to ensure compliance and proper claims payment.

Group Health Plan. We may disclose your protected medical information to your employer as necessary for the purpose of reporting claims experience or conducting an audit if you are covered under an employer-based group health insurance plan.

Business Associates. We may disclose your protected medical information to our business associates. There are some services provided in our company through contracts with our business associates.

Uses Permitted By Law. We may also use or disclose your protected medical information without your written permission for purposes permitted or required by law.

Authorized Uses. All other disclosures of your protected medical information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

COMPLAINTS ABOUT MISUSE OF INFORMATION - If you believe your privacy rights have been violated you may complain either directly to us or to the Secretary of Health and Human Services (H.H.S.). Please submit all complaints in writing to us or H.H.S. as follows:

[American Community Mutual Insurance Company
Attn: Privacy Officer
39201 Seven Mile Road
Livonia, MI 48152]

[U.S. Department of Health and Human Services (H.H.S.)
Attn: Secretary
200 Independence Ave. S.W.
Washington, DC 20201]

You will not be retaliated against in any way for filing a complaint.

OBTAINING FURTHER INFORMATION - Please call American Community at [(800) 991-2642] if you have any questions or comments.

Effective: [December 1, 2007]

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

MINOR CHILD COVERAGE RIDER

This Rider is a part of the Policy to which it is attached.

It is effective at 12:01 a.m. on the Effective Date of the Policy. It ends when the Policy ends.

It is subject to all the terms of the Policy not inconsistent with it.

The policy is issued to provide insurance coverage to a minor child or children listed on the Schedule of Family Members on the application.

The Owner is the parent or legal guardian of the minor(s) listed on the Schedule of Family Members who has signed the application for the Applicant.

The Owner represents that the questions on the application have been answered to the best of his or her knowledge and understands and agrees with the conditions of the application and Policy.

The Owner is not provided any insurance coverage under the policy.

The Owner may exercise any right provided in the Policy which the insured name on the Schedule could exercise if the Insured were not a minor.

Signed for American Community Mutual Insurance Company at Livonia, Michigan

[President]

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

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
[39201 Seven Mile Road, Livonia, Michigan 48152
(313) 591-9000 FAX (313) 591-4628]

EXCLUSION RIDER

ATTACHED TO AND MADE A PART OF POLICY NUMBER: [1234567]

NAME OF PERSON TO WHOM THE PROVISIONS OF THIS RIDER APPLY: [JOHN DOE]

EFFECTIVE DATE: [mm/dd/yyyy]

As a condition precedent to, and in consideration of, the issuance of the policy to which this rider is attached, I understand and agree that no benefits shall be payable for

[Any disease or disorder of the eyelids, lacrimal ducts and glands or meibomian glands, including treatment or operation for or complications thereof.]

Reconsideration Period: [Time Period]

NOTE: The rider may be reconsidered if the person ridered has been treatment-free and symptom-free for the reconsideration period. The Insured must apply for reconsideration in writing using a current application form. After reconsideration, the rider will be continued or removed at the discretion of American Community. Permanent riders will not be reconsidered.

ACCEPTED:

_____ _____
Signature of Insured – [JOHN DOE] Date

_____
Signature of Spouse – [JANE DOE]

_____
Signature of Dependent – [JACK DOE]

_____
Signature of Parent or Guardian (if minor child)

[Michael Etohr
President]

ALTERED EXCLUSION RIDERS WILL NOT BE ACCEPTED

[HOME OFFICE] COPY

IA
[**00000000000000**]

Amendment of Application

Referring to my application for insurance with AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY, dated [00/00/0000], hereby amend said application to read as follows:

[Description of change]

I hereby agree that this change shall be an amendment to and form a part of the original application and of the policy issued thereunder.

Dated at _____ Date _____

APPLICANT - [**JOHN DOE]**	SPOUSE - **[JANE DOE]**
DEPENDENT **[JACK DOE]**	DEPENDENT **[JANICE DOE]**
PARENT OR GUARDIAN (IF MINOR CHILD)	WITNESS - **[JOHN SMITH]**

ALTERED AMENDMENTS WILL NOT BE ACCEPTED

[COPY STAMP]

(IMPORTANT - THIS FORM SHOULD BE ATTACHED TO YOUR POLICY)

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

ENDORSEMENT

To be attached to and form a part of Policy No. [123456789]

Effective Date of endorsement [Month DD, YYYY]

[[Any Optional Benefit (Dental/Maternity/Rx Drugs)] Benefit [Added/Removed]]

[[X] Policyholder changed to: [Policyholder name]]

[[X] Dependent coverage is hereby [granted to/terminated for]: [Dependent Name]]

Other Changes:

[The [Calendar Year/Benefit Period] Deductible is changed from $[2,000] to $[1,500].]

[The Benefit Percentage is changed from [80]% to [90]%.]

[Coverage for [John Doe] is hereby terminated on Policy No. [123456]. Family Members, [Jane Doe and Jacob Doe] are hereby transferred to Policy No. [456789]. All policy applications, amendments and exclusion riders are transferred to Policy No. [456789].]

This change shall not alter any of the other terms and conditions of the Policy. If necessary, the premium will be adjusted from the effective date of this endorsement in accordance with the premium schedule as of that date. If a dependent is being added, the waiting periods as stated in the Policy shall begin on the effective date of this endorsement.

[President]

American Community Mutual Insurance Company
[39201 Seven Mile Rd., Livonia, Michigan 48152-1094
(734) 591-9000]

American Community
Mutual Insurance Company

[39201 Seven Mile Road, Livonia, Michigan 48152-1094**]**

INTERNAL GRIEVANCE AND EXTERNAL REVIEW PROCEDURES

If We deny, reduce, terminate or fail to make payment for a benefit, You or Your Authorized Representative may file a Grievance with Us.

Definitions

Adverse Determination means a determination made by Us or Our administrator that includes any denial, reduction, or termination of, or failure by Us to make payment (in whole or in part) for a benefit, including:

1. A determination that a service is not appropriate or medically necessary;
2. A determination that a service is experimental or investigational.

In order to qualify for External Review:

1. The Adverse Determination must be a final adverse determination except as may be provided herein.
2. The Adverse Determination must involve benefits of $500 or more.

An Adverse Determination does not include a denial based on the following:

1. An express exclusion under terms of the policy, other than medical necessity or experimental/investigational,
2. An express limitation under the terms of the policy, such as number of visits, number of treatments for a covered benefit in any given timeframe (calendar year, benefit period, lifetime),
3. An express limitation under the terms of the policy with respect to maximum dollar limits in any given timeframe (calendar year, benefit period, lifetime),
4. That the individual is not eligible to be a covered person,
5. That the services were requested or obtained by the covered person through fraud or material misrepresentation,
6. The services or the means or methods of administering them were illegal,
7. FDA or other government agency determinations, reports or statements, or
8. Licensure, permit or accreditation status of a health care provider.

Authorized Representative means a person to whom You give express written consent to represent You in an External Review; a person authorized by law to provide substituted consent for You; or when You are unable to provide consent, a member of Your family or Your treating health care professional if a member or Your family is not available.

Final Adverse Determination means an Adverse Determination involving a covered benefit that has been upheld by Us at the completion of Our Internal Grievance Procedure.

Grievance means any dissatisfaction expressed by You or on Your behalf regarding any denial, reduction, or termination of, or failure by Us to make payment (in whole or in part) for a benefit.

You, Your, Yours means the insured Family Member.

How To Contact Us

A Grievance or new information may be submitted to Us by telephone, through the U.S. mail, by fax, or e-mail. The contact person is:

Name:	**[**Kathy Walker**]**, **[**Vice President**]**
Address:	American Community Mutual Insurance Company 39201 Seven Mile Road, Livonia, MI 48152
Telephone:	**[**(800) 991-2642**]**, Extension **[**4566**]**
Fax:	**[**(734) 591-4628**]**
E-mail:	**[**ac-grievances@American-Community.com**]**

How To Contact Arkansas Commissioner of Insurance

You may contact the Arkansas Commissioner of Insurance for assistance at any time.

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904

Telephone: (800) 852-5494 or (501) 371-2640
E-mail: insurance.consumer@Arkansas.gov

DESCRIPTION OF THE INTERNAL GRIEVANCE REVIEW PROCESS

There are two Internal Grievance Review processes: A Standard Grievance process and an Expedited Grievance process for urgent matters.

Expedited Process	**Standard Process**
Expedited Internal Review	Level 1 Standard Internal Review
	Level 2 Standard Internal Review

Expedited Internal Review Process

You may file an expedited Grievance by calling, writing, or faxing Your request to Us (See *How To Contact Us*). Your Grievance will be expedited if Your treating provider certifies that the time required to process Your request through the standard Grievance process would seriously jeopardize Your life, health, or ability to reach and maintain maximum function.

Our review and decision: We will review the Grievance and provide notice of Our decision within 72 hours after We receive the Grievance.

If We deny Your Grievance: You may request an expedited external review only if We determined that the service is not appropriate or medically necessary or the service is experimental or investigational. (See *External Review Procedure)*

If We grant Your Grievance: We will authorize the service, and the Grievance process is over.

Standard Internal Review Process

Level 1 - Standard Internal Review

Our review and decision: We will notify You of Our decision as soon as possible, but no later than 30 calendar days after We receive Your Grievance. However, if We require a 30-day extension for circumstances beyond Our control, We will notify You of the extension within 30 calendar days after We receive the Grievance.

If We deny Your Grievance: You may file for a Level 2 - Standard Internal Review.

If We grant Your Grievance: We will authorize the service or pay the claim and the Grievance is over.

Level 2 - Standard Internal Review

Our review and decision: We will notify You of Our decision as soon as possible, but no later than 30 calendar days after We receive Your Grievance. However, if We require a 30-day extension for circumstances beyond Our control, We will notify You of the extension within 30 calendar days after We receive the Grievance.

If We deny Your Grievance: You may file a standard external review only if We determined that the service is not appropriate or medically necessary or the service is experimental or investigational. *(See External Review Procedure)*

If We grant Your Grievance: We will authorize the service or pay the claim and the Grievance is over.

DESCRIPTION OF THE EXTERNAL REVIEW PROCESS

Standard External Review

You or Your Authorized Representative may request a Standard External Review of an Adverse Determination after You have exhausted Our Internal Grievance Procedures. The request for a Standard External Review may be made before You have exhausted Our Internal Grievance Procedure if We agree that the matter may proceed directly to External Review. The request must be sent to Us in writing or via electronic media within 60 days after the date You receive notice of an Adverse Determination or Final Adverse Determination.

When We receive a request for a Standard External Review, We will assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. The IRO will conduct a preliminary review of the request to determine the following:

1. The request meets the requirements applicable to an External Review;
2. You have exhausted Our internal grievance process, unless this requirement is waived by Us; and
3. You have provided all the information and forms, including the appropriate authorization form, required to process an External Review.

Within 5 business days after receipt of the request for External Review, the IRO will complete the preliminary review and notify You, Your treating health care professional, and Us in writing that:

1. The request is complete and has been accepted for external review; and that **any additional information and supporting documentation that the IRO should consider during its review may be submitted in writing within 7 business days following the date of receipt of the notice.**

2. The request is not complete and what information or materials are needed to make the request complete. Upon receipt of any information from You, the IRO will immediately forward copies of the information to Us. Upon receipt of this information We may reconsider the Adverse Determination or Final Adverse Determination that is the subject of the External Review. If We decide to reverse Our previous Adverse Determination or Final Adverse Determination, the External Review will be terminated.

3. The request is not accepted for external review and the reasons for its non-acceptance.

Within 45 calendar days after the date of receipt of the request for an External Review, the IRO shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the Adverse Determination or Final Adverse Determination to You, Your treating health care professional and Us.

Upon receipt of a notice of a decision by the IRO reversing the Adverse Determination or Final Adverse Determination We will immediately approve the coverage and pay the claim.

Expedited External Review

1. You or Your Authorized Representative may file a request for an Expedited External Review of an Adverse Determination at the same time You file a request for an Expedited Internal Review under Our Internal Grievance Procedure, if:

   a. You have a medical condition where the timeframe to complete an Expedited Internal Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
   b. Our denial of benefits is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies with reasoning, rationale, or evidence that the recommended service or treatment would be significantly less effective if not promptly initiated.

   When We receive this type of request for an Expedited External Review, We will immediately assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. The IRO conducting the expedited external review will determine whether you will be required to exhaust the expedited internal review, before it conducts the Expedited External Review. Upon a determination that You must first complete the expedited internal grievance procedure, the IRO will immediately inform You and Your treating physician that it will not proceed with the Expedited External Review until the expedited internal review is completed and the denial of benefits is upheld.

2. You or Your Authorized Representative may file a request for an Expedited External Review of a Final Adverse Determination if it concerns:

   a. An admission, availability of care, continued stay or health care service for which You received emergency services, but you have not been discharged from a facility; or
   b. Our denial of benefits is based on a determination that the service or treatment is experimental or investigational and your treating physician certifies with reasoning, rationale, or evidence that the recommended service or treatment would be significantly less effective if not promptly initiated.

When We receive a request for an Expedited External Review, We will immediately assign an Independent Review Organization (IRO) from the list of approved IRO's compiled and maintained by the Commissioner. We will provide all documents and information considered in making the adverse determination or final adverse determination, as well as any additional information and supporting documentation We have or You have provided to Us, via electronically, facsimile or any other available expeditious method, to the IRO, You and Your treating health care professional. The IRO will conduct a review of the request to determine that the request meets the requirements applicable to an External Review.

As expeditiously as Your medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for the Expedited External Review that meets the requirements applicable to an External Review, the IRO shall make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination and notify You, Your treating health care professional and Us of the decision.

If the decision was not in writing, within 2 days after the date of providing that notice, the IRO shall provide a written or electronic media confirmation of the decision to You and Us.

Upon receipt of a notice of a decision by the IRO reversing the Adverse Determination or Final Adverse Determination We will immediately approve the coverage and pay the claim.

An Expedited External Review may not be provided for adverse or final adverse determinations involving a retrospective review.

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

Application for Removal of Exclusion Rider

Name of Policyholder _____ Policy No._____

1. List ridered condition for possible reconsideration and person ridered.
   _____ on _____ (Name)
2. Date of onset_____ .
3. What treatment or medical advice was given by your physician for the ridered condition? (Please give dates.)
   _____
   _____
4. If surgery advised, was it done? ☐ Yes ☐ No If yes, please give date. _____
5. Are you currently on medication for this condition? ☐ Yes ☐ No List all medications._____
   _____
6. What was the date of your ***last*** symptom or treatment for this condition? _____
7. Doctor's name and complete address who has your records for this condition
   _____
   _____
   _____
8. Is any surgery, testing or future treatment anticipated for this condition? Please give details._____
   _____
   _____
9. Have you been released from care? ☐ Yes ☐ No If yes, date_____

Notice: Any person, who with intent to defraud, or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I represent that the above statements and answers are true to the best of my knowledge and belief.

I hereby authorize any physician, hospital, clinic or other medical or medically related facility, insurance company, Medical Information Bureau, or other insurance support organization, institution or person that has any record or knowledge of the health or non-medical information of any persons proposed for insurance hereunder to give to American Community Mutual Insurance Company or its reinsurers, any such information. This authorization includes information about drug and alcohol abuse and psychiatric conditions. A photographic copy of this authorization shall be as valid as the original for 30 months from the date below.

I acknowledge receipt of the notification of investigation and Medical Information Bureau Notice.

Date_____

_____
Signature of Policyholder

_____
Signature of Agent

_____
Signature of Ridered Insured (age 16 and over)

( )
_____
Agent's Telephone Number

( )
_____
Policyholder's Telephone Number

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

Allergy/Asthma Questionnaire

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

A. Do you have allergies? ☐ Yes ☐ No If no, please skip to 'B' below.

If yes,

1. When were you first diagnosed with allergies?

2. Have you ever had a test to determine what you're allergic to? ☐ Yes ☐ No

   If yes, when were you last tested? _____

   Briefly describe the test results: _____

   _____

3. Desensitization shots? ☐ Yes ☐ No If yes, how often:_____

4. Please indicate the medications (including prescription and over the counter) you have taken in the past 12 months for the above condition:

Medication Name (Include all inhalers)	Dosage	How Often Taken	# of 30 Day Supply (Refills in last 12 months)

B. Do you have asthma? ☐ Yes ☐ No If no, please sign and date this questionnaire below and return to American Community Mutual Insurance Company.

If yes,

1. When were you first diagnosed with asthma?_____

2. How many episodes have you had in the past 12 months?_____

   Please give the date of your last episode:_____

3. Have you ever been hospitalized or been treated in the Emergency Room for asthma? ☐ Yes ☐ No

   If yes, when? _____ How often? _____

4. Do you take Nebulizer treatments? ☐ Yes ☐ No If yes, how often:_____

   Date of last treatment:_____

5. Please give the date of your most recent spirometry and/or pulmonary function testing_____

   What were the test results? _____

6. Please indicate the medications (including prescription and over the counter) you have taken in the past 12 months for the above condition:

Medication Name (Include all inhalers)	Dosage	How Often Taken	# of 30 Day Supply (Refills in last 12 months)

_____ Applicant Signature

_____ Date

Return to American Community Individual Underwriting Department in one of the following ways:

Mail To: American Community Mutual Insurance Company
Attn: Individual Underwriting
39201 Seven Mile Rd.
Livonia, MI 48152-1094

E-mail To: AC-IndUndFax@american-community.com

Fax To: (734) 853-3117

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Alcohol & Drug Questionnaire

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Driver's License #: _____

(If Driver's License # is unknown, please obtain from the state government)

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Do you currently use alcohol (beer, wine, liquor)? ☐ Yes ☐ No
   If yes, how much do you consume per day _____ per week _____
   (One drink = 12 ounces of beer, 4 ounces of wine or 1 ounces of liquor)
   If no, when was your last drink? _____

2. Do you currently use or have you ever used any of the following:

Drug Substance Used	Yes	No	How Often Used	Date Started	Date Stopped
a. Inhalants (i.e. glue, gases, solvents, aerosols)	☐	☐	_____	_____	_____
b. Narcotics (i.e. heroin, opium, Demerol)	☐	☐	_____	_____	_____
c. Hallucinogens (i.e. LSD, PCP, mushrooms)	☐	☐	_____	_____	_____
d. Stimulants (i.e. cocaine, crack, amphetamines, ecstasy)	☐	☐	_____	_____	_____
e. Depressants (i.e. bromides, barbiturates)	☐	☐	_____	_____	_____
f. Tranquilizers (i.e. valium, Librium, haldol)	☐	☐	_____	_____	_____
g. Marijuana (i.e. hash, pot, grass, tea)	☐	☐	_____	_____	_____

3. In the last 5 years have you ever been arrested and/or charged with an alcohol/drug/substance abuse related offense?
   ☐ Yes ☐ No
   If yes, when? _____ Where? _____

4. Have you ever undergone treatment for alcohol/drug/substance abuse? ☐ Yes ☐ No
   If yes, please explain: _____
   a. Type of treatment (hospitalization, medication, psychotherapy): _____
   b. Date treatment began _____ Date treatment ended _____
   c. Was any of the treatment court ordered? ☐ Yes ☐ No

5. In the last 10 years, have you been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar after care program? ☐ Yes ☐ No
   If yes, are you an active member? ☐ Yes ☐ No
   When did you attend last? _____

6. Have you been prescribed any medication for the above conditions? ☐ Yes ☐ No
If yes, please provide the following information.

Medication Name	Dosage	How Often Taken	# of 30-Day Supply (Refills in last 12 months)

Applicant Signature

Date

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Abnormal PAP/HPV

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

If no history of abnormal PAP smear, but history of HPV, please skip to question #7.

1. What was the date(s) of your abnormal PAP smear(s)?_____

2. What were the PAP test results? (Please circle all that apply. If unknown, please call your doctor.) ASCUS, AGUS, HGSIL, LGSIL, Inflammation, CIN I-mild dysplasia, CIN II-moderate dysplasia, CIN III-severe dysplasia, CIS-carcinoma in situ.
   Other, please explain: _____

3. Have you received any treatment **other than** follow up PAP smears (LEEP, colposcopy, etc)? ☐ Yes ☐ No
   If yes, please explain, give dates, and results: _____

4. Have you had any follow up PAP smear(s) that were normal? ☐ Yes ☐ No
   If yes, please give date(s) of all normal PAP smears:_____

5. Has any future treatment been recommended? ☐ Yes ☐ No
   If yes, please explain: _____

6. Has a follow up PAP smear been requested/recommended that has not yet been completed?
   If yes, please explain:_____

7. Have you ever been diagnosed with HPV (Human Papilloma Virus) or had a PAP smear that showed HPV? ☐ Yes ☐ No
   If yes, please give date(s):_____.

8. Have you had any follow up PAP smears after an HPV PAP smear? ☐ Yes ☐ No
   If yes, please give date(s) and results:_____.

_____ Applicant Signature

_____ Date & Time

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Arthritis

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Type of arthritis: ☐ Rheumatoid ☐ Osteoarthritis ☐ Psoriatic ☐ Juvenile Chronic ☐ Gouty ☐ Degenerative Joint Disease ☐ Other _____

2. Please list all joints that are affected: _____

3. Current symptoms: ☐ Stiffness ☐ Inflammation/swelling ☐ Arthralgia/pain ☐ Crepitus/creaking/popping/grating

4. Do you have any disability or deformity due to the arthritis? ☐ Yes ☐ No. If yes, please explain: _____

5. Does the condition limit your activity? ☐ Yes ☐ No If yes, please explain: _____

6. Do you require the use of a cane, crutches or wheelchair? ☐ Yes ☐ No If yes, please explain: _____

7. Have you ever been hospitalized or received any treatment? ☐ Yes ☐ No If yes, please explain: _____

8. Have you ever had testing performed such as x-rays, MRI, blood tests or bone density studies? ☐ Yes ☐ No If yes, please explain, and give dates and results: _____

9. What medications have you used, including but not limited to: any type of anti-inflammatories, steroid, Gold or Synvisc injections, Methotrexate, Enbrel, Remicade, Humira, Plaguenil, Kineret etc.? Please provide details and dates: _____

10. Have you ever used alternative medical treatment for your arthritis such as acupuncture, magnets, herbs, etc.? ☐ Yes ☐ No If yes, please give type of treatment, details and dates: _____

11. What is your current treatment? _____

12. Have you ever been advised to have surgery or a joint replacement? ☐ Yes ☐ No If yes, please give details, dates: _____

_____

13. Name and dosage of current medications: (copy from pharmacy bottle)

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

13. How many times do you fill each monthly prescription in a 12-month period? _____

14. If you were diagnosed with gout, please answer the following:

What was the date of your first attack?_____

What was the date of your last attack?_____

How often do you have attacks?_____

Do you have elevated blood pressure? ☐ Yes ☐ No
If yes, please list the name and dosage of your current blood pressure medications (copy from pharmacy bottle):

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

Have you ever had kidney stones? ☐ Yes ☐ No.
If yes, please explain including dates and treatment received: _____

_____

_____ _____
Applicant Signature Date & Time

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Cataract(s)

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Do you or did you have a cataract in your eye(s)? ☐ Yes ☐ No
   ☐ Right Eye ☐ Left Eye ☐ Both Eyes

2. When were the cataract(s) diagnosed? _____

3. Are the cataract(s) ☐ congenital related ☐ injury related ☐ age related?

4. Have the cataracts been removed? ☐ Yes ☐ No If yes, please provide dates and which eye(s) _____
   _____
   _____

5. Best corrected vision: Right Eye _____ Left Eye _____

6. Are you currently experiencing any symptoms, undergoing treatment or being monitored? ☐ Yes ☐ No
   If no, give dates of your last symptoms and treatment: _____
   If yes, please describe your symptoms and/or current treatment including medications or eye drops: _____
   _____ _____

7. Is future eye surgery planned, contemplated or has the possibility of future surgery been discussed? ☐ Yes ☐ No
   If yes, please provide details: _____
   _____

_____ Applicant Signature

_____ Date & Time

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Cesarean Section Questionnaire

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Have you or your spouse had any elective sterilization procedures performed? ☐ Yes ☐ No

2. Please provide dates and reasons for any c-sections you may have had: (example: baby was breech, hypertension, gestational diabetes, pre-eclampsia, toxemia, etc.)

Date	**Reasons**
_____	_____
_____	_____
_____	_____

_____ _____
Applicant Signature Date

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Carpal /Ulnar Tunnel

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1 Do you or did you have carpal/ulnar tunnel symptoms or problems in your wrist(s)? ☐ Yes ☐ No
Which wrist(s)? ☐ Right ☐ Left ☐ Both

2. How long have you had symptoms of this condition? _____ Please give date of first symptoms _____

3. Please describe treatment used for the condition, including but not limited to: Wrist brace, injections, physical therapy, medication etc. _____
_____

4. Has surgery been used to correct the condition? ☐ Yes ☐ No If yes, when was surgery completed? _____
Which wrist did you have surgery on? ☐ Right ☐ Left ☐ Both
If no, has surgery been discussed or planned? Please explain: _____

5. Are you still experiencing symptoms? ☐ Yes ☐ No
If no, when did you last experience symptoms? Month_____ Year_____

6. Please indicate any medications (including injections, prescription drugs, and over the counter medication) you have taken in the past 12 months for the above condition:

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

_____ _____
Applicant Signature Date & Time

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Otitis Media/Ear

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Have you ever been diagnosed with any of the following disorders? Please check all that apply.
   ☐ Otitis/Ear Infections ☐ Hearing Loss ☐ Vertigo ☐ Cholesteatoma ☐ Dizziness
   ☐ Otitis Externa Maligna ☐ Otosclerosis ☐ Labyrinthitis ☐ Other

   Which ear was affected? ☐ Right Ear ☐ Left Ear ☐ Both Ears

2. When were you first diagnosed? _____

3. What was the date of last treatment? _____

4. What type of treatment has been received (such as tube placement, long term antibiotics)? _____
   _____

5. If tubes have been placed, are they still present? ☐ Yes ☐ No.

   If no, are there plans to replace them? ☐ Yes ☐ No.

   If present and they fall out, are there plans to replace them? ☐ Yes ☐ No.

6. Has surgery been recommended or have you had surgery? ☐ Yes ☐ No.
   If yes, list date(s) and type of procedure(s) completed or recommended: _____
   _____

7. Have you ever been referred to a specialist or Ear Nose and Throat physician? ☐ Yes ☐ No.
   If yes, please explain including date and results of the evaluation: _____
   _____

8. How many ear infections have you had in the last 12 months? _____

9. Have you ever had a hearing test or tympanogram? ☐ Yes ☐ No. If yes, please list the date and test results: _____
   _____

10. Name and dosage of current medications:

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

11. If you have hearing loss, please list if the loss is considered: mild, moderate, or severe and the type of treatment you are receiving or have been recommended, such as a hearing aid, etc:

	Amount of hearing loss:	Treatment received or recommended:
Right ear:		
Left ear:		
Both ears:		

_____ Applicant Signature

_____ Date & Time

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GASTROESOPHAGEAL REFLUX DISEASE (GERD), HIATAL / DIAPHRAGMATIC HERNIA, ULCER

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1 Have you been diagnosed with any of the following? (please check all that apply)

☐ Gastroesophageal reflux disease (GERD)

☐ Hiatal/Diaphragmatic Hernia ☐ Esophagitis ☐ Esophageal spasm

☐ Esophageal stricture ☐ Heartburn ☐ Gastritis

☐ Dysphagia (difficulty swallowing) ☐ Barrett's Esophagus ☐ Ulcer

2. When were you first diagnosed with the condition(s) listed above? _____

3. What symptoms do you experience from this condition? Please include the date of the last symptoms: _____

_____

4. Has testing been done? ☐ Yes ☐ No. If yes, please specify type of testing such as x-rays, upper GI, endoscopy, blood test, ultrasound, etc.; provide dates and results of test _____

_____

If no, please explain: _____

5. How frequent are the episodes? (Daily, Weekly, Monthly, less than Monthly) _____

6. What is the present treatment? (If medication, please list the name and dosage of your medications and how often the prescription has been filled in the last 12 months)

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

7. Have you had surgery? ☐ Yes ☐ No If yes, please list the date of surgery and type of surgery done such as: repair of hiatal/diaphragmatic hernia, pyloroplasty, vagotomy, partial gastrectomy, total gastrectomy: _____

_____

If no, has surgery been planned, contemplated or discussed? Please explain: _____

_____

8. Do you have any other medical condition related to this diagnosis? (examples asthma, chest pain, sleep apnea, gall bladder disease, allergies, sinusitis) ☐ Yes ☐ No If yes, please describe any testing or treatment you have received including dates of treatment:_____

9. Have you ever been diagnosed with Dumping Syndrome? ☐ Yes ☐ No
   If yes, when were your latest symptoms of Dumping Syndrome? Month____Year____
   Please describe the treatment you receive for Dumping Syndrome, (if medication, please include the name of the medication, dosage, how often taken, and number of refills in past 12 months): _____
   _____
   Have you had surgery to correct Dumping Syndrome: ☐ Yes ☐ No
   If yes, please list the date and type of surgery done: _____
   If no, has surgery been planned, contemplated or discussed? Please explain:_____
   _____

_____ Applicant Signature

_____ Date & Time

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Gastrointestinal

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

Have you ever been diagnosed with any of the following conditions?

1. **Crohn's disease:** ☐ Yes ☐ No
   Date of first episode: _____ Date last treated: _____
   Number of episodes in the past 12 months: _____
   Number of episodes since first diagnosed: _____
   Names and dosages of medication: _____
   How often taken per day: _____
   Number of refills in the past 12 months: _____
   Has surgery been discussed or recommended? ☐ Yes ☐ No
   If yes, please explain (including type of surgery, date, follow up plans etc.): _____
   _____

2. **Enteritis:** ☐ Yes ☐ No
   Date of first episode: _____ Date last treated: _____
   Number of episodes in the past 12 months: _____
   Number of episodes since first diagnosed: _____
   Names and dosages of medication: _____
   How often taken per day: _____
   Number of refills in the past 12 months: _____
   Has surgery been discussed or recommended? ☐ Yes ☐ No
   If yes, please explain (including type of surgery, date, follow up plans etc.): _____
   _____

3. **Ulcerative Colitis/proctitis:** ☐ Yes ☐ No
   Date of first episode: _____ Date last treated: _____
   Number of episodes in the past 12 months: _____
   Number of episodes since first diagnosed: _____
   Names and dosages of medication: _____
   How often taken per day: _____
   Number of refills in the past 12 months: _____
   Has surgery been discussed or recommended? ☐ Yes ☐ No
   If yes, please explain (including type of surgery, date, follow up plans etc.): _____
   _____

4. **Irritable bowel:** ☐ Yes ☐ No
Date of first episode:_____ Date last treated:_____
Number of episodes in the past 12 months: _____
Number of episodes since first diagnosed:_____
Names and dosages of medication:_____
How often taken per day: _____
Number of refills in the past 12 months: _____
Has surgery been discussed or recommended? ☐ Yes ☐ No
If yes, please explain (including type of surgery, date, follow up plans etc.): _____
_____

5. **Diverticulosis:** ☐ Yes ☐ No
Date of first episode:_____ Date last treated:_____
Number of episodes in the past 12 months: _____
Number of episodes since first diagnosed:_____
Names and dosages of medication:_____
How often taken per day: _____
Number of refills in the past 12 months: _____
Has surgery been discussed or recommended? ☐ Yes ☐ No
If yes, please explain (including type of surgery, date, follow up plans etc.): _____
_____

6. **Diverticulitis:** ☐ Yes ☐ No
Date of first episode:_____ Date last treated:_____
Number of episodes in the past 12 months: _____
Number of episodes since first diagnosed:_____
Names and dosages of medication:_____
How often taken per day: _____
Number of refills in the past 12 months: _____
Has surgery been discussed or recommended? ☐ Yes ☐ No
If yes, please explain (including type of surgery, date, follow up plans etc.): _____
_____

7. **Polyps:** ☐ Yes ☐ No
Date of most recent colonoscopy: _____
Were polyps removed? ☐ Yes ☐ No
If yes number of polyps:_____
Size of polyps (if unknown, please call your doctor):_____
Pathology results (if unknown, please call your doctor): _____
If no, please explain (including type of surgery, date, follow up plans etc.): _____
_____

When is followup colonoscopy recommended (example: 1 year, 5 years, 10 years)? _____

_____ Applicant Signature

_____ Date & Time

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High Cholesterol/Lipids Questionnaire

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

A. Have you been diagnosed with High Cholesterol (>250)? ☐ Yes ☐ No
High Triglycerides (>300)? ☐ Yes ☐ No

If yes, for either High Cholesterol or High Triglycerides:

1. When were you first diagnosed with High Cholesterol?_____ High Triglycerides?_____
2. Have you ever been hospitalized or treated for heart problems? ☐ Yes ☐ No

   If yes, please explain the heart condition and detail the treatment including any treatment dates: _____

3. What were your last two cholesterol panel readings: (If unknown, please contact your Doctor's office to obtain this information.)

   a. Date: _____ Total Cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

   b. Date: _____ Total Cholesterol: _____ HDL: _____ LDL: _____ Triglycerides: _____

4. Please give the date of your last visit to the physician listed above (or any other physician) for this condition: _____
5. Please indicate the prescription medications you have taken in the past 12 months for the above conditions.

Medication Name	Dosage	How Often Taken	# of 30 Day Supply (Refills in last 12 months)

(Over)

Do you tak your medications as prescribed? ☐ Yes ☐ No

Has your physician had to change your medication since you received your diagnosis? ☐ Yes ☐ No

If yes, when and why was your medication changed:_____

_____

_____ _____

Applicant Signature Date

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Heart Murmur

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. When were you first told you had a heart murmur? _____

2. Have you had any cardiac testing performed? ☐ Yes ☐ No
   If yes, please provide: Date(s) of testing: _____
   Reason for testing: _____
   The name of the test(s) performed (including but not limited to: EKG, Echocardiogram, Stress Test, etc): _____
   _____
   Results of those tests: _____

3. What is the underlying cause of your heart murmur, if known? _____

4. Is your murmur systolic or diastolic? _____

5. Do you have, or have you ever had any symptoms such as irregular heartbeat, racing heart, palpitations, chest pain, etc?
   ☐ Yes ☐ No If yes, please explain and give dates/details: _____
   _____

6. Have you ever, or do you receive any treatment for your murmur, including but not limited to antibiotics prior to dental work?
   ☐ Yes ☐ No If yes, please provide the type of treatment received, if medication include the name, dosage, how often taken per day, and how long it was taken: _____
   Date of first treatment: _____
   Date of last treatment: _____

7. Have you ever been hospitalized or visited the emergency room due to your murmur? ☐ Yes ☐ No If yes, please explain and give dates and details: _____
   _____

8. Are you being periodically monitored or followed-up? ☐ Yes ☐ No If yes, how often and what testing is being ordered as part of your follow-up? _____
   _____

9. Have you ever been told that you have any of the following (please circle all that apply): aortic regurgitation (insufficience), aortic stenosis (acquired or congenital), idiopathic hypertrophic subaortic stenosis, tricuspid regurgitation, mitral insufficiency, mitral regurgitation or incompetence, mitral stenosis, pulmonary (pulmonic) insufficiency, pulmonary (pulmonic) regurgitation or incompetence, pulmonary (pulmonic) stenosis, bicuspid aortic valve, mitral valve prolapse, click, murmur, floppy mitral valve, or Barlow's syndrome, functional or innocent murmur? If yes, please explain and give dates/details: _____
   _____
   _____

Applicant Signature

Date & Time

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Hypertension

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

CURRENT HISTORY OF HIGH BLOOD PRESSURE:

1. When were you diagnosed with high blood pressure? _____

2. Name and dosage of your medications and how often has the prescription been filled in the last 12 months (drug strength listed on pharmacy bottle):

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

3. How long have you been on blood pressure medications? _____

4. How long has your blood pressure been **controlled** (below 140/90)? _____

5. What were your three most recent blood pressure readings (If unknown, please contact your physician's office to aid you in completing this information):

   Reading: _____ Date: _____

   Reading: _____ Date: _____

   Reading: _____ Date: _____

6. Have you ever been hospitalized or seen in the emergency room for high blood pressure? ☐ Yes ☐ No
   If yes, please explain including dates: _____

7. Have you consulted with a physician for or been treated for any of the following (please circle all that apply): Diabetes or insulin resistance, heart attack, chest pain, irregular heartbeat, stroke, heart failure, severe headaches, metabolic disorder, hypertensive retinopathy, kidney disease, atherosclerosis, carotid artery disease or any other condition your doctor has related to your hypertension (high blood pressure): ☐ Yes ☐ No
   If yes to any of the conditions above, please explain including dates: _____

8. Have you seen your doctor in the last year? ☐ Yes ☐ No
   If no, please explain: _____

PREVIOUS HISTORY OF HIGH BLOOD PRESSURE (to be completed only if you previously had or were being treated for high blood pressure and now no longer have high blood pressure or are no longer taking medication or being treated for high blood pressure):

1. When did you discontinue your blood pressure medication?_____
2. Was this on the advice of your physician? ☐ Yes ☐ No
3. Have you been back to see your physician since going off your medications? ☐ Yes ☐ No
   If yes, when: _____
4. What was your blood pressure reading at that time?_____
5. What is your most recent blood pressure reading?_____
   On what date?_____

_____ Applicant Signature

_____ Date & Time

Return to American Community Individual Underwriting Department in one of the following ways:

Mail To: American Community Mutual Insurance Company
Attn: Individual Underwriting
39201 Seven Mile Rd.
Livonia, MI 48152-1094

E-mail To: AC-IndUndFax@american-community.com or **Fax To:** (734) 853-3117

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

Infertility

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

Are you over 45, or have you or your spouse been sterilized? ☐ Yes ☐ No

If yes, please sign and date at the bottom.

If you answered no, please answer the following questions:

1. When was infertility first diagnosed? _____

2. What is the cause of your infertility, if known (endometriosis, polycystic ovaries,blocked tubes, low sperm mobility, history of miscarriage, etc)? _____

   _____

3. Type of infertility workup performed, including the results: _____

   _____

4. Are you still receiving treatment for infertility? ☐ Yes ☐ No

   What treatment are/were you receiving and what was the date of last treatment? _____

   _____

5. Was corrective surgery performed? ☐ Yes ☐ No

   If yes, please explain, including date performed: _____

   _____

   If no, has corrective surgery been planned, contemplated or discussed? Please explain _____

   _____

6. Have in vitro fertilization, artificial insemination or embryo implants been used or considered: ☐ Yes ☐ No

   If yes, when: _____ Please give details: _____

7. Name and dosage of your infertility medications and how often each prescription was filled in the last 12 months (drug strength listed on pharmacy bottle):

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

_____ _____
Applicant Signature Date & Time

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Joint Injury

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Which joint was injured (shoulder, ankle, knee, etc.)? _____
   ☐ Right ☐ Left ☐ Both

2. What was the date of your injury? Month: _____ Year: _____

3. How did the injury occur? Please explain: _____

4. What is your diagnosis? _____ _____

5. Was surgery performed? ☐ Yes ☐ No If yes, please describe surgery, date of surgery: _____

6. If yes, is there any internal fixation still present (artificial joint, pins, prosthesis, screws, etc.)? ☐ Yes ☐ No

7. If internal fixation is present, are there plans to remove them? ☐ Yes, When _____ ☐ No

8. Do you have any remaining symptoms or problems, such as pain, weakness, deformity or limitation of movement?
   ☐ Yes ☐ No If yes, please explain: _____

   If no, please provide date of last symptoms or problems and treatment: _____

9. Do you anticipate any future treatment, surgery, medications, etc? ☐ Yes ☐ No If yes, please explain: _____

_____ Applicant Signature

_____ Date & Time

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Livonia, MI 48152-1094

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Kidney/Urinary Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ ID/SSN: _____

Form No._____

Name of person treated: _____ Relationship to applicant: _____

1. What type of kidney or urinary disorder did you have? Please check all that apply.

☐ **Bladder infection.** Date symptoms first occurred:_____What date did you last have symptoms?_____
How many occurrences have you had? _____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Involuntary urine loss.** Date symptoms first occurred:_____What date did you last have symptoms?_____
How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Kidney stones.** Date symptoms first occurred:_____ What date did you last have symptoms?_____
How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Nephritis.** Date symptoms first occurred:_____ What date did you last have symptoms?_____ How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Prostate.** Date symptoms first occurred:_____ What date did you last have symptoms?_____ How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Cystitis.** Date symptoms first occurred:_____ What date did you last have symptoms?_____ How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Reflux.** Date symptoms first occurred:_____ What date did you last have symptoms?_____ How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Renal failure.** Date symptoms first occurred:_____ What date did you last have symptoms?_____
How many occurrences have you had?_____ List any medications prescribed for this condition, include amount taken per day and how often per day: _____

_____

☐ **Other:** _____

_____

2. Other than medications, have you received any other treatment for this condition (such as special therapy, dialysis, bladder training treatments, etc)? _____

_____

3. Have you had any of the following testing done? Check all that apply.
   ☐ Blood test ☐ Renal biopsy ☐ Urine test ☐ Renal scan ☐ Ultrasound
   ☐ Renal angiography ☐ Cystoscope ☐ 24 hour urine ☐ Cystogram
   If yes, give dates of testing and results:_____
   _____
   _____

4. Have you ever been hospitalized for this condition? ☐ Yes ☐ No If yes, please give details such as name and address of hospital, date of admission and discharge, surgery or testing that was done and results: _____
   _____
   _____

5. Have you ever had any heart trouble or high blood pressure? ☐ Yes ☐ No If yes, please explain (ie, date condition started, surgery, medications) _____
   _____
   _____

6. Name and address of treating physician: _____
   _____

7. Please list your exact current height:_____weight:_____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

_____ _____
Signature of person treated (or parent/guardian if under 18) Date

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Mental Health

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Have you been diagnosed with any of the following (please check all that apply)?
   ☐ ADD/ ADHD ☐ Depression ☐ Major Depression ☐ Situational Depression ☐ Panic Disorder
   ☐ Manic Depression ☐ Bipolar ☐ Anxiety ☐ Schizophrenia
   ☐ Dysthmia/Cyclothymia ☐ Alcoholism or Substance Abuse ☐ Obsessive/Compulsive Disorder
   Other _____

2. Have you sought treatment from a psychologist, psychiatrist, physician, social worker, or another type of counselor? ☐ Yes ☐ No

   If yes, what type of treatment (such as medications, group and/or individual counseling sessions, electric shock/convulsive therapy, etc.) _____

   _____

   Date of onset: _____

3. If treatment has ended, provide date of last visit: _____

4. Is your condition considered mild, moderate or severe? _____

5. List all medications prescribed for this condition and when prescribed (copy from pharmacy bottle):

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

6. Are you still taking the prescribed medication? ☐ Yes ☐ No If not, please give name of medication and date(s) discontinued: _____

   _____

7. Have you been hospitalized for this, or a similar condition? ☐ Yes ☐ No If yes, provide complete details regarding date(s) of hospitalization, including length of stay, treatment given, testing and name and address of facility: _____

   _____

   _____

8. If this was a "situational" diagnosis, please list the cause(s) and date of event: _____

   _____

   _____

9. Have you ever attempted or contemplated suicide? ☐ Yes ☐ No If yes, please explain: _____

   _____

10. Do you have any activity limitations or restrictions? ☐ Yes ☐ No If yes, please explain: _____

Applicant Signature

Date & Time

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Livonia, MI 48152-1094

E-mail To: AC-IndUndFax@american-community.com or **Fax To:** (734) 853-3117

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Migraine/Headache

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. When did you start having headaches? _____

2. When did you first start seeing a doctor for your headaches? _____

   _____

3. What other symptoms do you have when you have a headache? _____

   _____

4. What is the cause of your headaches, if known? (Some examples are eyestrain, sinus infection, pre-menstrual, high blood pressure, viral infection, head injury, aneurysm, temporal arteritis, brain tumor, and cervical neck problems) _____

   _____

5. Please give results of the following:

   EEG _____ Date done _____ Not done _____

   Cat scan/MRI _____ Date done _____ Not done _____

6. How frequently do you experience headaches and how long do they last?
   (daily, weekly, monthly, etc.) _____

7. Please list the names and dosages of medications you take for headaches:

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

8. Do you take medication on a daily basis as a preventive, on an "as needed" basis, or both? _____

9. How frequently do you see your physician for your headaches? _____

_____ Applicant Signature

_____ Date & Time

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Livonia, MI 48152-1094

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Seizure/Epilepsy

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. What type of seizure disorder do you have?
   ☐ Grand mal (Generalized Tonic-Clonic) ☐ Petit Mal (Generalized Absence) ☐ Febrile
   ☐ Jacksonian (Partial, simple or complex) ☐ Other _____

2. Please give the underlying cause/reason for your seizures, if known: _____

3. When was Epilepsy/Seizure Disorder first diagnosed or what was the date of your first seizure? _____

   _____

4. When was your last seizure? _____

5. How often do the seizures occur? _____

6. Do you participate in hazardous activities or occupations? ☐ Yes ☐ No If yes, please explain: _____

   _____

7. Has your doctor advised you not to drive? ☐ Yes ☐ No

8. Has any surgery or other methods of seizure control been performed, planned, contemplated or discussed? ☐ Yes ☐ No

   If yes, please explain: _____

9. Are you on medication now? ☐ Yes ☐ No If yes, please list the medications below:

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

If no, please list the date you stopped taking medication: _____

Please explain why you stopped taking the medication: _____

_____ Applicant Signature

_____ Date & Time

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Spinal

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Have you ever suffered pain in any of the following areas?
   ☐ Neck (cervical) ☐ Middle Back (thoracic) ☐ Lower Back (lumbosacral)
   If yes, please explain how often you have the pain and the severity of the pain: _____

2. Are you experiencing pain in your neck or back now? ☐ Yes ☐ No
   If yes, please describe the location and severity of the pain: _____
   _____

3. Does the pain radiate to your legs/feet or shoulders/arms/hands? ☐ Yes ☐ No
   If yes, please explain: _____
   _____ _____

4. Do you have numbness or tingling sensations in your arms or legs? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

5. Have you ever had any of the following testing on your back or neck?
   ☐ CT scan ☐ Myelogram ☐ X-ray ☐ MRI ☐ MRA
   If yes, please explain including dates of testing and results: _____
   _____

6. Please give your diagnosis, if known:
   ☐ DJD (degenerative joint or disc disease) ☐ Arthritis ☐ Disc Herniation ☐ Disc Rupture
   ☐ Disc Protrusion (bulging) ☐ Spondylitis ☐ Spondylosis ☐ Spondylolithesis
   ☐ Sprain ☐ Other: _____

7. Have you ever been diagnosed with Scoliosis, Kyphosis, or Lordosis? ☐ Yes ☐ No

   If yes, is your curvature noticeable? ☐ Yes ☐ No
   Has your doctor told you that the Scoliosis/Kyphosis/Lordosis is mild, moderate or severe? _____
   Do you have any symptoms from your Scoliosis/Kyphosis/Lordosis? ☐ Yes ☐ No If yes, please explain: _____
   _____

8. Have you ever taken prescription medication for pain or muscle spasms in your back or neck? ☐ Yes ☐ No
If yes, please list the name and dosage of your medications and how often the prescription has been filled in the last 12 months (drug strength listed on pharmacy bottle):

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Have you ever had or been advised to have surgery or spinal fusion? ☐ Yes ☐ No If yes, please explain: _____
_____

10. Date released from your physician's care, with a full recovery and no further need for treatment or medication: _____

11. If not a full recovery, please describe your symptoms and treatment received: _____
_____

12. Have you ever had, or currently use, physical therapy treatment for your back or neck condition? ☐ Yes ☐ No
If yes, please explain including the length and type of treatment: _____
_____

13. Have you ever had, or currently use, any injection treatments for your back or neck condition? ☐ Yes ☐ No
If yes, please explain including type of injection, frequency and date of last injection: _____
_____

14. Have you ever been referred to a pain specialist? ☐ Yes ☐ No
If yes, please explain including treatment recommended: _____
_____

15. Have you ever had, or currently use, chiropractic treatment for your back or neck condition? ☐ Yes ☐ No
If yes, please explain including how often per month and date last seen: _____
_____

16. Have you ever had, or currently use any medical equipment or devices such as a TENS unit, traction, neuromuscular stimulator for treatment of your back or neck condition? ☐ Yes ☐ No If yes, please include the equipment used, date of last use and how often used: _____
_____

_____ Applicant Signature

_____ Date & Time

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Livonia, MI 48152-1094

E-mail To: AC-IndUndFax@american-community.com or **Fax To:** (734) 853-3117

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Tumor/Cyst

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Applicant Name: _____ File Number: _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. Diagnosis (type) of tumor/cyst: _____

2. Date of onset or date of diagnosis: _____

3. Was your tumor/cyst diagnosed as malignant or benign? ☐ Yes ☐ No If yes, please explain: _____

   _____

   What was the size of the tumor/cyst: _____

   Where was the location of the tumor/cyst: _____

   Have there been metastasis or spread to any other location(s)? ☐ Yes ☐ No If yes, please provide details: _____

   _____

   _____

   Has there been a recurrence or relapse? ☐ Yes ☐ No If yes, please give details: _____

   _____

   _____

4. Name and dosage of current medications:

Medication Name (Include injections)	Dosage	How often taken per day	# of 30 day supply refills in the last 12 months

   Did you receive radiation or chemotherapy for your tumor/cyst? ☐ Yes ☐ No If yes, please give details (include type of therapy, date therapy started and ended) _____

   _____

   _____

5. Have you had surgery or been advised to have surgery to remove the tumor/cyst? ☐ Yes ☐ No If yes, please give details (date of surgery, type of surgery, date of discharge): _____

   _____

6. Have you been released from all treatment for your tumor/cyst? ☐ Yes ☐ No If no, please explain details of current treatment: _____

   _____

7. Are further studies or future operations for the tumor/cyst anticipated? ☐ Yes ☐ No If yes, when? _____

   _____

8. Name and address of treating physician: _____

_____ _____

Applicant Signature Date & Time

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Livonia, MI 48152-1094

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Thyroid

Addendum to Application for Health Insurance

Applicant Name: _____ **File Number:** _____

Contact Information for the Treating Physician(s) for the above condition(s):

Name: _____

Address: _____

Phone Number: _____

1. What is your **current** thyroid condition? (please check all that apply)
   - ☐ Hyperthyroid (over active)
   - ☐ Hypothyroid (under active)
   - ☐ Thyroiditis
   - ☐ Enlargement
   - ☐ Goiter
   - ☐ Graves Disease
   - ☐ Plummer's Disease
   - ☐ Hashimoto's
   - ☐ Hot Nodule(s)
   - ☐ Cold Nodule(s)
   - ☐ Cancer
   - ☐ Other _____

2. Date diagnosed: _____

3. Current medication: (copy from pharmacy bottle)
   Name: _____ Dosage: _____

4. Are you receiving any treatment other than medication? ☐ Yes ☐ No If yes, please explain: _____

5. Have you ever had surgery or been advised to have surgery for this condition? ☐ Yes ☐ No
   If yes, please explain: _____

6. Do you have or did you have any complications, including but not limited to, thyroid storm, cretinism, myxedema?
   ☐ Yes ☐ No If yes, please explain: _____

7. Date of last thyroid blood test: _____

8. Was your thyroid testing within normal range? ☐ Yes ☐ No If no, please explain: _____

9. Please provide **past** thyroid conditions? (Please check all that apply)
   - ☐ Hyperthyroid (over active)
   - ☐ Hypothyroid (under active)
   - ☐ Throiditis
   - ☐ Enlargement
   - ☐ Goiter
   - ☐ Graves Disease
   - ☐ Plummer's Disease
   - ☐ Hashimoto's
   - ☐ Hot Nodule(s)
   - ☐ Cold Nodule(s)
   - ☐ Cancer
   - ☐ Other _____

10. Please provide past thyroid treatment and dates including but not limited to, surgery, radioactive iodine treatment, medication:
    _____

Applicant Signature _____ Date & Time _____

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Livonia, MI 48152-1094

E-mail To: AC-IndUndFax@american-community.com or **Fax To:** (734) 853-3117

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved-Closed	Rate Sheet	IND09, AR-RX-GENERICO9-AR, AR-RX-TIER09-AR, 650DR	New		OLYMRT012009ARrev10032008.pdf

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09

Monthly Base Rate and Factors

Monthly Medical Base Rate (1/1/2009 effective date): $129.71

State Factor:	Arkansas	0.77
Product Factor:	IND09	1.000

New Business Inflationary Trend Increase Factors:

Date	Factor
1/1/2009	1.0000
4/1/2009	1.0333
7/1/2009	1.0677
10/1/2009	1.1033

Each additional quarter, multiply by 1.0333

Factors for Deductible Options:

Deductible (Network)	Factor
$500	1.39
$1,000	1.15
$1,500	1.00
$2,500	0.76
$3,500	0.62
$5,000	0.55
$7,500	0.48
$10,000	0.43

Factors for Benefit Percentage:

Benefit % (Network)	Factor
60%	0.91
80%	1.00
100%	1.09

Factors for Coinsurance Maximum:

Coins Max (Network)	Factor
$0 (100%)	1.00
$10,000	1.00
$20,000	0.95

Modal Factors and Fees:

Mode	Modal Factor	Billing Fee per Bill
Annual	12	$10.00
Semi-Annual	6	$10.00
Quarterly	3	$10.00
Monthly Direct	1	$10.00
Monthly EFT	1	$0
Credit Card Convenience Fee		$6.25/trans.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09

Age/ Gender and Status Factors

Age Last	**all deductibles**		Non-	Standard
Birthday	Male	Female	smoker	Smoker
0-17	0.83	0.83	1.00	1.00
18-24	0.83	1.16	1.00	1.10
25	0.87	1.19	1.00	1.10
26	0.90	1.22	1.00	1.11
27	0.93	1.24	1.00	1.12
28	0.95	1.27	1.00	1.13
29	0.98	1.31	1.00	1.14
30	1.00	1.35	1.00	1.15
31	1.03	1.40	1.00	1.16
32	1.06	1.45	1.00	1.17
33	1.09	1.50	1.00	1.18
34	1.13	1.55	1.00	1.19
35	1.16	1.60	1.00	1.20
36	1.20	1.65	1.00	1.21
37	1.25	1.71	1.00	1.22
38	1.30	1.77	1.00	1.23
39	1.35	1.83	1.00	1.24
40	1.40	1.87	1.00	1.25
41	1.45	1.93	1.00	1.27
42	1.52	2.00	1.00	1.29
43	1.60	2.07	1.00	1.30
44	1.70	2.12	1.00	1.32
45	1.81	2.19	1.00	1.34
46	1.92	2.28	1.00	1.36
47	2.03	2.36	1.00	1.37
48	2.14	2.43	1.00	1.39
49	2.28	2.52	1.00	1.41
50	2.45	2.63	1.00	1.43
51	2.63	2.76	1.00	1.44
52	2.81	2.87	1.00	1.46
53	3.02	2.97	1.00	1.48
54	3.22	3.07	1.00	1.50
55	3.42	3.17	1.00	1.51
56	3.62	3.27	1.00	1.53
57	3.82	3.38	1.00	1.55
58	4.02	3.49	1.00	1.57
59	4.21	3.61	1.00	1.58
60	4.38	3.72	1.00	1.60
61	4.57	3.84	1.00	1.60
62	4.75	3.96	1.00	1.60
63	4.93	4.09	1.00	1.60
64 & over	5.09	4.21	1.00	1.60
Childrider*	0.83	0.83	1.00	

* Each Child; Three or More Children at Three Children Rate

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09

County Area and Network Factors

COUNTY	Area Factor	FirstHealth Factor	AMCO Factor
Arkansas	0.95	0.64	0.67
Ashley	0.95	0.71	0.75
Baxter	0.82	0.71	0.75
Benton	0.90	0.64	0.67
Boone	0.82	0.71	0.75
Bradley	0.95	0.71	0.75
Calhoun	0.95	0.71	0.75
Carroll	0.82	0.71	0.75
Chicot	0.95	0.71	0.75
Clark	0.95	0.71	0.75
Clay	0.90	0.71	0.75
Cleburne	0.90	0.71	0.75
Cleveland	0.95	0.71	0.75
Columbia	0.95	0.71	0.75
Conway	0.95	0.64	0.67
Craighead	0.90	0.71	0.75
Crawford	0.86	0.64	0.67
Crittenden	0.82	0.71	0.75
Cross	0.82	0.71	0.75
Dallas	0.95	0.71	0.75
Desha	0.95	0.71	0.75
Drew	0.95	0.71	0.75
Faulkner	0.95	0.64	0.67
Franklin	0.86	0.64	0.67
Fulton	0.82	0.71	0.75
Garland	0.95	0.64	0.67
Grant	0.95	0.64	0.67
Greene	0.90	0.71	0.75
Hempstead	0.95	0.71	0.75
Hot Spring	0.95	0.64	0.67
Howard	0.95	0.71	0.75
Independence	0.90	0.71	0.75
Izard	0.82	0.71	0.75
Jackson	0.95	0.64	0.67
Jefferson	0.95	0.71	0.75
Johnson	0.90	0.64	0.67
Lafayette	0.86	0.71	0.75
Lawrence	0.90	0.71	0.75
Lee	0.82	0.71	0.75
Lincoln	0.95	0.71	0.75
Little River	0.95	0.71	0.75
Logan	0.86	0.64	0.67
Lonoke	0.95	0.64	0.67
Madison	0.86	0.64	0.67
Marion	0.82	0.71	0.75
Miller	0.95	0.71	0.75
Mississippi	0.82	0.71	0.75
Monroe	0.95	0.64	0.67
Montgomery	0.95	0.71	0.75
Nevada	0.86	0.71	0.75
Newton	0.82	0.71	0.75
Ouachita	0.86	0.71	0.75
Perry	0.95	0.64	0.67
Phillips	0.82	0.71	0.75
Pike	0.95	0.71	0.75
Poinsett	0.82	0.71	0.75
Polk	0.95	0.71	0.75
Pope	0.90	0.64	0.67
Prairie	0.95	0.64	0.67
Pulaski	1.05	0.64	0.67
Randolph	0.90	0.71	0.75
Saint Francis	0.82	0.71	0.75
Saline	0.95	0.64	0.67
Scott	0.86	0.64	0.67
Searcy	0.82	0.71	0.75
Sebastian	0.86	0.64	0.67
Sevier	0.95	0.71	0.75
Sharp	0.90	0.71	0.75
Stone	0.90	0.71	0.75
Union	0.95	0.71	0.75
Van Buren	0.95	0.64	0.67
Washington	0.90	0.64	0.67
White	0.95	0.64	0.67
Woodruff	0.95	0.64	0.67
Yell	0.86	0.64	0.67

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09 Optional Benefits and Riders

Factors for Optional Gold Benefits Package:
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	Factor
$500	0.21
$1,000	0.21
$1,500	0.22
$2,500	0.29
$3,500	0.35
$5,000	0.44
$7,500	0.47
$10,000	0.50

Factors for Optional Prescription Drug Benefits - Generics Only (Form AR-RX-GENERIC09-AR)
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	
$500	0.04
$1,000	0.05
$1,500	0.06
$2,500	0.07
$3,500	0.09
$5,000	0.13
$7,500	0.14
$10,000	0.16

Factors for Optional Prescription Drug Benefits - Four Tier Coverage (Form AR-RX-TIER09-AR)
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	
$500	0.15
$1,000	0.17
$1,500	0.20
$2,500	0.25
$3,500	0.31
$5,000	0.39
$7,500	0.44
$10,000	0.50

Optional Dental Expense Rider (Form 650DR) - All Areas, All Ages

Male	$30.00
Female	$30.00
Each Child*	$15.00

* Three or more children at three children rate

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	10/07/2008

Comments:

The Consumer Information Notice is included on the second page of policy form IND09.

Attachments:

GAD (AR) - Guarantee Assoc Disc.pdf
Certificate of Unfair Sex Discrimination-IND09.pdf
IND09 - Readability Certification.pdf

		Review Status:	
Satisfied -Name:	Application	Approved-Closed	10/07/2008

Comments:

Please see new application for approval under the Form Schedule.

		Review Status:	
Satisfied -Name:	Health - Actuarial Justification	Approved-Closed	10/07/2008

Comments:

Attachments:

Act Memo OLYMPIC 200901ARrev.pdf
Exhibit A (AR mentalhealthparity 20080903).pdf

		Review Status:	
Satisfied -Name:	Outline of Coverage	Approved-Closed	10/29/2008

Comments:

Page 9 has been updated to include benefits for dental anesthesia

Attachment:

AR IND09 OOC 1-09(Rev 10.29.08).pdf

		Review Status:	
Satisfied -Name:	Statement of Variability	Approved-Closed	10/07/2008

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

Comments:

Attachment:

IND09 - Statement of Variability AR-Rev9.29.08.pdf

SERFF Tracking Number:	*AMCM-125834735*	*State:*	*Arkansas*
Filing Company:	*American Community Mutual Insurance Company*	*State Tracking Number:*	*40396*
Company Tracking Number:	*IND09*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Olympic*		
Project Name/Number:	*/*		

		Review Status:	
Satisfied -Name:	Letter from Actuary	Approved-Closed	10/07/2008

Comments:

Attachment:

ResponseToObjections.pdf

LIMITATIONS AND EXCLUSIONS UNDER
THE ARKANSAS LIFE ANDHEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 300,000 in health insurance benefits, $ 300,000 in present value of annuity benefits, or $ 300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Certificate of Unfair Sex Discrimination

I certify that we, American Community Mutual Insurance Company, are in compliance with Arkansas Rules and Regulation 19 – Unfair Sex Discrimination in the Sale of Insurance.

Francis P. Dempsey

Digitally signed by Francis P. Dempsey
DN: cn=Francis P. Dempsey, c=US, o=American Community Mutual Insurance Company, ou=Senior Vice-President & General Counsel, email=fdempsey@american-community.com
Date: 2008.09.12 08:10:40 -04'00'

Francis P. Dempsey
Senior Vice President & General Counsel

September 15, 2008

Date

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road, Livonia, Michigan 48152
NAIC Company #60305 • NAIC Group #166

READABILITY CERTIFICATION

TO: THE ARKANSAS DEPARTMENT OF INSURANCE

RE: IND09, et al

DATE: September 15, 2008

Form Number	Description
IND09	Medical Expense Policy
AR-RX-GENERIC09-AR	Outpatient Prescription Drug Rider - Generic Drugs Only
AR-RX-TIER09-AR	Outpatient Prescription Drug Rider
650DR	Dental Rider
AR HA-1 1/09	Application
MCCR-95	Minor Child Rider
EXR-04-99	Exclusion Rider
33-41 R/99	Amendment of Application
13-52 (4-89)	Endorsement
GP-AR (1/09)	Internal Grievance & External Review Procedures
33-133 605 4/93	Application of Removal of Exclusion Rider
33-AAQ 3/07	Allergy/Asthma Addendum
33-ADQ 3/07	Alcohol & Drug Addendum
33-APHQ 6/08	Abnormal Pap/HPV Addendum
33-ARQ 6/08	Arthritis Addendum
33-CATQ 6/08	Cataracts Addendum
33-CSQ 3/07	Cesarean Section Addendum
33-CTUQ 6/08	Carpal/Ulnar Tunnel Addendum
33-EAQ 6/08	Otitis Media/Ear Addendum
33-GHDUQ 6/08	GERD, Hiatal/Diaphragmatic Hernia, Ulcer Addendum
33-GIQ 6/08	Gastrointestinal Addendum
33-HCLQ 3/07	High Cholesterol/Lipids Addendum
33-HMQ 6/08	Heart Murmur Addendum
33-HYPQ 6/08	Hypertension Addendum
33-INFQ 6/08	Infertility Addendum
33-JNTQ 6/08	Joint Injury Addendum
33-KUQ	Kidney/Urinary Addendum
33-MHQ 6/08	Mental Health Addendum
33-MIQ 6/08	Migraine/Headache Addendum
33-SEQ 6/08	Seizure/Epilepsy Addendum
33-SPQ 6/08	Spinal Addendum
33-TCQ 6/08	Tumor/Cyst Addendum
33-THQ 6/08	Thyroid Addendum

I certify that the above forms meet or exceed a score of forty (40) on the Flesch Readability Test.

Francis P. Dempsey

Digitally signed by Francis P. Dempsey
DN: cn=Francis P. Dempsey, c=US, o=American Community Mutual Insurance Company, ou=Senior Vice-President & General Counsel, email=fdempsey@american-community.com
Date: 2008.09.12 08:18:05 -04'00'

Francis P. Dempsey, Senior Vice President
General Counsel & Corporate Secretary

September 15, 2008
DATE

OLIVER WYMAN

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
Actuarial Memorandum
Medical Expense; Preferred Provider Option
Policy Form IND09; Rate Sheet OLYMRT012009AR

I. I, Beth R. Fritchen, am a Principal with Oliver Wyman Actuarial Consulting, Inc. (OWAC), and have been retained by American Community Mutual Insurance Company (ACM) to develop the rates of Policy Form IND09. I am a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and am qualified to render an opinion for health insurance rates and plans. The purpose of this rate filing is to demonstrate compliance with State regulation. This memorandum should not be used for any purpose other than those expressly stated.

II. Scope

Policy Form IND09 is a new collectively renewable medical expense; preferred provider option policy. Premium rates increase with increases in age. Issue ages are 0-64, age last birthday. This filing has been prepared for the purpose of demonstrating compliance with regulatory authority and may not be appropriate for other purposes. The policy will be sold through independent agents.

III. Description of Benefits

A summary of major benefit provisions of the form follows. The policy form should be consulted for specific benefit provisions, limitations, and exclusions.

A. Calendar year single deductible amounts:
   1. Network: $500*, $1,000, $1,500, $2,500, $3,500, $5,000, $7,500, and $10,000**
   2. Non-Network deductible is twice the Network deductible.

B. Calendar year family deductible amounts:
   1. Network: $1,000*, $2,000, $3,000, $5,000, $7,000, $10,000, $15,000, and $20,000**
   2. Non-Network deductible is twice the Network deductible.

C. Calendar year benefit percentage options (Network/Non-Network):
   1. 100% / 75% of $10,000
   2. 80% of $10,000 or $20,000 / 55% of $10,000 or $20,000
   3. 60% of $10,000 or $20,000 / 50% of $20,000

4. The family out-of-pocket maximum is 2 times the individual out-of-pocket maximum, met collectively by 2 or more persons.

* $500/$1,000 deductible only available with the 60%/50% benefit percentage option.
** $10,000/$20,000 deductible only available with the 100%/75% benefit percentage option.

D. Network charges apply to the Network deductible and benefit percentage. Non-Network charges apply to the Non-Network deductible and benefit percentage.

E. Maximum Lifetime Benefit: $5,000,000 per family member

F. Miscellaneous Benefits:
1. Accident benefit: Deductible is waived and covered charges related to the injury are paid at the benefit percentage shown on the policy schedule, after any applicable copayment, for services incurred if treatment provided within 30 days of date of injury. The deductible will be applied to any covered charges incurred after the 30-day limit has been met.
2. Physician's services (including x-ray and laboratory performed in the office): Subject to deductible and benefit percentage.
3. Allergy injections: Subject to deductible and benefit percentage
4. Preventive care: $1,000 calendar year maximum, subject to deductible and benefit percentage except where mandated by state law.
5. Emergency room services: Subject to $250 copay, and network deductible and benefit percentage. Copay waived if admitted to hospital within 24 hours.
6. Prescription drug discount card
7. Accidental Death and Dismemberment
   a. Primary Insured: $10,000
   b. Spouse: $2,500
   c. Dependent Children: $1,000 each

G. Optional Benefits
1. Gold Benefits Package
   a. Physician's services in office
      i. Deductibles less than $5,000: $30 copay
      ii. Deductibles $5,000 and greater: $40 copay
      iii. Non-Network: Non-Network deductible and benefit percentage
   b. Physician's services in urgent care centers
      i. Deductibles less than $5,000: $60 copay
      ii. Deductibles $5,000 and greater: $80 copay
      iii. Non-Network: Non-Network deductible and benefit percentage
   c. Allergy injections: Covered at 100%, no copay applies

   d. Preventive care: Office visit copay, then 100% up to $1,000 calendar year maximum except when mandated by state law
   e. Emergency room services: Subject to $150 copay, and network deductible and benefit percentage. Copay waived if admitted to hospital within 24 hours.
2. Prescription Drug Coverage Options
   a. Option A – Generics only (Form AR-RX-GENERIC09-AR): 20% copay ($15 minimum; mail order $45 minimum)
   b. Option B – Four Tier Coverage (Form AR-RX-TIER09-AR)
      i. $250 deductible (waived for Generic)
      ii. Generic: 20% copay ($15 minimum; mail order $45 minimum)
      iii. Select Brand: 30% copay ($30 minimum; mail order $90 minimum)
      iv. Additional Brand: 50% copay ($60 minimum; mail order $180 minimum)
      v. Specialty: 25% copay, $250 maximum copay per prescription; $2,500 out-of-pocket maximum per calendar year
3. Dental Benefit Rider (Form 650DR)
   a. $1,000 maximum per person per calendar year
   b. Type 1 procedures: 6 month waiting period; charges are covered at 80%
   c. Type 2 procedures: 12 month waiting period; charges subject to $100 calendar year deductible and are covered at 50%

IV. Development of Rates

The rates for this product were generated on historical national claims experience from ACMIC and adjusted to reflect trend, benefits, geography and the anticipated morbidity of the population. The following is a summary of the methodology used to generate these rates.

The base rates were developed using ACMIC historical experience from calendar year 2007 from a policy form expected to attract a similar population. The historical allowed claims were divided by the corresponding member months to generate an allowed cost per member per month (PMPM). These costs were then trended forward to the period of the rates using trend consistent with ACMIC experience.

Next, the allowed claim cost PMPM was adjusted to reflect the benefit differences of this product. These benefit adjustment factors include utilization adjustments as well as the pure cost of the benefit in the determination of the rate. These adjustments are based on information provided by ACMIC as well as information in our proprietary database.

The costs PMPM were next modified to reflect the costs and utilization inherent in Arkansas. Area factors are applied to generate rates. In addition, the level of the provider reimbursements were taken into account and the rates were further adjusted.

Administrative costs, commissions, net investment income and profit loads were added to the claim costs to generate rates for this product.

These rates are subject to individual underwriting. As such, we anticipate the effect of underwriting will wear-off over time. In our calculation of the lifetime loss ratio, we anticipate the underwriting wear-off will occur by the fourth duration.

Market adjustments have been applied where competitively necessary.

Expected Average Annual Base Premium per Individual: $1,300

The anticipated lifetime loss ratio for this policy for is expected to exceed 50%. The company anticipates managing this product to a 61% lifetime loss ratio. In the development of the lifetime loss ratio, we have included the impact of the underwriting wear-off, future trend assumptions and rate increases, lapse assumptions consistent with ACMIC historical experience, interest and selection.

V. Past Experience

Policy Form IND09 is a new policy form. No policies have been issued.

VI. Mental Health Parity Exemption

Exhibit A attached to this actuarial memorandum provides the demonstration that this product would qualify for the mental health parity exemption. As the cost of providing mental health parity benefits would exceed 1.5% of the total premium, we are using the exemption requirements to provide mental health benefits at a level less than parity. This is in accordance with Arkansas Code 23-99-505.

VII. Certification

In my opinion and to the best of my knowledge and judgment, this rate filing is in compliance with the applicable laws and regulations of this state, and the premiums are reasonable in relation to the benefits. The premium rates are not excessive, inadequate, or unfairly discriminatory.

It is anticipated that the lifetime loss ratio will equal or exceed 50%. Therefore, I believe the benefits provided are reasonable in relation to the premium charged.

Beth R. Fritchen

September 26, 2008

Beth R. Fritchen, FSA, MAAA

Date

EXHIBIT A

American Community Mutual Insurance Company
Arkansas Mental Health Parity Rider Pricing

All highlighted values from 2005 Milliman Health Cost Guidelines Basic Tables and Commercial Area Factors

Level of Healthcare Management 25%

Benefit	Nationwide Utilization per 1,000			Nationwide Average Charge		Net Nationwide Per Member Per Month Net Claim Cost			Arkansas Area Factors Adjustments		Arkansas Adjusted Net PMPM Net Claim Cost
	Loosely Managed	Well Managed		Loosely Managed	Well Managed	Loosely Managed	Well Managed	Weighted	Utilization Adjustment	Charge Adjustment	
Hospital Inpatient - Non-Maternity											
Psychiatric	26.0	6.8	days	$1,366.51	$1,384.06	$2.96	$0.78	$2.42	1.21	0.75	**$2.19**
Inpatient Visits											
Psychiatric	34.0	13.0	visits	$194.04	$217.09	$0.55	$0.24	$0.47	1.21	0.89	**$0.51**
Other Physician Services											
Outpatient Psychiatric	349.0	209.0	visits	$135.51	$136.57	$3.94	$2.38	$3.55	0.88	0.89	$2.78
Current plan covers outpatient Mental Health Care up to $1,000 max, so an adjustment needs to be made to include portion not covered*											0.374
											$1.04
										Unadjusted PMPM	**$3.74**

Adjustments

Trend Adjustment (at 14% annually from 2005 to a projection period of 1/1/09 - 12/31/09)	1.689
Cost Sharing Adjustment** (most popular PPO plan; $1,000 deductible, 80% benefit, $10,000 stop-loss)	0.626
Average State Network Discount (assumes 90% in-network utilization / 10% out-of-network with 5% discount)	0.672
Selection Adjustment (assume this would be a highly selected against benefit if it is optional)	2.000
Adjusted PMPM	**$5.31**

* Adjustment calculated using Claim Probability Distribution Table 15 (Psychiatric and Alcohol & Drug Abuse) from 2005 Milliman Health Cost Guidelines
** Cost Sharing Adjustment calculated using Claim Probability Distribution Tables 17B (Other than Maternity) and 15 (Psychatric and Alcohol & Drug Abuse) from 2005 Milliman Health Cost Guidelines

Monthly Rate Calculation for Male Age 40 in Little Rock (Pulaski County) on most popular plan:

Base Rate (1/1/2009)	129.71
Trend to midpoint of projection period	1.0615
State factor	0.77
Product factor (OLYM)	1.00
Deductible factor ($1,000)	1.15
Benefit % Factor (80%)	1.00
Coinsurance Maximum ($10,000)	1.00
Age factor (male age 40)	1.40
Non-smoker factor	1.00
County factor (Pulaski county)	1.05
Network factor (FH, Pulaski county)	0.64
Total Monthly Rate	**114.71**

Rider as a percentage of rate **4.6%** ◄ greater than a 1.5% increase

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

[Olympic]
Preferred Provider Option (PPO)
Arkansas - 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. Basic hospital or basic medical insurance coverage is not provided.

COVERED CHARGES

[Olympic] 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: 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.

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

PLAN CHOICE	**[Olympic] 100**		**[Olympic] 80**		**[Olympic] 60**	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
DEDUCTIBLES						
Individual Calendar Year Deductible	[$5,000 $7,500 $10,000]	[$10,000 $15,000 $20,000]	[$1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$2,000 $3,000 $5,000 $7,000 $10,000 $15,000]	[$500 $1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$1,000 $2,000 $3,000 $5,000 $7,000 $10,000 $15,000]

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%]	[75% of $10,000]	[80% of $10,000]	[55% of $10,000]	[80% of $20,000]	[55% of $20,000]	[60% of $10,000]	[50% of $20,000]	[60% of $20,000]	[50% of $20,000]
Individual Out-of-Pocket Maximums (Includes deductible)	**Network [100%]**	**Non-Net [75% of $10,000]**	**Network [80% of $10,000]**	**Non-Net [55% of $10,000]**	**Network [80% of $20,000]**	**Non-Net [55% 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 $7,500 $10,000]	[$12,500 $17,500 $22,500]	[$3,000 $3,500 $4,500 $5,500 $7,000 $9,500]	[$6,500 $7,500 $9,500 $11,500 $14,500 $19,500]	[$5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $14,000 $16,000 $19,000 $24,000]	[$4,500 $5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]	[$8,500 $9,000 $9,500 $10,500 $11,500 $13,000 $15,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]

Family Calendar Year Deductible and Family Out-of-Pocket Maximum	Family deductible is 2 times the individual deductible, met collectively by 2 or more persons. A family member begins receiving benefits after his/her individual deductible amount has been met or the family deductible has been met, whichever occurs first. Family Out of Pocket maximum is 2 times the individual Out-of-Pocket maximum, met collectively by 2 or more persons.

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	[First Health Network]

ACCIDENT BENEFIT	
Accident	If a family member sustains an injury, we will waive the deductible (copayments 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.

	[Olympic] 100		**[Olympic] 80**		**[Olympic] 60**	
PHYSICIAN SERVICES	**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 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	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)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]						

	[Olympic] 100		[Olympic] 80		[Olympic] 60	
PREVENTIVE CARE SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Human papillomavirus (HPV) Immunizations; Bone Density Test; Colorectal Cancer Exams; Lab work sent to an independent lab; all other preventive care services not specified elsewhere in the policy	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
[$1,000 Calendar Year maximum per family member] for the following services: Immunizations (except HPV) & Routine Physical Exams (age 19 and older); PSA Testing & Exams; Routine Mammograms; Pap Smears; Lab work performed in the office						
Childhood Immunizations (except HPV) (Birth through age 18)	100%	100%	100%	100%	100%	100%
Well Child Care (from birth through age 18)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
HOSPITAL SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Inpatient **Non-emergency admissions**	Deductible, then we pay 100%	[$500] copay per admission, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per admission, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per admission, 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%	[$500] copay per surgery, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per surgery, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per surgery, then Deductible, then we pay 50%
Diagnostic Services Pre-admission Testing; X-rays; Nuclear Medicine; Ultrasounds; M.R.I.; Non-routine Mammograms; Lab Tests	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%

	[Olympic] 100		[Olympic] 80		[Olympic] 60	
EMERGENCY ROOM	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Emergency Injury Copay waived if admitted to hospital within 24 hours See Accident Benefit on page 2 **Emergency Sickness** Copay waived if admitted to hospital within 24 hours	[$250] copay per visit, then Deductible, then we pay 100%	[$250] copay per visit, then **Network** Deductible, then we pay 100%	[$250] copay per visit, then Deductible, then we pay 80%	[$250] copay per visit then **Network** Deductible, then we pay 80%	[$250] copay per visit, then Deductible, then we pay 60%	[$250] copay per visit, then **Network** Deductible, then we pay 60%
Non-emergency Sickness or Injury	Not Covered					
OTHER COVERED SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Air Ambulance	Network Deductible, then 80% Charges do not apply to out of pocket maximums and will be paid at 80% even after the out of pocket maximum has been met.					
Ambulance (other than air ambulance)	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 type of therapy] **Home Health Care** [20 visits per family member per Calendar Year] **Hospice** Up to [$200 per day, a lifetime maximum of $10,000 or 6 months, whichever comes first] **Skilled Nursing Facility** [60 days per family member per Calendar Year]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Durable Medical Equipment	Deductible, then 50% Charges do not apply to out of pocket maximums and will be paid at 50% even after the out of pocket maximum has been met.					
Organ Transplants: Combined maximum lifetime benefit of [$1 million] per person **Designated Transplant Facility:** [$1 million] maximum benefit **Non-designated Transplant Facility:** [$750,000] maximum benefit	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Maternity	Not Covered					
Mental Health	Not Covered					

OTHER COVERED SERVICES	
Accidental Death and Dismemberment	Primary Insured [$10,000]; Spouse [$2,500]; and Dependent Children [$1,000] (Full Amounts)

OPTIONAL BENEFITS	
GOLD BENEFITS	
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500-$3,500] the copay is [$30] Deductibles of [$5,000-$10,000] the copay is [$40] Non-Network: Non-Network Deductible and Benefit Percentage
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500 - $3,500] the copay is [$60] Deductibles of [$5,000 - $10,000] the copay is [$80] Non-Network: Non-Network Deductible and Benefit Percentage
Allergy Injections	Network: 100% - Office Visit Copay does not apply Non-Network: Non-Network Deductible and Benefit Percentage
Preventive Care Immunizations (except HPV) & Routine Physical Exams (age 19 and older); Routine Mammograms; PSA Testing & Exams; Pap Smears; Lab work performed in the office The following will not be applied to or limited by the [$1,000] maximum: Well Child Care from birth through age 18	Network: Office Visit Copay, then we pay 100% up to [$1,000 calendar year maximum per family member] Non-Network: Non-Network Deductible and Benefit Percentage
Childhood Immunizations (except HPV) from birth through age 18	Network & Non-Network: 100%
Human papillomavirus (HVP) immunizations; Bone Density Tests; Colorectal Cancer Exams; Lab work sent to an independent lab; All other preventive care services not specified elsewhere in the policy	Network: Deductible, then we pay 100%, 80% or 60% based on plan chosen. Non-Network: Non-Network Deductible and Benefit Percentage
Emergency Room - Emergency Sickness or Injury	[$150] Copay per visit, then Network Deductible and Benefit Percentage Copay waived if admitted to hospital within 24 hours Non-emergency sickness or injury is not covered.

PRESCRIPTION DRUG OPTIONS

GENERIC PLAN OPTION		
	Retail	**Mail Order**
Generic Drugs Only	Up to [30-day] supply [20%] copay per prescription or refill [$15] Minimum	Up to [90-day] supply [20%] copay per prescription or refill [$45] Minimum
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy.		
Contraceptive Drugs and Devices are covered		

FOUR TIER PLAN OPTION		
Individual Prescription Drug Deductible: [$250] per Calendar Year Individual Out of Pocket Maximum for Specialty Drugs: [$2,500] per Calendar Year		
Family prescription drug deductible is 2 times the individual prescription drugs deductible, met collectively by 2 or more persons. A family member begins receiving prescription drug benefits after his/her individual prescription drug deductible amount has been met or the family prescription drug deductible has been met, whichever occurs first. Family Out of Pocket maximum for Specialty Drugs is 2 times the individual Out-of-Pocket maximum for Specialty Drugs, met collectively by 2 or more persons.		
	Retail Up to [30-day] supply	**Mail Order** Up to [90-day] supply
Generic Drugs & Diabetic Supplies:	[20%] copay per prescription or refill [$15] Minimum	[20%] copay per prescription or refill [$45] Minimum
Select Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$30] Minimum	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$90] Minimum
Additional Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$60] Minimum	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$180] Minimum
Specialty Drugs:	Subject to Prescription Drug Deductible, then [25%] copayment per prescription or refill (maximum [$250]) up to the Out of Pocket Maximum shown above, then 100% Up to [30 day] supply	
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy. Specialty Drug benefits only apply at a Participating Specialty Pharmacy. No benefits are payable if a Specialty Drug is purchased at any other pharmacy.		
Mandatory Generic Provision If an Additional Brand Name Drug or Select Brand Name Drug is chosen when a Generic Drug is available, then the family member is responsible for the Generic Drug copay plus the difference between the cost of the Additional Brand Name Drug or Select Brand Name Drug and the cost of the Generic Drug and any deductible.		
Contraceptive Drugs and Devices are covered		

DENTAL OPTION

Dental Benefit [$1,000] calendar year maximum	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%

COVERED CHARGES

1) Daily hospital room and board:
   a. 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.
   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.
3) Surgical services:
   a. Surgeon's medical care or surgery. If two or more procedures are performed at the same operative session, the most We will pay:
      (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. Hospital Inpatient post mastectomy care of not less than 48 hours, however, the attending Physician after consulting with the Family Member may approve a shortened length of Hospital Inpatient stay.
   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. **Skilled Nursing Care** - Room and board, nursing care, medical services and supplies while Confined in a Skilled Nursing Facility covered at [60 days per calendar year].
   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 $10,000 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; and respite care
   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.
   e. **Preventive Care** - Covered Charges are subject to a maximum benefit of [$1,000 per calendar year] include the following:
      (1) Routine physical exams including lab services not sent to an independent lab, for a Family Member age 19 and older;
      (2) Immunizations, other than the human papillomavirus immunization for a Family Member age19 and older;
      (3) An annual Prostate-Specific Antigen (PSA) blood test and Digital Rectal Examination upon the recommendation of a licensed Physician for:
         (a) All males age 50 and over; and
         (b) Males age 40 and over with a family history of prostate cancer or men at risk;
      (4) An annual cervical smear or pap smear;
      (5) Routine mammograms, limited to:
         (a) One mammogram between the ages of 35 and 39;
         (b) One mammogram per year after age 39; and
         (c) One mammogram per year for women at risk.

      Covered Charges not subject to the Preventive Care Maximum include the following services:
      (1) Colorectal cancer screening for a Family Member who is:
         (a) Age 50 or older;
         (b) Less that age 50 who is at high risk for colorectal cancer according to the American Cancer Society guidelines for colorectal cancer screening; or
         (c) Experiencing symptoms of colorectal cancer as determined by a Physician.

         Covered Charges for colorectal cancer screening include the following:
         (a) An annual fecal occult blood test, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
         (b) A double-contract barium enema every 5 years; or
         (c) A colonoscopy every 10 years; and
         (d) Any additional medically recognized screening tests required by the Director of the Department of Health, determined in

consultation with appropriate health care organizations.

(2) Well child care benefits for a Family Member from birth through 18 years of age. Covered Charges for well child care must be rendered by or under the supervision of a single Physician during the course of one visit and include the following:
   (a) A medical history;
   (b) A complete physical exam;
   (c) A developmental assessment;
   (d) Anticipatory guidance;
   (e) *****Age appropriate immunizations, other than the Human papillomavirus (HPV) immunization; and
   (f) Appropriate laboratory test(s).

   *** Age appropriate immunizations are not subject to the Deductible, Benefit Percentage or Preventive Care maximum benefit. Immunizations will be covered at 100%.**

(3) Human papillomavirus (HPV) immunizations;
(4) Bone density tests;
(5) Lab work sent to an independent lab; and
(6) All other preventive services not specifically shown elsewhere in the policy.

f. **Physical, Occupational & Speech Therapy** - Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury. Services are limited to a maximum of [20 visits per calendar year per type of therapy].

g. **Outpatient spinal manipulation -** 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** - Services are subject to a maximum benefit of [$500 per calendar year].

i. **Allergy Injections**.

7) Other Benefits:

a. Injectable Prescription Drugs are covered subject the 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 is included in the policy and provides coverage for Generic Drugs only, then injectable Prescription Drugs are covered subject to the policy's Deductible and Benefit Percentage.
   If the Outpatient Prescription Drug Benefit Rider is included in the policy and provides coverage for Specialty Drugs, then injectable Prescription Drugs that are administered in a Physician's office are covered subject to the policy's Deductible and Benefit Percentage.

b. Prosthetics, except myo-electric or microprocessor prosthetics and dental prosthetics.

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 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. 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.

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. Coverage also includes reconstructive surgery of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

h. Contraceptive drugs and devices approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the terms, conditions and limitations contained on the Outpatient Prescription Drug Program Benefit Rider.

i. Contraceptive devices that are surgically implanted and are approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the Benefit Provisions section of the policy and are not covered under the Outpatient Prescription Drug Benefit Rider.

j. Treatment of Type 1, Type 2, and gestational diabetes, if determined to be Medically Necessary and prescribed by a licensed Physician, including the following equipment, supplies and appliances:
   (1) Blood glucose monitors and blood glucose monitors for the legally blind;
   (2) Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
   (3) Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
   (4) Insulin;
   (5) Injection aids;
   (6) Syringes, including pen-like insulin injection devices and pen needles;
   (7) Insulin pumps and appurtenances which include insulin infusion pumps and supplies such as skin

preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;

(8) Oral agents for controlling the blood sugar level, which are Prescription Drugs;

(9) Podiatric appliances for prevention of complication associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and

(10) Glucagon emergency kits and Injectable glucagon.

k. Diabetes Self-Management Training must be provided by an appropriately licensed health care professional in accordance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Covered Charges is limited to:

(1) One training session per lifetime;

(2) Additional training sessions that are Medically Necessary because of a significant change in the Family Member's symptoms or condition and are order in writing by a Physician.

l. Medically Necessary Treatment of loss or impairment of speech or hearing, including communicative disorders generally treated by a speech pathologist or audiologist. Coverage does not include hearing instruments or devices.

m. Medical Foods and Low Protein Modified Food Products that are prescribed as Medically Necessary for the therapeutic treatment of a Family Member inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism. To be covered under the policy, the food products must be administered under the direction of a licensed Physician and the cost of the food products must exceed the income tax credit of $2,400 per year per person as allowed by Arkansas law.

n. The following care and Treatment of Your newborn child, provided the child is covered under the policy from the moment of birth as described under the Addition of a Newborn Child provision contained in the policy:

(1) Testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants that may be mandated by Arkansas law in the future.

(2) Treatment related to a premature birth.

(3) Routine nursery care and pediatric charges for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

o. Medically Necessary diagnosis and Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorders. Treatment includes both surgical and non-surgical procedures whether prescribed or administered by a Physician or a dentist.

p. General anesthetics and Hospital or ambulatory surgical treatment center facility charges incurred when dental care is provided for the following Family Members:

(1) A child age 6 or under;

(2) A person with a diagnosed serious mental or physical condition; or

(3) A person with a diagnosed significant behavioral problem as determined by an Arkansas licensed attending physician.

8) <u>Organ Transplants</u>

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 [$750,000].

c. Covered Charges include Approved Transplant Procedures which are 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. If any benefits remain and are available under the Policy after the recipient's expenses have been paid, medical expenses of a live donor will be reimbursed.

f. Only approved Transplant Procedures are covered. No benefits will be paid if the transplant procedure is not approved in advance.

10) <u>Accidental Death</u> (including dismemberment and loss of sight) provides the following full amounts of insurance:

a. Primary Insured: [$10,000]

b. Spouse: [$2,500]

c. Child: [$1,000]

Benefits are payable if the loss results from an accidental bodily injury which occurred while insured under the policy; was independent of all other causes; and the loss occurs within 90 days after the accident bodily injury. However, benefits will be paid if use of extraordinary life support systems delays the loss for more than 90 days from the date of the accidental 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.

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.

PRE-EXISTING CONDITIONS LIMITATION
We will pay no benefits for charges due to a Pre-existing Condition for 3 years starting on the Effective Date of a Family Member's coverage under the policy.

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

We will pay no charges, including the diagnosis and/or Treatment, due to any of the following. These charges are not Covered Charges and cannot be used to satisfy the policy's Deductible, Copayments or Benefit Percentage.

1. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.
2. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
3. Charges for an Injury received while committing or attempting to commit a felony.
4. Charges caused by or contributed to by war or any act of war, whether or not declared, or participation in a riot or insurrection.
5. Charges for any Sickness contracted or Injury sustained while a member of the Military, Navy, or Air Force of any country or combination of countries.
6. Charges for any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, except for Medicaid.
7. Charges for Treatment of Sickness or Injury covered by workers' compensation insurance or similar laws.
8. 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.
9. Charges for services or supplies for personal comfort or convenience.
10. Charges for travel or lodging expenses.
11. Charges for maintenance care, Custodial Care or homemaker services.
12. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.
13. Charges for dental services, supplies, or Prosthetics 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.
14. Charges for 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.
    b. Due to mastectomy as provided under the Medical Benefits section of the policy.
    c. Due to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.
15. Charges for 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. 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, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury, except as provided under the Medical Benefits section of the policy.
17. 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.
18. 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.
19. Charges for care of a well, newborn child, except as provided under the Medical Benefits or Preventive Care Benefits section of the policy.
20. Charges for contraceptives, contraceptive methods or aids, unless the Schedule shows that the Outpatient Prescription Drug Benefit Rider is included in the policy.
21. Charges for emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
22. 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, in vitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.
23. Charges for gender reassignment or charges due to complications of gender reassignment.
24. Charges for the diagnosis and/or Treatment of acne.

25. Charges for the diagnosis and/or Treatment of eating disorders.
26. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.
27. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and nonchemical addictions.
28. Charges for hair loss, hair restoration or removal.
29. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.
30. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.
31. Charges for the diagnosis and/or Treatment of Substance Abuse.
32. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.
33. Charges for transplants, except as provided under the Medical Benefits section of the policy.
34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.
36. Charges for the 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.
37. Charges for court-ordered evaluation, Treatment or testing.
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.
41. Charges for services available in the community through educational or school programs.
42. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.
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, except podiatric appliances for prevention of complications associated with diabetes, as provided under the Medical Benefits section of the policy.
45. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
46. Charges for the 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 telephone or electronic mail.
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 Treatment of an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to the following:
    a. Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
    b. Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.
52. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.
53. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.
54. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of the policy.
55. 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, reike therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
56. Charges for myo-electric or microprocessor Prosthetics.
57. 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.
58. 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.
59. 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.
60. Charges for which benefits are not provided in the policy.

PRESCRIPTION DRUG PROGRAM EXCLUSIONS

We will pay no benefits for charges due to any of the following:

1. Brand Name Drugs (this exclusion applies to the Generic Drug Plan only).
2. Prescription Drugs used to treat medical conditions that have been excluded from coverage by amendment or rider to the policy;
3. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy;

4. Non-federal legend drugs;
5. Contraceptive medications or devices that are not approved by the United States Food and Drug Administration for use as a contraceptive;
6. Contraceptive devices that are surgically implanted;
7. Fertility agents and medications;
8. Injectable or any prescription directing parenteral administration or use, except insulin (this exclusion applies to the Generic Drug Plan only);
9. Emergency contraception kits or any drugs that are intended to induce abortion;
10. Antidepressants;
11. Tranquilizers;
12. Miscellaneous psychotherapeutic agents;
13. Benzodiazepines;
14. Anti-manic agents;
15. Drugs to treat Attention Deficit Hyperactivity Disorder;
16. Substance abuse treatment agents;
17. Oral and topical acne medications;
18. Smoking deterrents;
19. All anti-obesity preparations;
20. Amphetamines;
21. Legend vitamins and fluoride products;
22. Drugs to treat influenza or lessen its symptoms;
23. Therapeutic devices or appliances;
24. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
25. Immunization agents and vaccines;
26. Biologicals, blood or blood plasma;
27. Off-label use of prescription drugs except when insurance coverage is required by law;
28. Drugs labeled "Caution - limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
29. 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;
30. 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;
31. 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;
32. 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;
33. Charges for the administration or injection of any drug;
34. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
35. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
36. 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;
37. Drugs for Treatment of onychomycosis (nail fungus);
38. Drugs for Treatment of impotency;
39. Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose;
40. Drugs to treat a cough or cold or lessen its symptoms;
41. Drugs to treat a migraine or headache;
42. Drugs not listed on the Formulary; and
43. Proton Pump Inhibitors.

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.

ACCIDENTAL DEATH EXCLUSIONS

No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

1. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;
2. Insurrection, riot or war;
3. The committing of, or the attempt to commit, an assault or felony;
4. Disease or disorder of the body or mind;
5. Medical or surgical treatment or diagnosis, preventive care or complications of care;
6. The voluntary taking of drugs (except drugs taken as prescribed by a physician) or poison; or inhaling of gas or other inhalants;
7. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or
8. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of an accidental wound).

COORDINATION OF BENEFITS (COB)

COB may limit benefits when a Family Member is entitled to benefits from more than one source. It does this by relating the Family Member's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of a Family Member's Allowable Expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out in the

policy, so that from all sources, a Family Member will not be paid for more than 100% of his or her Allowable Expenses.

ELIGIBILITY

The following persons are eligible to be Family Members:

1. You;
2. Your spouse; and
3. Your and Your spouse's children and adopted children, provided they are:
   a. not married,
   b. dependent on You for at least 50% of their support, and
   c. less than 22 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.

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 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 Renewal Date after Your marriage is dissolved; (2) Your child's coverage ends on the first Renewal Date after the date the child attains age 23, marries, or is no longer dependent upon you for at least 50% of their support, whichever is earliest; (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 outpatient prescription drug 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 actually dependent on You for a majority of their support, and covered by the policy on the date immediately preceding the day their coverage would have ended due to age. We may ask for proof of incapacity and dependency annually.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the date the child becomes capable of self-support, (2) the date the child's coverage under the policy ends for any reason other than age, (3) the date the policy ends; or (4) the date a Covered Charge is incurred if, as part of the required proof of loss, We ask for proof of the child's status and You fail to provide proof that as of the date the expense was incurred the child remains mentally or physically incapable of earning their own living and actually dependent on You for a majority of their support.

CONVERSION

We will issue a new policy to insure a Family Member whose coverage ends for any reason described in sections (1) and (2) of the End of Coverage provision. The new policy will be issued on this policy form. The premium will be based on the table of rates for the Family Member's age and sex.

We must receive a written request and the first premium:

1. Within 31 days after the coverage ends; or
2. In the case of dissolution of marriage, within 60 days from the date of the judgment granting the dissolution, 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

Pre-existing condition means a medical condition, for which, prior to the Effective Date of coverage: (1) the Family Member received medical advice or Treatment from a Physician within 60 months before the Effective Date of coverage, (2) medical advice or

Treatment was recommended by a Physician within 60 months before the Effective Date of coverage; or (3) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or Treatment within 60 months before the Effective Date of the Family Member's coverage under this policy.

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.

Arkansas Statement of Variability
IND09 et al

Form: IND09

Face Page

- Our contact information is bracketed in case this information changes.

Consumer Information Notice

- Our contact information is bracketed in case this information changes.
- Agent contact information is bracketed because this will vary from policy to policy.
- Arkansas Insurance Department contact information is bracketed in case this information changes.

Table of Contents

- The entire page is bracketed in case pagination changes due to policy issue system.

Schedule

- Page 3:
  - There are 5 versions of Page 3 included in the filing to show all of the plan options available to policyholders. Notes are included in the right footer for clarification.
  - The Benefit Period line will either appear or not appear in the policy. The start and end dates will vary for each policyholder, but it will always be a 12-month period.
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - The bracketed text in the deductibles, benefit percentages, and out-of-pocket maximums show all of the current options available to policyholders.
  - The bracketed numbers in the asterisk paragraph shows the worst benefit that will be used.
  - All other bracketed material will vary for each policyholder.

- Page 3(a):
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - Maximum Benefit Section:
    - All bracketed material shows the worst benefit that will be used.
  - Optional Benefits Section:
    - Dental - The first sentence will show either "Included" or "Not Included." The second sentence will only appear if the policyholder chooses the optional dental benefit.
    - Outpatient Prescription Drugs - The first sentence will show either "Included" or "Not Included." The second sentence will only appear if the policyholder chooses the optional Outpatient Prescription Drugs benefit.

Form: IND09 - continued

- Page 3(b):
  - The name at the top right corner of the page will be the primary insured's name, so it varies from policy to policy.
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - Office Visits:
    - If the optional Gold Benefits Package **is not** selected, the network benefit will be "Subject to Network Deductible & Benefit Percentage."
    - If the optional Gold Benefits Package **is** selected, the network benefit will be "[$30/$40] Copayment per visit, then 100%." The copayment varies depending on the deductible that is chosen by the policyholder.
  - Urgent Care Center Visits:
    - If the optional Gold Benefits Package **is not** selected, the network benefit will be "Subject to Network Deductible & Benefit Percentage."
    - If the optional Gold Benefits Package **is** selected, the network benefit will be "[$60/$80] Copayment per visit, then 100%." The copayment varies depending on the deductible that is chosen by the policyholder.
  - Allergy Injections
    - If the optional Gold Benefits Package **is not** selected, the network benefit will be "Subject to Network Deductible & Benefit Percentage."
    - If the optional Gold Benefits Package **is** selected, the network benefit will be 100%.
- Page 3(c):
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - Preventive Care:
    - If the optional Gold Benefits Package **is not** selected, the network benefit will be "Subject to Network Deductible & Benefit Percentage."
    - If the optional Gold Benefits Package **is** selected, the network benefit for some of the benefits will be "[$30/$40] Copayment per visit, then 100%." The copayment varies depending on the deductible that is chosen by the policyholder.
  - All other bracketed material shows the worst benefit that will be used.

- Page 3(d):
  - The name at the top right corner of the page will be the primary insured's name, so it varies from policy to policy.
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - Emergency Room: If the optional Gold Benefits Package **is not** selected, the copay will be $250. If the optional Gold Benefits Package **is** selected, the copay will be $150.
  - All other bracketed material shows the worst benefit that will be used.

Form: IND09 - continued

- Page 3(e)
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - All other bracketed material shows the worst benefit that will be used.

- Page 3(f)
  - The name at the top right corner of the page will be the primary insured's name, so it varies from policy to policy.
  - The phrase "Calendar Year/Benefit Period" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - All other bracketed material shows the worst benefit that will be used.

- Page 3(g)
  - All bracketed material shows the worst benefit that will be used.

Definitions

- Page 4:
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - The definition of "Benefit Period" will only appear in the policy if applicable.
- Page 6: The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
- Page 8: The Home Office definition shows the city and state bracketed in case this changes.
- Page 11: The bracketed text in the Pre-existing Condition definition may or may not appear.
- Page 12: The definition of Schedule includes brackets in case pagination varies within our policy issue system.

Benefit Provisions

- Pages 14 & 15:
  - The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."
  - All other bracketed material shows the worst benefit that will be used.

Prior Notification Requirements

- Page 16: The telephone number is bracketed in case it changes.

General Exclusions

- Page 32: #60 may or may not appear in the policy. The subsequent item may be renumbered.

Form: IND09 - continued

General Provisions

- Page 33: The dependent child age limit has been bracketed in case we decide to raise the age limit. It will never be lower than the ages shown.
- Page 35: The contact telephone number is bracketed in case this changes.

Coordination of Benefits

- Page 37: The phrase "Calendar Year" is bracketed throughout the policy. It will either be "Calendar Year" or "Benefit Period."

Standard Provisions

- Pages 41 and 43: All bracketing is used for administrative purposes only.
- All other bracketing is used for administrative purposes only.

Back Page

- All bracketing on this page is used for administrative purposes only.

Form: AR-RX-GENERIC09-AR, Outpatient Prescription Drug Rider-Generic Drugs Only

- The phrase "Calendar Year" is bracketed throughout the rider. It will either be "Calendar Year" or "Benefit Period."
- Page 1: The definition of formulary may or may not appear in the rider.
- Page 2: The phrase "and listed on the Formulary" may or may not appear in the rider.
- Page 3: Items 39 through 45 may or may not appear in the rider. The subsequent items may be renumbered.
- The bracketing on the Rider Schedule shows the worst benefits that will be used.
- All other bracketing is used for administrative purposes only.

Form: AR-RX-TIER09-AR, Outpatient Prescription Drug Rider

- The phrase "Calendar Year" is bracketed throughout the rider. It will either be "Calendar Year" or "Benefit Period."
- Page 2: The definition of formulary may or may not appear in the rider.
- Page 3: The phrase "listed on the Formulary" may or may not appear in the rider.
- Page 5: Items 37 through 43 may or may not appear in the rider. The subsequent items may be renumbered.
- The bracketing on the Rider Schedule shows the worst benefits that will be used.
- All other bracketing is used for administrative purposes only.

Form: 650DR, Dental Benefit Rider

- The phrase "Benefit Period/Calendar Year" is bracketed throughout the rider. It will either be "Calendar Year" or "Benefit Period."
- The Rider Effective Date is bracketed because it will vary by policyholder.
- The bracketing on the Rider Schedule shows the worst benefit that will be used.
- All other bracketing is used for administrative purposes only.

Form: AR HA-1 (1/09), Application for Individual Health Insurance

- The maximum dependent age is bracketed in case we decide to raise the age limit. It will never be lower than the ages shown.
- The references to students under Item B are bracketed because we may or may not offer a discounted rate to full-time students.
- All other bracketed text (pages 1, 2, & privacy notice) is for administrative purposes only.

Form: MCCR-95, Minor Child Coverage Rider

- All bracketing is used for administrative purposes only.

Form: EXR-04/99, Exclusion Rider

- All bracketing after the signature block is used for administrative purposes only.
- All other bracketing varies by policyholder.
- The paragraph in the middle will list the condition(s) and/or body part(s) that are excluded from coverage:

  An example of an exclusion of a body part would be: "Any disease or disorder of the right knee, including diagnostic testing, procedures, treatment, surgery, and complications thereof."

  We would use this type of exclusion with respect to an applicant with any combination of the following:

  (a) A history of problems with the named body part that can lead to future complications. *For example:* A history of injuries to the right knee, therefore there is reason to believe that the knee is weakened and can easily suffer future injury.

  (b) A current problem with a diagnosis that is commonly subjected to re-diagnosis. *For example:* A current diagnosis of bursitis in the right knee. A bursitis diagnosis can easily be re-diagnosed as tendonitis or even arthritis.

  (c) Current symptoms of a problem that has not yet been diagnosed. *For example:* The applicant reports that his right knee regularly hurts, but that he has not yet consulted a doctor or that the doctor has simply treated the pain and not assigned a formal diagnosis.

Form: 33-41 R 99, Amendment of Application

- The center paragraph will list the change(s) to the application. This amendment is used for the following reasons:
  - To correct a mistake on the application, such as a misspelling or to correct height/weight if the applicant was unsure at the time of application;
  - To change the requested effective date; and
  - To remove an applicant's name if they withdraw or are declined.

- All other bracketing will vary by policyholder.

Form: 13-52 (4/89), Endorsement

- The endorsement includes all possible changes that policyholders can make to their coverage. This amendment is intended to be used with all of our products, so the bracketed amounts are just sample numbers.

- All other bracketing is for administrative purposes only.

Form: GP-AR (1/09), Internal Grievance & External Review Procedures

- All bracketing is used for administrative purposes only.

All bracketing on the following forms is for administrative purposes only.

33-133 605 4/93 - Application for Removal of Exclusion Rider
33-AAQ 3/07 - Allergy/Asthma Addendum
33-ADQ 3/07 - Alcohol & Drug Addendum
33-APHQ 6/08 - Abnormal Pap/HPV Addendum
33-ARQ 6/08 - Arthritis Addendum
33-CATQ 6/08 - Cataracts Addendum
33-CSQ 3/07 - Cesarean Section Addendum
33-CTUQ 6/08 - Carpal/Ulnar Tunnel Addendum
33-EAQ 6/08 - Otitis Media/Ear Addendum
33-GHDUQ 6/08 - GERD, Hiatal/Diaphragmatic Hernia, Ulcer Addendum
33-GIQ 6/08 - Gastrointestinal Addendum
33-HCLQ 3/07 - High Cholesterol/Lipids Addendum
33-HMQ 6/08 - Heart Murmur Addendum
33-HYPQ 6/08 - Hypertension Addendum
33-INFQ 6/08 - Infertility Addendum
33-JNTQ 6/08 - Joint Injury Addendum
33-KUQ - Kidney/Urinary Addendum
33-MHQ 6/08 - Mental Health Addendum
33-MIQ 6/08 - Migraine/Headache Addendum
33-SEQ 6/08 - Seizure/Epilepsy Addendum
33-SPQ 6/08 - Spinal Addendum
33-TCQ - Tumor/Cyst Addendum
33-THQ 6/08 - Thyroid Addendum

Form: AR OLYMPIC OOC 1/09, Outline of Coverage

Page 1
- Our contact information is bracketed in case this changes.
- The bracketed text in the deductibles, benefit percentages, and out-of-pocket maximums show all of the current options available to policyholders.

Page 2
- Network Available is bracketed in case the name of the network changes or we add new networks.
- All other bracketed material shows the worst benefits that will be used.

Pages 3 - 14
- All bracketed material shows the worst benefits that will be used.

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

October 3, 2008

Ms. Rosalind Minor
Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

Re: Objection letter dated 10/1/08

Dear Ms. Minor:

I appreciate your help in finding a quick resolve to the recent objections to our filing. In regard to Objection 1 and its resolution a revised Rate Sheet with the quarterly inflationary trend increase is attached.

In response to Objection 2, as we discussed in our phone conversation on October 2, 2009, Bulletin 9-85 specifies taking into consideration deductibles, co-pays and coinsurance when determining if policies meet the qualification that the network benefits do not exceed the non-network benefits by more than 25%. As indicated in the actuarial memorandum, the average annual premium on this product is $1,300 and the lifetime loss ratio is 61%. Therefore, the average annual benefit cost is $793. This annual benefit cost is determined by weighting the network and non-network benefit cost. The network benefit cost is $798 and will be utilized 90% of the time. The non-network benefit cost is $749 and will be utilized 10% of the time. The difference between the network and non-network benefit cost is 6.5%. We certify that this difference for all of our benefit plans is not more than 25% as required in Bulletin 9-85.

Sincerely,

Jeff Erickson
VP and Chief Actuary

39201 Seven Mile Road, Livonia, Michigan 48152
Phone: 800-991-2642 Fax: 734-591-4628

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Policy	09/29/2008	IND09 (Arkansas) Rev 9.24.08.pdf
No original date	Supporting Document	Outline of Coverage	10/08/2008	AR IND09 OOC 1-09 bracketed.pdf
No original date	Supporting Document	Outline of Coverage	09/26/2008	AR Olympic OOC 1-091(REV 9.26.08) bracketed.pdf
No original date	Rate and Rule	Rate Sheet	09/29/2008	Rate Sheet OLYMRT012009 ARrev.pdf

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

POLICY STATEMENT

We issue this policy to You for the premium payment and the statements made in Your application. We will pay for certain medical expenses incurred as a result of a Family Member's Injury or Sickness. The benefits depend strictly upon the terms in this policy. These terms, along with the application and any riders or endorsements form the policy. Your insurance begins at 12:01 a.m. on the Effective Date. Your insurance will end at 12:00 midnight at the end of the period for which premium has been paid. The time is determined at Your place of residence.

YOU MAY EXAMINE YOUR POLICY FOR 10 DAYS

Please read Your policy carefully. If You are not satisfied with the policy for any reason, return it to Our Home Office within 10 days after You receive it. If You do, We will refund any premium paid and treat the policy as if it was never issued.

RENEWAL CONDITIONS AND RATES

This policy renews on a monthly basis as long as You pay Your premium on or before the Due Date. The Renewal Date is shown on page 3 of the policy. 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 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.

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. The renewal premium is calculated from a table of rates We use for this policy form on the Due Date of the premium. This calculation takes into account the number of Family Members covered under this policy and their classification on the premium Due Date. Premiums may also change as a Family Member's age increases. If We change the premium, We must mail You written notice at least 30 days before a premium is due.

CANCELLATION AFTER THE FIRST 10 DAYS

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

OTHER INSURANCE REDUCES BENEFITS - READ CAREFULLY

MAJOR MEDICAL EXPENSE POLICY - PREFERRED PROVIDER OPTION

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

CONSUMER INFORMATION NOTICE

Policyholder Service Office of Company:	American Community Mutual Insurance Company
Address:	**[**39201 Seven Mile Road, Livonia, Michigan 48152**]**
Telephone Number:	**[**(800) 991-2642**]**
Name of Agent:	**[**Robert Agent**]**
Address:	**[**123 North Main, Livonia, Michigan 48152**]**
Telephone Number:	**[**(734) 555-1212**]**

If we at American Community Mutual Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
[1200 West Third Street
Little Rock, Arkansas 72201-1904
(800) 852-5494 or (501) 371-2640**]**

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POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$5,000/$7,500/$10,000**]**
Non-Network . . . . . **[**$10,000/$15,000/$20,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**100%**]***
Non-Network . . . . . **[**75% of the 1st $10,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$5,000/$7,500/$10,000**]**
Non-Network . . . . . **[**$12,500/$17,500/$22,500**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$10,000/$15,000/$20,000**]***
Non-Network . . . . . **[**$20,000/$30,000/$40,000**]***

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**100%**]****
Non-Network . . . . . **[**75% of the 1st $20,000; then 100% thereafter**]****

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**10,000/$15,000/$20,000**]**
Non-Network . . . . . **[**$25,000/$35,000/$45,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . **[**$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . **[**80% of the 1st $10,000; then 100% thereafter**]***
Non-Network . . . . . **[**55% of the 1st $10,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$3,000/$3,500/$4,500/$5,500/$7,000/$9,500**]**
Non-Network . . . . **[**$6,500/$7,500/$9,500/$11,500/$14,500/$19,500**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]***
Non-Network . . . . . **[**$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]***

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . **[**80% of the 1st $20,000; then 100% thereafter**]****
Non-Network . . . . . **[**55% of the 1st $20,000; then 100% thereafter**]****

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$6,000/$7,000/$9,000/$11,000/$14,000/$19,000**]**
Non-Network . . . . . **[**$13,000/$15,000/$19,000/$23,000/$29,000/$39,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
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[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**80% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . . **[**55% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$5,000/$5,500/$6,500/$7,500/$9,000/$11,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$14,000/$16,000/$19,000/$24,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]***
Non-Network . . . . . **[**$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]***

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**80% of the 1st $40,000; then 100% thereafter**]****
Non-Network . . . . . **[**55% of the 1st $40,000; then 100% thereafter**]****

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$10,000/$11,000/$13,000/$15,000/$18,000/$23,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$28,000/$32,000/$38,000/$48,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$500/$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $10,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$4,500/$5,000/$5,500/$6,500/$7,500/$9,000/$11,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$13,000/$15,000/$17,000/$20,000/$25,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]***
Non-Network . . . . . **[**$2,000/$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]***

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $20,000; then 100% thereafter**]****
Non-Network . . . . . **[**50% of the 1st $40,000; then 100% thereafter**]****

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$9,000/$10,000/$11,000/$13,000/$15,000/$18,000/$23,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$26,000/$30,000/$34,000/$40,000/$50,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

[BENEFIT PERIOD **[**January 1st through December 31st**]]**

[Calendar Year**]** Deductible per Person
Network . . . . . **[**$500/$1,000/$1,500/$2,500/$3,500/$5,000/$7,500**]**
Non-Network . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]**

Benefit Percentage per Person **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $20,000; then 100% thereafter**]***
Non-Network . . . . . **[**50% of the 1st $20,000; then 100% thereafter**]***

Out of Pocket Maximum per Person **[**per Calendar Year**]**
Network . . . . . **[**$8,500/$9,000/$9,500/$10,500/$11,500/$13,000/$15,500**]**
Non-Network . . . . . **[**$11,000/$12,000/$13,000/$15,000/$17,000/$20,000/$25,000**]**

[Calendar Year**]** Deductible per Family
Network . . . . . **[**$1,000/$2,000/$3,000/$5,000/$7,000/$10,000/$15,000**]***
Non-Network . . . . **[**$2,000/$4,000/$6,000/$10,000/$14,000/$20,000/$30,000**]***

Benefit Percentage per Family **[**per Calendar Year**]**
Network . . . . . **[**60% of the 1st $40,000; then 100% thereafter**]****
Non-Network . . . . . **[**50% of the 1st $40,000; then 100% thereafter**]****

Out of Pocket Maximum per Family **[**per Calendar Year**]**
Network . . . . . **[**$17,000/$18,000/$19,000/$21,000/$23,000/$26,000/$31,000**]**
Non-Network . . . . . **[**$22,000/$24,000/$26,000/$30,000/$34,000/$40,000/$50,000**]**

Network Covered Charges apply only to the Network Deductible, Benefit Percentage and Out of Pocket Maximum.

Non-Network Covered Charges apply only to the Non-Network Deductible, Benefit Percentage and Out of Pocket Maximum.

***** **[80%] Benefit Percentage for air ambulance and [50%] Benefit Percentage for Durable Medical Equipment. Covered Charges for these services do not apply to the Benefit Percentage or Out of Pocket Maximums and will be paid at these percentages even after the Out of Pocket Maximum has been met.**

PRIMARY INSURED:	**[**Doe, John C.**]**
POLICY NUMBER:	**[**2001023**]**
EFFECTIVE DATE:	**[**February 9, 2009**]**
RENEWAL DATE:	**[**9th**]** of each month
TOTAL AMOUNT OF PREMIUM:	**[**$xxx.xx**]**
[PREMIUM FOR PRESCRIPTION DRUGS:	**[**$xxx.xx**]**
[PREMIUM FOR DENTAL:	**[**$xxx.xx**]**
PREMIUM PERIOD:	**[**Monthly/Quarterly/Semi-Annually/Annually**]**
AGE AT ISSUE:	**[**35**]**

POLICY SCHEDULE

MAXIMUM BENEFITS PER FAMILY MEMBER:

Maximum Lifetime Benefit. . . . . **[**$5,000,000**]**

Accidental Death Benefit - Primary Insured. . . . . **[**$10,000**]**
Spouse . . . . . **[**$2,500**]**
Child . . . . . **[**$1,000**]**

Combined Maximum Lifetime Transplant Benefit. . . . . **[**$1,000,000**]**
Designated Transplant Facility Maximum . . . . . **[**$1,000,000**]**
Non-Designated Transplant Facility Maximum . . . . . **[**$750,000**]**

Skilled Nursing Facility. . . . . **[**60 days**]** per **[**Calendar Year**]**

Home Health Care. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Hospice. . . . . up to **[**$200 per day**]**
Lifetime Maximum . . . . . **[**$10,000 or 6 months, whichever comes first**]**

Outpatient Physical Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Outpatient Speech Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Outpatient Occupational Therapy. . . . . **[**20 visits**]** per **[**Calendar Year**]**

Preventive Care. . . . . **[**$1,000**]** per **[**Calendar Year**]**

Outpatient Spinal Manipulation. . . . . **[**$500**]** per **[**Calendar Year**]**

Allergy Testing and Serums.. . . . . **[**$500**]** per **[**Calendar Year**]**

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

OPTIONAL BENEFITS:

Dental Benefits. . . . . **[**Included/Not Included**]**
[See Dental Benefit Rider for Benefits & Schedule**]**

Outpatient Prescription Drug Rider . . . . . **[**Included/Not Included**]**
[See Outpatient Prescription Drug Rider for Benefits & Schedule**]**

POLICY SCHEDULE

PHYSICIAN'S SERVICES		
	Network	**Non-Network**
Office Visits: Visits for Sickness, Injury, or Follow-up, including lab tests and x-rays (See Non-Hospital Services for lab work sent to an independent lab)	[Subject to Network Deductible & Benefit Percentage] [[$30/$40] Copayment per visit, then 100%]	Subject to Non-Network Deductible & Benefit Percentage
Urgent Care Centers Visits: Office Visits for Sickness, Injury, or Follow-up, including lab tests and x-rays (See Non-Hospital Services for lab work sent to an independent lab)	[Subject to Network Deductible & Benefit Percentage] [[$60/$80] Copayment per visit, then 100%]	Subject to Non-Network Deductible & Benefit Percentage
Surgery, Equipment, Supplies, Injections (other than allergy injections):	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
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	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Chemotherapy, Infusion Therapy and Sclerotherapy (vein surgery or treatment):	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Allergy Injections:	[Subject to Network Deductible & Benefit Percentage][100%]	Subject to Non-Network Deductible & Benefit Percentage
Allergy Testing and Serums: $500 maximum benefit per Family Member per [Calendar Year]	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage

POLICY SCHEDULE

PHYSICIAN'S SERVICES

	Network	Non-Network
Preventive Care:		
Preventive Care Maximum: **[**$1,000**]** per Family Member per **[**Calendar Year**]**		
The following services are subject to the Preventive Care Maximum:		
Routine physical exams Age 19 & older Immunizations other than human papillomavirus Age 19 & older Routine mammograms PSA testing & exams Pap smears Lab work performed in the office	**[**Subject to Network Deductible & Benefit Percentage**]** **[[**$30/$40**]** Copayment per visit, then 100%**]**	Subject to Non-Network Deductible & Benefit Percentage
The following services are <u>not</u> subject to the Preventive Care Maximum:		
Immunizations other than human papillomavirus Birth through age 18	100%	100%
Well Child Care Birth through age 18	**[**Subject to Network Deductible & Benefit Percentage**]** **[[**$30/$40**]** Copayment per visit, then 100%**]**	Subject to Non-Network Deductible & Benefit Percentage
Human papillomavirus immunizations Bone density tests Colorectal cancer exams Lab work sent to an independent lab All other preventive care services	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Outpatient Spinal Manipulation:		
$500 maximum benefit per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
In-Hospital Services:		
Surgery; consultations; radiology; anesthesiology; pathology; physical, occupational and speech therapy	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Accident Benefit:		
Applies to any Covered Charges incurred due to an Injury when Treatment is received within **[**30 days**]** after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit.

POLICY SCHEDULE

HOSPITAL SERVICES

	Network	Non-Network
Inpatient:		
Non-Emergency Admissions	Subject to Network Deductible & Benefit Percentage	[$500] Copayment per Confinement, then subject to Non-Network Deductible & Benefit Percentage
Emergency Admissions	Subject to Network Deductible & Benefit Percentage	Subject to **Network** Deductible & Benefit Percentage
Emergency Room Services:		
Emergency Injury (Copayment waived if Admitted to Hospital within 24 hours)	[$250][$150] Copayment per visit, then subject to Network Deductible & Benefit Percentage	[$250][$150] Copayment per visit, then subject to **Network** Deductible & Benefit Percentage
Emergency Sickness (Copayment waived if Admitted to Hospital within 24 hours)	[$250][$150] Copayment per visit, then subject to Network Deductible & Benefit Percentage	[$250][$150] Copayment per visit, then subject to **Network** Deductible & Benefit Percentage
Non-Emergency Injury or Sickness	Not Covered	Not Covered
Diagnostic Services:		
Pre-admission testing, x-rays, lab tests, MRI, nuclear medicine, non-routine mammograms, and ultrasounds	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Outpatient Surgery:	Subject to Network Deductible & Benefit Percentage	[$500] Copayment per surgery, then subject to the Non-Network Deductible & Benefit Percentage
Accident Benefit:		
Applies to any Covered Charges incurred due to an Injury when Treatment is received within [30 days] after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.

POLICY SCHEDULE

NON-HOSPITAL SERVICES		
	Network	**Non-Network**
Air Ambulance:	Subject to Network Deductible, then **[**80%**]**	Subject to **Network** Deductible, then **[**80%**]**
Ambulance other than Air Ambulance:	Subject to Network Deductible & Benefit Percentage	Subject to **Network** Deductible & Benefit Percentage
Facility Charges for Outpatient Surgery:		
For procedures performed in a Free-Standing Outpatient Surgery Center or other non-hospital facility:	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Diagnostic Services:		
Nuclear medicine; non-routine mammograms; M.R.I.; cat scans; ultrasounds; x-rays; lab tests (including lab work sent by a physician to an independent lab).	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Skilled Nursing Facility:		
[60 days**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Hospice:		
Up to **[**$200 per day**]** Lifetime Maximum per Family Member of **[**$10,000 or 6 months, whichever comes first**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Home Health Care:		
[20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Physical Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Occupational Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Speech Therapy:		
Maximum of **[**20 visits**]** per Family Member per **[**Calendar Year**]**	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage

POLICY SCHEDULE

NON-HOSPITAL SERVICES		
Durable Medical Equipment:	Subject to Network Deductible, then [50%]	Subject to Non-Network Deductible, then [50%]
Accident Benefit: Applies to any Covered Charges incurred due to an Injury when Treatment is received within [30 days] after the Injury is sustained.	We will waive the Deductible and pay the Covered Charges at the Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.	We will waive the Deductible and pay the Covered Charges at the Non-Network Benefit Percentage after any applicable Copayment. The Deductible will be applied to any Covered Charges incurred after the [30 day] limit.

POLICY SCHEDULE

ORGAN TRANSPLANT BENEFITS		
	Designated Transplant Facility	**Non-Designated Transplant Facility**
Maximum Benefit per Family Member	**[**$1,000,000***]**	**[**$750,000***]**
Transplant Facility Charges	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Organ Procurement & Acquisition Expenses	Subject to Network Deductible & Benefit Percentage	Subject to Non-Network Deductible & Benefit Percentage
Charges by the Transplant Network	Subject to Network Deductible & Benefit Percentage	Not Applicable

*** The Combined Maximum Lifetime Transplant Benefit is [$1,000,000]. This includes all charges incurred at a Designated Transplant Facility and a Non-Designated Transplant Facility.**

DEFINITIONS

This section defines many of the terms used in this policy. Defined terms are capitalized and have the meanings set forth in this section.

Accident or Accidental means an event that meets all of the following requirements:

1. Causes harm to the physical structure of the body;
2. Is the direct cause of a loss, independent of any disease, bodily infirmity or any other cause;
3. Happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

An Accident does not include harm resulting from a Sickness.

Approved Transplant Procedures are human to human transplants which include:

1. Heart transplants;
2. Combined heart and lung transplants;
3. Lung transplants;
4. Kidney transplants;
5. Kidney and pancreas transplants;
6. Liver transplants;
7. Bone marrow transplants, either allogeneic or autologous; and
8. Peripheral stem cell transplants.

Approved Transplant Services 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.

Benefit Percentage means the percentage of Covered Charges that are payable by Us after the Deductible has been met. The Benefit Percentage is shown on the Schedule.

Benefit Percentage Maximum means the amount of Covered Charges a Family Member will have to pay in a **[**Calendar Year**]** after the Deductible has been met. The Benefit Percentage Maximum is shown on the Schedule.

[Benefit Period means the 12 month period beginning on the Effective Date of this policy and re-occurring every 12 months thereafter. The Benefit Period is shown on the Schedule.**]**

Clean Claim means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or on Our standard claim form with all required fields completed in accordance with Our published claim filing requirements. A Clean Claim does not include a claim

1. For payment of expenses incurred during a period of time for which premiums are delinquent, or
2. For which We need additional information in order to resolve one or more of the following issues:
   a. Information in order to determine if a policy limitation or exclusion is applicable to the claim;
   b. Medical information in order to determine the price for a medical procedure without a Current Procedural Terminology (CPT) Code or a Health Care Financing Administration Common Procedure (HCPC) Code;
   c. Information in order to determine if the Family Member who received the claimed services is eligible under the terms of the policy;
   d. Information in order to determine if the claim is covered by another health carrier, workers' compensation, a government supported program, or a liable third party;
   e. Information in order to determine the obligation of each health carrier or government program under coordination of benefits rules;
   f. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim; or
   g. Payment of premiums that were delinquent at the time the claimed services were rendered.

Cognitive means of or pertaining to thinking skills including but not limited to language use, memory, judgment, reasoning, intellect, social skills, and calculations skills; the mental process by which knowledge is acquired.

Combined Maximum Lifetime Transplant Benefit means the maximum amount that We will pay for a person covered under the policy for all covered transplants combined. The amount is shown on the Schedule. This amount is included in and part of the Maximum Lifetime Benefit.

Complications to a Pregnancy means Hospital Confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis; nephrosis; cardiac decompensation; HELLP syndrome; uterine rupture; amniotic fluid embolism; chorioamnionitis; fatty liver in pregnancy; septic abortion; placenta accreta; gestational hypertension; puerperal sepsis; peripartum cardiomyopathy; cholestasis in pregnancy; thrombocytopenia in pregnancy; placenta previa; placental abruption; acute cholecystitis and pancreatitis in pregnancy; postpartum hemmorrhage; septic pelvic thromboplebitis; retained placenta; venous air embolus associated with pregnancy; or miscarriage. It also includes an emergency cesarean section required because of fetal or maternal distress during labor; severe pre-eclampsia; arrest of descent or dilatation; or obstruction of the birth canal by fibroids or ovarian tumors; necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. A cesarean section delivery is not considered to be an emergency cesarean section if it is merely for the convenience of the patient and/or Physician or solely due to a previous cesarean section.

Complications of Pregnancy also includes treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, human papilloma virus, abnormal PAP, syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy.

Confined or Confinement means admitted as a resident bed patient to a Hospital or Skilled Nursing Facility.

Copayment means the amount a Family Member must pay for a provider's services or for purchase of medications or other medical supplies each time a service or medication is obtained. Copayments are not considered as part of any related Covered Charges and do not satisfy any Deductible or Benefit Percentage. Copayments may apply in addition to the Deductible and Benefit Percentage for certain Covered Charges.

Cosmetic means surgery or any other Treatment directed at changing the normal or abnormal physical appearance of any body structure in the absence of functional impairment of that body part.

Covered Charge means a medical expense of a Family Member due to Sickness or Injury, which subject to limitations expressed with the Covered Charge, on the Schedule, or in the Exclusions:

1. Is due to Medically Necessary care or Treatment;
2. Is incurred while this policy is in effect with regard to the Family Member;
3. Is incurred on the advice of a licensed Physician;
4. Is not more than the Usual, Customary, and Reasonable Charge for Non-Network services;
5. Is not more than the charge which would have been made had no insurance been in force; and
6. Is not excluded from coverage by the terms of this policy.

A medical expense will be deemed to have been incurred on the date the service is performed or the date the purchase occurs.

Custodial Care means care that is provided to assist the patient with activities of daily living. These types of services include help in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, supervision of medication that can usually be self-administered or administered by a non-licensed person, organizing appointments or activities, transporting to or from appointments or activities, or acting as a coordinator or liaison for care or services.

Deductible means a set amount of Covered Charges that must be paid each **[**Calendar Year**]** by or for the Family Member and which is not Our obligation. The Network and Non-Network **[**Calendar Year**]** Deductibles per Family Member and per Family are shown on the Schedule.

Designated Transplant Facility means a facility, affiliated with a national organ transplant network, which has entered into an agreement to render the required type of Approved Transplant Procedures to persons insured by Us. Selection of the Designated Transplant Facility to be used for a particular transplant will be determined by the Family Member's attending Physician in consultation with the transplant network's staff and Us. The Designated Transplant Facility chosen may or may not be located within the Family Member's geographic area.

Developmental means the progression of skills or abilities that demonstrate increasing Cognitive, intellectual, social, educational and physical competence in an individual who has never attained these levels.

Diabetes Self-Management Training means instruction in an inpatient or outpatient setting, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs the primary purpose of which is weight reduction. The training is to enable diabetic patients to understand the diabetic management process and daily management of diabetic therapy as method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program developed by the American Diabetes Association.

Due Date means the day of the month on which the premium payment is due.

Durable Medical Equipment means basic equipment which is approved for use for a particular condition and:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of Sickness or Injury; and
4. Is appropriate for use in the patient's home.

Effective Date means the day the insurance coverage begins under this policy.

Emergency means a medical condition which is sudden in its onset and manifests itself by symptoms of sufficient severity that a reasonably prudent person, with average knowledge of medicine would conclude that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the person's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Executive Officer means the President, a Vice President, the Secretary, or the Treasurer of American Community Mutual Insurance Company.

Experimental, Investigational, Unproven and/or for Research means that the procedure, test, Prescription Drug, Treatment, or complications as a result thereof, at the time We make a determination regarding coverage is:

1. Not generally accepted in the medical community in the United States as effective in treating the condition, Sickness, or diagnosis for which their use is proposed;
2. Not proven by scientific evidence to be effective in treating the condition, Sickness, or diagnosis for which their use is proposed;
3. Part of a research protocol or clinical trial; or
4. Not approved by the federal Food and Drug Administration.

Family Member means You and any persons You listed in Your application whom We accepted for insurance. You may add persons to this policy by following the policy provision entitled Family Members. The provision entitled End of Coverage tells when a Family Member's insurance ends.

Free Standing Outpatient Surgery Center means a facility which:

1. Operates according to the law;
2. Has facilities for surgery on its premises;
3. Is solely for outpatient or same day surgery; and
4. Is separate from Hospital facilities.

Home Health Agency means an agency designed to provide those services listed in the Home Health Care Covered Charges within the patient's home and is licensed by the state to provide home health care.

Home Office means Our main office in **[**Livonia, Michigan**]**.

Hospice means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

Hospital means an institution that is either accredited by the Joint Commission on Accreditation of Health Care Organizations as a general acute care Hospital under the Hospital Accreditation Program or that:

1. Operates according to the law;
2. Is primarily for Treatment of sick and injured people as Inpatients and is open at all times;
3. Is supervised by a staff of one or more licensed Physicians, and has a 24 hour nursing service;
4. Has facilities for surgery on its premises; and
5. Is licensed by the state as an acute care Hospital.

A facility will not be considered a Hospital if it is primarily for:

1. Aged persons;
2. Care of alcoholics or substance abusers;
3. Custodial Care, rest, convalescent or transitional care;
4. Educational or Developmental services or care; or
5. A residential facility.

Hospital Admission means admitted to a Hospital as a resident bed patient for Treatment or surgery.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry.

Injury means Accidental bodily damage or loss.

Inpatient means Confined in a Hospital or Skilled Nursing Facility.

Intensive Care Unit means a section within a Hospital which:

1. Is solely for the care of critically ill patients;
2. Has special supplies and equipment for such care ready for immediate use;
3. Is under constant observation by registered nurses (R.N.) or other highly trained personnel; and
4. Is separate from other Hospital facilities.

A facility will not be considered an Intensive Care Unit if it is mainly for normal recovery care after an operation.

Low Protein Modified Food Product means a food product that is specifically formulated to have less then one (1) gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease.

Maximum Lifetime Benefit per Family Member means the maximum amount that We will pay for a person covered under the policy for all Sicknesses and Injuries combined. The amount is shown on the Schedule. This maximum applies even if the Family Member's coverage lapses and is later reinstated.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary means medical, surgical, or other health care services, supplies, Treatments, procedures, drug therapies, or devices which are necessary to treat the Family Member's condition. Determination of medical necessity is done on a case by case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a Physician has performed or prescribed a procedure or Treatment or the fact that it may be the only available Treatment for a particular Injury or Sickness does not, alone, mean that it is Medically Necessary. In addition, the service must be:

1. Consistent with the diagnosis of and prescribed course of Treatment for the Family Member's condition;
2. Required for reasons other than the convenience of the Family Member or their Physician, and not required solely for custodial, comfort, maintenance, or quality of life reasons;
3. Performed in the most cost efficient type of setting appropriate for the condition;
4. Rendered at the frequency which is accepted by the medical community;
5. Likely to be effective in treating the Family Member's condition;
6. Not for Cosmetic purposes; and
7. Not Experimental, Investigational, Unproven and/or for Research.

Medicare means Title XVIII of the Social Security Act, as amended.

Mental or Nervous Disorder means a clinically significant behavioral or psychological condition or syndrome causing distress, disability or functional impairment, regardless of the cause. Mental or Nervous Disorder includes: psychosis, depression, schizophrenia, bipolar affective disorder and other psychiatric illnesses listed in the current DSM, the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. For purposes of this policy, the term Mental or Nervous Disorder does not include learning disabilities, attitudinal disorders, disciplinary problems or Substance Abuse.

Network means the Preferred Provider Network named by Us.

Network Provider means a Hospital, Physician, or other provider or supplier of health care services that has signed an agreement with the Network named by Us.

Non-Designated Transplant Facility means a facility which has not entered into a special transplant agreement with Us to provide Approved Transplant Procedures to persons insured by Us.

Non-Emergency means a medical condition that is not an Emergency.

Non-Network Provider means a Hospital, Physician, or other provider or supplier of health care services that has not signed an agreement with the Network named by Us.

Office Visit means a meeting between a Family Member and a Physician in the Physician's office or an Urgent Care Center. During this visit the Physician performs evaluation and management services as defined in the most recent edition of Current Procedural Terminology.

Organ Procurement and Acquisition Expenses shall include expenses directly related to:

1. Removal of the organ or bone marrow from the donor;
2. Preparation of the organ or bone marrow after removal from the donor for transplant for a period not to exceed 30 days; and
3. Transportation of the organ or bone marrow to the transplant facility.

If any benefits remain and are available under this Policy after the recipient's expenses have been paid, medical expenses of a live donor will be reimbursed.

Other Valid Coverage means coverage, whether or not issued on an excess basis, for medical expenses by or under:

1. Blue Cross or Blue Shield;
2. A union;
3. Membership in an association;
4. Group insurance;
5. Automobile medical payments insurance;
6. Personal injury protection under no fault automobile insurance;
7. A union welfare plan;
8. An employer or employee benefit plan;
9. A Hospital or medical service organization;
10. Any other insurance, welfare, or prepayment plan;
11. An expense incurred hospital, surgical, medical, or sick care insurance policy or certificate;
12. A hospital or medical service subscriber contract, medical practice or other prepayment plan; or
13. Other expense incurred plan or program.

Other Valid Coverage does not mean Medicaid, hospital indemnity plans, specified disease only policies, or limited occurrence policies that provide only for intensive care or coronary care at a Hospital, first aid outpatient medical expense resulting from accidents, or specified accidents such as travel accidents.

Outpatient means a person who receives Treatment at a Hospital, Physician's office, or clinic but is not hospitalized.

Physician means a medical doctor (M.D.) or Doctor of Osteopathy (D.O.) practicing within the scope of his or her license issued by the jurisdiction in which such person's services are rendered. Such jurisdiction must be in the United States of America. The Physician may not be the insured or related by blood or marriage to the insured.

Pre-existing Condition means a medical condition, for which, prior to the Effective Date of coverage:

1. The Family Member received medical advice or Treatment from a Physician within 60 months before the Effective Date of coverage;
2. Medical advice or Treatment was recommended by a Physician within 60 months before the Effective Date of coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or Treatment within 60 months before the Effective Date of the Family Member's coverage under this policy.

[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.**]**

Preferred Provider Network means that group of providers of medical services including, but not limited to, Hospitals, Physicians, laboratories, pharmacies, and providers of Hospice, home health care services and medical equipment that are approved for the Network by the Preferred Provider Network Administrator. The Preferred Provider Network Administrator will provide the Family Member with a list of Network Providers of medical services.

Preferred Provider Network Administrator is the entity that is:

1. Named by Us; and
2. Responsible for managing the Network.

Prescription Drug means a drug or medicine, which can be obtained only by prescription and, except for insulin bears the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription."

Preventive Care means health care provided to a Family Member in order to promote or maintain the individual's good health and prevent health problems.

Prosthetic means an external or implanted device that substitutes for or supplements a missing or defective part of the body.

Rehabilitation means the use of physical, occupational or speech therapy to restore physical function after a Sickness or Injury that is provided with the expectation that the condition will improve in a reasonable and predictable period of time and the services:

1. Can only be performed safely and effectively by a qualified therapist;
2. Must be related directly to the Sickness or Injury;
3. Must be ordered by a Physician;
4. Must be consistent with accepted standards of medical practice; and
5. Must be proven effective in treating the condition.

Renewal Date means the date shown on the Schedule.

Schedule means the Policy Schedule on pages **[**3 - 3(g)**]**.

Sickness means illness, disease, or Complications to a Pregnancy.

Skilled Nursing Facility means an institution which:

1. Is licensed as a Skilled Nursing Facility by the state;
2. Operates according to the law;
3. Is approved for payment of Medicare benefits (or is qualified for approval);
4. Is mainly engaged in providing, in addition to room and board, skilled nursing care on a 24 hour basis by or under the supervision of a registered nurse (R.N.);
5. Provides medical care under the supervision of a licensed Physician; and
6. Keeps a medical record of each patient.

A facility will not be considered a Skilled Nursing Facility if it is primarily for:

1. Aged persons;
2. Care of alcoholics or substance abusers;
3. Custodial Care, rest, convalescent or transitional care;
4. Educational or Developmental services or care; or
5. A long-term care or residential facility.

Speech Therapist means someone who:

1. Has a master's degree in speech pathology;
2. Has completed an internship; and
3. Is licensed by the state in which he or she performs his or her services, if that state requires licensing.

Substance Abuse means the taking or use of alcohol or other drugs at dosages that place a Family Member's social, economic, psychological, and physical welfare in potential hazard; or to the extent that a Family Member loses the power of self-control as a result of the use of alcohol or drugs; or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.

Treatment means medical or surgical management of a Sickness or Injury, including seeking medical advice, consultation, diagnosis, surgery, testing, therapy, or the use of Prescription Drugs.

Treatment Plan means the Family Member's Physician's written or oral plan, which includes but is not limited to:

1. The anticipated date of Confinement;
2. The facility to be used;
3. The Family Member's medical indications requiring Confinement;
4. The recommended procedures, Treatment or surgery; and
5. The procedure code or diagnostic code applicable to the Family Member's Sickness or Injury.

Urgent Care Center means a freestanding facility, center, or other entity that operates primarily to provide specialty medical treatment of an unforeseen, unexpected Sickness or Injury on an urgently needed or prompt basis.

Usual, Customary, and Reasonable Charge (Applicable only to Non-Network services or supplies) means a charge which does not exceed the amount usually accepted by providers in the general area where the charge is incurred.

Waiting Period means the length of time an eligible Family Member must be covered under this policy before benefits are payable.

We, Us, Our means American Community Mutual Insurance Company.

You, Your, Yours means the Primary Insured named on the Schedule.

BENEFIT PROVISIONS

We will pay Covered Charges as defined and limited in the policy. During a **[**Calendar Year**]**, Covered Charges may be subject to Copayments, the Deductible, and/or the Benefit Percentage as shown on the Schedule. Covered Charges must be incurred while coverage under the policy is in force, and are subject to the terms, conditions, limitations, exclusions, and maximum benefit amounts stated in the policy. If a Family Member incurs Covered Charges from a Network Provider, We will pay benefits for those Covered Charges according to the Schedule column headed Network. If a Family Member incurs Covered Charges from a Non-Network Provider, We will pay benefits for those Covered Charges according to the Schedule column headed Non-Network.

Copayment. Some benefits are subject to a Copayment, which is the amount a Family Member must pay for a provider's services or for the purchase of medications or other medical supplies each time a service or medication is obtained. Copayments are not considered as part of any related Covered Charges and do not satisfy any Deductible or Benefit Percentage for a Family Member. Copayments may apply in addition to the Deductible and Benefit Percentage for certain Covered Charges.

Deductible. This is a set amount of Covered Charges that must be paid by or for the Family Member and which is not Our obligation. Benefits that are subject to the Deductible, will be payable for a Family Member when the earlier of the following occurs:

1. The Family Member's Covered Charges in a **[**Calendar Year**]** exceed the **[**Calendar Year**]** Deductible per Person shown on the Schedule; or
2. The combined Covered Charges for all Family Members in a **[**Calendar Year**]** exceed the **[**Calendar Year**]** Deductible per Family shown on the Schedule.

Family Members must meet a new Deductible each **[**Calendar Year.**]**

Benefit Percentage. Once the Deductible has been met, We pay a percentage of the Family Member's Covered Charges that exceed the **[**Calendar Year**]** Deductible. These percentages are shown on the Schedule. The Family Member is responsible for their percentage of the Covered Charges up to the Out of Pocket Maximum shown on the Schedule. Unless otherwise provided under the policy and subject to any applicable Copayments or maximums, benefits will be paid at 100% for a Family Member when the earlier of the following occurs during a **[**Calendar Year**]**:

1. The Family Member's out of pocket expenses in a **[**Calendar Year**]** reach the Out of Pocket Maximum per Person per **[**Calendar Year**]** shown on the Schedule; or
2. The combined out of pocket expenses for all Family Member's in a **[**Calendar Year**]** reach the Out of Pocket Maximum per Family per **[**Calendar Year**]** shown on the Schedule.

Out of Pocket Maximum: The Out of Pocket Maximum per Person is the sum of the **[**Calendar Year**]** Deductible per Person and Benefit Percentage per Person per **[**Calendar Year**]** shown on the Schedule.

The Out of Pocket Maximum per Family is the sum of the **[**Calendar Year**]** Deductible per Family and Benefit Percentage per Family per **[**Calendar Year**]** shown on the Schedule.

In addition to the **[**Calendar Year**]** Deductible and Benefit Percentage, the Family Member is responsible for the following, which are not included in the Out of Pocket Maximum:

1. Copayments;
2. Charges in excess of the benefit limits included in this policy;

3. Medical expenses which are not eligible to be Covered Charges under this policy;
4. Medical expenses which are more than the Usual, Customary and Reasonable Charge for services performed by a Non-Network Provider;
5. Medical expenses which are incurred during any Waiting Period included in this policy;
6. Charges for Durable Medical Equipment that are payable after the Deductible has been met; and
7. Charges for an air ambulance that are payable after the Deductible has been met.

Maximum Lifetime Benefit. The most We will pay under this policy during the lifetime of any one Family Member is the Maximum Lifetime Benefit shown on the Schedule. The Maximum Lifetime Benefit applies even if the Family Member's coverage lapses and is later reinstated.

Accident Benefit. If a Family Member sustains an Injury, We will waive the Deductible and pay the Covered Charges related to the Injury at the Benefit Percentage shown on the Schedule for services incurred within **[**30 days**]** of the Injury subject to the maximum shown on the Schedule. The Deductible will be applied to any Covered Charges incurred after the **[**30 day**]** limit has been met.

Common Accident Benefit: 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.

Medicare Coordination: Benefits which We will pay are limited to those Covered Charges which are within the policy limits and which are in excess of those Covered Charges which qualify for reimbursement under Medicare.

THE DEDUCTIBLES, COPAYMENTS, BENEFIT PERCENTAGES, OUT OF POCKET MAXIMUMS, AND MAXIMUM BENEFITS ARE SHOWN ON THE SCHEDULE.

PRIOR NOTIFICATION REQUIREMENTS

FOLLOWING THESE PROCEDURES DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. WE WILL PAY BENEFITS ACCORDING TO THE TERMS OF THE POLICY.

Prior Notification means contacting Us by telephone at **[**800-991-2642**]** and providing Us with information regarding the Hospital Admission.

PRIOR NOTIFICATION IS REQUIRED FOR THE FOLLOWING HOSPITAL ADMISSIONS:

A. Non-Emergency Hospital Admission

The provider, Doctor, or Family Member must contact Us prior to any Non-Emergency Hospital Admission.

B. Emergency Hospital Admission

The provider, Doctor, or Family Member must contact Us within 48 hours following any Emergency Hospital Admission.

MEDICAL BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy.

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 shown on the Schedule.

4. Medical services and supplies furnished by the Hospital.

5. Treatment given in a Hospital emergency room for an Emergency 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 allowance for the most expensive procedure and 50% of the Preferred Provider Network allowance 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.

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 a Family Member on or after the day such individual is entitled to benefits under Medicare, except as provided by law.

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. Coverage also includes reconstructive surgery of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

25. Approved Transplant Procedures up to the Combined Maximum Lifetime Transplant Benefit shown on the Schedule. To be eligible to receive the benefits available, transplants must be approved by Us 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, and Organ Procurement and Acquisition Expenses as defined in the policy and subject to the maximum benefits shown on the Schedule.

26. 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. Hospital Inpatient post-mastectomy care of not less than 48 hours, however, the attending Physician after consulting with the Family Member may approve a shortened length of Hospital Inpatient stay.

27. Allergy testing and serums, subject to the maximum benefit shown on the Schedule.

28. Allergy injections.

29. 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.

30. The following care and Treatment of Your newborn child, provided the child is covered under the policy from the moment of birth as described under the Addition of a Newborn Child provision contained in this policy:

    a. Testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants that may be mandated by Arkansas law in the future.

    b. Treatment related to a premature birth.

    c. Routine nursery care and pediatric charges for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

31. Medically Necessary Treatment of loss or impairment of speech or hearing, including communicative disorders generally treated by a speech pathologist or audiologist. Coverage does not include hearing instruments or devices.

32. Medical Foods and Low Protein Modified Food Products that are prescribed as Medically Necessary for the therapeutic treatment of a Family Member inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism. To be covered under the policy, the food products must be administered under the direction of a licensed Physician and the cost of the food products must exceed the income tax credit of $2,400 per year per person as allowed by Arkansas law.

33. Medically Necessary diagnosis and Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorders. Treatment includes both surgical and non-surgical procedures whether prescribed or administered by a Physician or a dentist.

34. Contraceptive drugs and devices approved by the United States Food and Drug Administration are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the terms, conditions and limitations contained on the Prescription Drug Program Benefit Rider included in the policy.

35. Contraceptive devices that are surgically implanted and are approved by the United State Food and Drug Administration are covered only if the Schedule shows that the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the Benefit Provisions section of the policy and are not covered under the Outpatient Prescription Drug Benefit Rider.

36. Treatment of Type 1, Type 2, and gestational diabetes, if determined to be Medically Necessary and prescribed by a licensed Physician, including:

    a. Diabetes equipment, supplies and appliances; and
    b. Diabetes Self-Management Training.

    Covered Charges include the following equipment, supplies and appliances:

    a. Blood glucose monitors and blood glucose monitors for the legally blind;
    b. Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
    c. Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
    d. Insulin;
    e. Injection aids;
    f. Syringes, including pen-like insulin injection devices and pen needles;
    g. Insulin pumps and appurtenances which include insulin infusion pumps and supplies such as skin preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;
    h. Oral agents for controlling the blood sugar level, which are Prescription Drugs;
    i. Podiatric appliances for prevention of complication associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and
    j. Glucagon emergency kits and Injectable glucagon.

    Diabetes Self-Management Training must be provided by an appropriately licensed health care professional in accordance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Covered Charges is limited to:

    a. One training session per lifetime;
    b. Additional training sessions that are Medically Necessary because of a significant change in the Family Member's symptoms or condition and are order in writing by a Physician.

HOSPICE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy, subject to the Hospice maximum benefit shown on the Schedule.

We will pay Hospice Benefits for a Family Member, provided:

1. All Hospice care services, whether provided in a Hospice facility or at the Family Member's home, are coordinated by a Hospice. (A copy of the Hospice program's Treatment Plan may also be required.)

2. The Family Member:

   a. Is terminally ill;
   b. Has a life expectancy of six months or less; and
   c. Would otherwise have been Confined in a Hospital or Skilled Nursing Facility.

3. The attending Physician certifies:

   a. The Family Member's illness, including a prognosis for life expectancy; and
   b. Hospice care is Medically Necessary.

4. The attending Physician reviews the care given at least once a month.

Covered Charges include the following:

1. Home health aide services under the supervision of a registered nurse or licensed therapist;

2. Home health services performed by a licensed registered nurse or licensed therapist;

3. Physical therapy;

4. Respiratory and inhalation therapy;

5. Professional nutrition counseling;

6. Medical social services;

7. Family counseling due to the Family Member's terminal condition; and

8. Respite care.

HOME HEALTH CARE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of this policy, subject to the Home Health Care maximum benefit shown on the Schedule.

We will pay Home Health Care Benefits for a Family Member, provided:

1. This service is necessary as an alternative to care in a Hospital or Skilled Nursing Facility. Confinement in a Hospital or Skilled Nursing Facility is not required before the start of home health care.

2. The service requires the use of a licensed registered nurse, licensed physical, occupational, speech or respiratory therapist when the Family Member is confined to home due to their medical condition.

3. The Family Member is under the direct care of a Physician.

4. The Treatment Plan for home health care is established in writing by the attending Physician prior to the start of the Treatment.

5. The Family Member is examined by the attending Physician at least once each 60 days.

6. The attending Physician certifies that Confinement in a Hospital or Skilled Nursing Facility would be required in the absence of home health services.

7. The Treatment Plan is coordinated by a Home Health Agency.

8. The cost of the home health service is less than the cost of the same service provided in a Hospital.

Covered Charges include the following:

1. Home health services performed by a licensed registered nurse or licensed therapist;

2. Physical and occupational therapy;

3. Speech therapy and audiology;

4. Respiratory and inhalation therapy; and

5. Professional nutrition counseling.

PREVENTIVE CARE BENEFITS

Benefits will be paid in accordance with the Benefit Provisions section of the policy.

The following requirements included in the definition of a Covered Charge do not apply to the Preventive Care Covered Charges:

1. The medical expense is due to Sickness or Injury; or
2. The medical expense is due to Medically Necessary care or Treatment.

Covered Charges subject to the Preventive Care Maximum shown on the Schedule include the following services:

1. Routine physical exams including lab services not sent to an independent lab, for a Family Member age 19 and older;

2. Immunizations, other than the human papillomavirus immunization for a Family Member age 19 and older;

3. An annual Prostate-Specific Antigen (PSA) blood test and Digital Rectal Examination upon the recommendation of a licensed Physician for:

   a. All males age 50 and over; and
   b. Males age 40 and over with a family history of prostate cancer or men at risk;

4. An annual cervical smear or pap smear;

5. Routine Mammograms, limited to:

   a. One mammogram between the ages of 35 and 39;
   b. One mammogram per year after age 39;
   c. One mammogram per year for women at risk.

Covered Charges <u>not</u> subject to the Preventive Care Maximum shown on the Schedule include the following services:

1. Colorectal cancer screening for a Family Member who is:
   a. Age 50 or older;
   b. Less that age 50 who is at high risk for colorectal cancer according to the American Cancer Society guidelines for colorectal cancer screening; or
   c. Experiencing symptoms of colorectal cancer as determined by a Physician.

   Covered Charges for colorectal cancer screening include the following:
   a. An annual fecal occult blood test, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
   b. A double-contract barium enema every 5 years; or
   c. A colonoscopy every 10 years; and
   d. Any additional medically recognized screening tests required by the Director of the Department of Health, determined in consultation with appropriate health care organizations.

2. Well child care benefits for a Family Member from birth through 18 years of age.

   Covered Charges for well child care must be rendered by or under the supervision of a single Physician during the course of one visit and include the following:

   a. A medical history;
   b. A complete physical exam;
   c. A developmental assessment;
   d. Anticipatory guidance;
   e. *Age appropriate immunizations, other than the human papillomavirus immunization; and
   f. Appropriate laboratory test(s).

   ***Age appropriate immunizations are not subject to the Deductible, Benefit Percentage or Preventive Care maximum benefit. Immunizations will be covered at 100%.**

3. Human papillomavirus immunizations;

4. Bone density tests;

5. Lab work sent to an independent lab; and

6. All other preventive services not specifically shown elsewhere in the policy.

ACCIDENTAL DEATH
(Including Dismemberment and Loss of Sight)

A. Accidental Death Benefits

Benefits will be paid if a Family Member incurs any of the losses listed in item C. below, if and only if:

1. The loss:

   a. Results from an accidental bodily injury which occurred while the Family Member was insured;
   b. Was independent of all other causes; and

2. The loss occurs within 90 days after the accidental bodily injury. However, benefits will be paid if use of extraordinary life support systems delays the loss for more than 90 days from the date of the accidental bodily injury.

B. Exclusions

No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

1. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;

2. Insurrection, riot, or war;

3. The committing of, or the attempt to commit, an assault or felony;

4. Disease or disorder of the body or mind;

5. Medical or surgical Treatment or diagnosis, preventive care or complications of care;

6. The voluntary:

   a. Taking of drugs (except drugs taken as prescribed by a Physician) or poison; or
   b. Inhaling of gas or other inhalants;

7. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or

8. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of, an accidental wound).

C. Table of Losses

In the Event of Loss of:	**The Amount Payable will be:**
Life	The Full Amount of Insurance
Both Hands or Both Feet	The Full Amount of Insurance
Sight of Both Eyes	The Full Amount of Insurance
One Hand and One Foot	The Full Amount of Insurance
One Hand and Sight of One Eye	The Full Amount of Insurance
One Foot and Sight of One Eye	The Full Amount of Insurance
One Hand	One-Half The Full Amount of Insurance
One Foot	One-Half The Full Amount of Insurance
Sight of One Eye	One-Half The Full Amount of Insurance

With respect to hands or 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.

NOTE: IN ANY EVENT, 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 THE RESULT OF THAT ACCIDENT.

THE AMOUNT OF INSURANCE IS SHOWN ON THE SCHEDULE.

PRE-EXISTING CONDITION LIMITATION

We will pay no benefits for charges due to a Pre-Existing Condition for 3 years starting on the Effective Date of a Family Member's coverage under the policy.

GENERAL EXCLUSIONS

We will pay no benefit for charges, including the diagnosis and/or Treatment, due to any of the following. These charges are not Covered Charges and cannot be used to satisfy this policy's Deductible, Co-payments, or Benefit Percentage.

1. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.

2. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.

3. Charges for an Injury received while committing or attempting to commit a felony.

4. Charges caused by or contributed to by war or any act of war, whether or not declared, or participation in a riot or insurrection.

5. Charges for any Sickness contracted or Injury sustained while a member of the Military, Navy, or Air Force of any country or combination of countries.

6. Charges for any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, except for Medicaid.

7. Charges for Treatment of Sickness or Injury covered by workers' compensation insurance or similar laws.

8. 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.

9. Charges for services or supplies for personal comfort or convenience.

10. Charges for travel or lodging expenses.

11. Charges for maintenance care, Custodial Care or homemaker services.

12. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.

13. Charges for dental services, supplies, or Prosthetics 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.

14. Charges for 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.
    b. Due to mastectomy as provided under the Medical Benefits section of this policy.
    c. Due to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.

15. Charges for 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. 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, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury, except as provided under the Medical Benefits section of this policy.

17. 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.

18. 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.

19. Charges for care of a well, newborn child, except as provided under the Medical Benefits or Preventive Care Benefits section of this policy.

20. Charges for contraceptives, contraceptive methods or aids, unless the Schedule shows that the Outpatient Prescription Drug Benefit Rider is included in the policy.

21. Charges for emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.

22. 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, in vitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.

23. Charges for gender reassignment or charges due to complications of gender reassignment.

24. Charges for the diagnosis and/or Treatment of acne.

25. Charges for the diagnosis and/or Treatment of eating disorders.

26. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.

27. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and non-chemical addictions.

28. Charges for hair loss, hair restoration or removal.

29. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.

30. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.

31. Charges for the diagnosis and/or Treatment of Substance Abuse.

32. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.

33. Charges for transplants, except as provided under the Medical Benefits section of this policy.

34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.

35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.

36. Charges for the 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.

37. Charges for court-ordered evaluation, Treatment or testing.

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.

41. Charges for services available in the community through educational or school programs.

42. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.

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, except podiatric appliances for prevention of complications associated with diabetes, as provided under the Medical Benefits section of this policy.

45. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.

46. Charges for the 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 telephone or electronic mail.

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 Treatment of an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to the following:

    a. Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
    b. Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.

52. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.

53. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.

54. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of this policy.

55. 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, reike therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

56. Charges for myo-electric or microprocessor Prosthetics.

57. 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.

58. 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.

59. **[**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.**]**

[60**]**. Charges for which benefits are not provided in this policy.

GENERAL PROVISIONS

Family Members

Eligibility. The following persons are eligible to be Family Members:

1. You;
2. Your spouse;
3. Your and Your spouse's children and adopted children, provided they are:
   a. Not married,
   b. Dependent on You for at least 50% of their support, and
   c. Less than **[**22**]** 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.

Addition of Family Members. To add a person as a Family Member, You must apply to Us on Our form and pay the required premium. All persons must be insurable under Our usual underwriting standards.

Addition of a Newborn Child. Your child born after the Effective Date is covered under the policy from the moment of birth provided more than one Family Member is insured under this policy when the birth occurs and We are given notice of the child's birth within 90 days of the birth or before the next premium due date, whichever is later. If You are the only Family Member covered under the policy when the birth occurs, the newborn child is subject to Our usual underwriting standards and the exclusion of any Pre-existing Conditions as provided in the policy.

Any additional premium required to cover the newborn child will be charged as of the Effective Date of the coverage for the newborn child.

Addition of an Adopted Child. A minor child adopted by You after the Effective Date is covered under the policy as of the date of the filing of the petition for adoption provided, more than one Family Member is insured under this policy when the petition for adoption is filed and You apply for coverage of the adopted child within 60 days after the date the petition for adoption is filed. If the adopted child is a newborn, coverage begins from the moment of birth provided more than one Family Member is insured under this policy when the birth occurs and the petition for adoption and application for coverage are both filed within 60 days after the date of birth. If You are the only Family Member covered under the policy the adopted child will be subject to Our usual underwriting standards and the exclusion of any Pre-existing Conditions as provided in the policy. Coverage for an adopted child will terminate upon the dismissal or denial of the petition for adoption.

Any additional premium required to cover the adopted child will be charged as of the Effective Date of the coverage for the adopted child.

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 first Renewal Date after the earliest of the following:

   a. The date the child marries,
   b. The date the child ceases to be dependent on You for at least 50% of their support, or
   c. The date the child attains age **[**23**]**.

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 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.

Mentally or Physically Handicapped Child. Your child's coverage will not end due to age while the child is:

1. Mentally or physically incapable of earning their own living;
2. Actually dependent on You for a majority of their support; and
3. Covered by the policy on the date immediately preceding the day their coverage would have ended due to age.

We may ask for proof of incapacity and dependency annually.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates:

1. The date the child becomes capable of self-support;
2. The date the child's coverage under the policy ends for any reason other than age;
3. The date the policy ends; or
4. The date a Covered Charge is incurred if, as part of the required proof of loss, We ask for proof of the child's status and You fail to provide proof that as of the date the expense was incurred the child remains:
    a. Mentally or physically incapable of earning their own living; and
    b. Actually dependent on You for a majority of their support.

Change of Residence. If You change Your residence and move into a different county in the same state or into a different state, You will keep this policy. We may adjust Your premium on the next Renewal Date based upon Your new geographic location.

Survivorship. If You die while this policy is in force, We will refund the unearned portion of Your premium. The refund will be prorated. If Your spouse is a Family Member then We will deem the policy to be issued to Your spouse. If Your spouse is not a Family Member and other Family Members are covered by this policy, We will issue a rider naming Your spouse or the Family Member's legal guardian as owner of the policy.

Continuity of Care. If on the Effective Date a Family Member is receiving Treatment from a Non-Network Provider for an acute condition, We will cover the current episode of Treatment for the acute condition at the Network benefit level until the current episode of Treatment ends or until the end of 90 days, whichever occurs first.

If a provider's participation in the Network has been terminated, We will continue to cover a current episode of Treatment for an acute medical condition at the Network benefit level until the current episode of Treatment ends or until the end of 90 days, whichever occurs first.

The Family Member should contact us at **[**800-991-2642**]** to request to continue services as described above.

Conversion. We will issue a new policy to insure a Family Member whose coverage ends for any reason described in sections 1 and 2 of the End of Coverage provision. The new policy will be issued on this policy form. The premium will be based on the table of rates for the Family Member's age and sex.

We must receive a written request and the first premium:

1. Within 31 days after the coverage ends; or
2. In the case of dissolution of marriage, within 60 days from the date of the judgment granting the dissolution, 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.

COORDINATION OF BENEFITS

COB may limit benefits when a Family Member is entitled to benefits from more than one source. It does this by relating the Family Member's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of a Family Member's Allowable Expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out below, so that from all sources, a Family Member will not be paid for more than 100% of his or her Allowable Expenses.

Allowable Expense means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Following is a list of the sources (plans) with which this policy coordinates:

1. Group or blanket insurance and group subscriber contracts.

2. Employer or employee benefit organization insurance or workmen's compensation insurance.

3. Union welfare plans.

4. Group or group-type coverage through health maintenance organizations (HMOs) and other prepayment group practice plans.

5. Group-type contracts which are contracts not available to the general public and which can be obtained and maintained only because of membership in or connection with a particular organization or group.

6. The amount by which group or group-type hospital indemnity benefits exceed $30 per day.

7. Student insurance. (COB will not apply to accident-only coverage for grammar, high school, college or post high school students for which the parent pays the entire Premium and which is sponsored by or provided through a school.)

8. The medical benefits coverage in group, group-type, individual automobile "no fault" and traditional automobile "fault" type contracts.

Any plan that does not have this COB provision, or one like it, pays first. Plans providing individual or group no-fault auto insurance coverage and plans providing automobile medical payments insurance coverage pay first for medical, hospital, nursing, dental, surgical, ambulance, and prosthetic services incurred within 24 months after the automobile accident, up to an aggregate of $2,000 per person. For plans having a COB provision, or one like it, these rules apply to determine which benefit plan pays first and the order in which the other plans follow:

1. The plan that covers a Family Member as an employee/insured will be considered before the plan that covers the Family Member as a dependent. The plan that covers a Family Member as an employee will be considered before the plan that covers the Family Member as a member/insured.

2. For dependents who are covered under two or more plans, other than children whose parents are divorced or otherwise separated, the plan of the parent with the earlier birthday will be considered before the other parent's plan. If the birthdays fall on the same day, the plan that has covered the parent longer will be considered before the other plan. If the other plan does not have a birthday anniversary rule as described above, but instead has a rule based on the gender of the parent, and as a result the plans do not agree on the order of benefits, the rule in the other plan utilizing the gender rule will determine the order of benefits.

3. For dependent children whose parents are divorced or legally separated, the following rules apply:

   a. When the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be considered before the benefits of a plan which covers the child as a dependent of the parent without custody.

   b. When the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be considered before the benefits of a plan which covers that child as a dependent of his or her step-parent; and the benefits of a plan which covers that child as a dependent of the parent without custody will be considered last.

   c. If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, (a) and (b) above will not apply; instead, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be considered before the benefits of any other plan which covers the child as a dependent child.

4. In the case the above rules still produce a conflict, the plan which has covered the Family Member the longest will be considered first.

In determining total expenses, each item of expense will be considered by Us under this COB provision if it is payable in whole or in part by at least one of the sources whose benefits are being coordinated.

Benefits will be coordinated on a **[**Calendar Year**]** basis. This is called the "Claim Determination Period".

In order to make this COB provision work:

1. The Family Member, if requested, is required to furnish Us complete information concerning all sources and all benefits paid or payable from those sources.

2 As permitted by law, We may, without the Family Member's consent:

   a. Obtain information from all plans which might be involved.

   b. Release to such other plans any information it has.

   c. Reimburse such other plans, to the extent necessary, if We determine that benefits have been paid by another plan which should have been paid by Us. Such reimbursement will count as a valid payment under this plan.

d. Obtain reimbursement from any such other plan(s), and/or from the Family Member, if We have paid benefits which should have been paid by any such other plan(s). Such reimbursement is a valid payment under the other plan(s).

e. Obtain repayment of whatever amount is appropriate for the proper working of this provision, if payment from all sources exceeds 100% of total expenses, and if We determine that the 100% of Allowable Expenses was exceeded as a result of Our payment.

THIRD PARTY REIMBURSEMENT

This provision applies when a third party or its insurer is liable as a result of the negligence or intentional act of the third party for a loss for which medical or dental benefits are payable under this policy to or on behalf of a Family Member. If a third party or its insurer is liable for past, present or future medical or dental charges, the following rules will apply.

A. If the third party makes payment before Us, benefits provided under this policy will be reduced to the extent of the third party's payment.

B. If the third party does not make payment before Us:

1. We will pay any benefits due under this policy;

2. When payment is later made by the third party, We are entitled to be repaid first; the Family Member or legal representative is obligated to return to Us the payment less reasonable prorated expenses, such as lawyer's fees and court costs, incurred by the Family Member in seeking the third party payment.

3. The Family Member's obligation to repay Us will be binding upon the Family Member or legal representative regardless of whether:

   a. The payment, received from the third party or its insurer, is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement;

   b. The third party or its insurer admits liability;

   c. The medical or dental expenses are itemized in the third party payment; or

   d. The Family Member has been paid by the third party for all loss sustained or alleged.

SUBROGATION

This provision applies when a third party or its insurer is liable as a result of the negligence or intentional act of the third party for a loss for which medical or dental benefits are payable under this policy to or on behalf of a Family Member. If a third party or its insurer is liable for past, present or future medical or dental charges, the following rules will apply.

Before payment is made by the third party, We have the right of subrogation to attempt to recover the amount of Our payment, including the right to file or intervene in a lawsuit. We will give the Family Member or representative prior written notice of Our intent to file suit. The Family Member must cooperate in full with Our effort to seek recovery from the third party. The Family Member must do nothing to hinder Our attempt to recover from the third party or to resolve the claim with the third party unless We give prior written consent. Our recovery from the third party will be limited to the lesser of:

1. The amount We paid in benefits under this policy as a result of the medical or dental charges; or

2. The amount recovered from the third party.

Our recovery will apply whether or not payment has been made by the third party for all of the Family Member's losses.

STANDARD PROVISIONS

Entire contract; Changes. The policy, Your signed application and any attached riders, endorsements, or amendments form the entire contract. We can change benefits and/or policy terms, as of the Renewal Date specified by Us, provided:

1. We give You 30-days written notice in advance; and

2. The changes are made on a uniform basis for all policies issued in this state under this policy form.

No change in this policy is allowed until approved by one of Our Executive Officers. Any change must be written and attached to this policy for the change to be effective. No agent may authorize a change in this policy or waive any of its provisions.

Payment of Premiums. A premium must be paid on or before its Due Date. You must pay Your premiums to Our Home Office. If You do not pay a premium when due, the policy will end.

Returned Check Fee. If any premium payment made directly by check or by EFT (electronic funds transfer), is returned for non-sufficient funds, a nonrefundable service fee will be applied. This fee will be due with Your next premium payment.

Grace Period. A grace period of 31 days, measured from the premium Due Date, will be allowed for payment of all premium due, other than the initial premium. The policy will remain in force during the grace period, unless You give Us written notice that the policy is to be terminated earlier. If We pay any claims incurred during the grace period and premium has not been paid, We will deduct the premium for the grace period from the claims. However, if We deduct the premium from any claims incurred during the grace period, it will not keep Your policy in force past the end of the grace period.

Reinstatement. If the renewal premium and any applicable returned check fee(s) are not paid before the Grace Period ends, the policy will end in accordance with the Grace Period provision. Once per year, We will accept premium postmarked within **[**29 days**]** after the Grace Period ends. This acceptance of the premium will reinstate the policy.

The reinstated policy will cover only loss that results from an Injury that occurs after the reinstatement date or a Sickness that occurs more than 10 days after that date. In all other respects, Your rights and Ours will remain the same, subject to any provisions noted or attached to the reinstated policy.

Time Limit on Certain Defenses.

1. After 3 years from the Effective Date of this policy no statements, except fraudulent statements, made by a Family Member in the application can be used to void this policy or deny a claim which starts after the end of the 3 years.

2. No claim, for a Sickness or Injury commencing after 3 years from the Effective Date, will be reduced or denied on the ground that the Sickness or Injury not excluded from coverage by name or specific description had existed prior to the Effective Date of this policy.

Notice of Claim. Written notice of claim must be given within 20 days after the occurrence of any loss covered by this policy or as soon as reasonably possible. The notice must be given to Our Home Office. Your name and policy number should be in the notice.

Proof of Loss. You must send written proof of loss to Us within 90 days of the date the loss occurred. We will not deny Your claim for being late if You give Us the proof of loss as soon as it is possible to do so. No proof of loss will be accepted later than 1 year after the time the proof is otherwise required, unless You were not legally capable.

Time Payment of Claims. We will pay any benefits due:

1. Immediately upon receipt of proof of loss; or
2. In accordance with the Payment of Clean Claims provision below, whichever is more favorable to the Family Member.

Payment of Clean Claims. We will pay or deny each Clean Claim as follows:

1. If the claim is filed electronically, within 30 days after the claim is received by Us.
2. If the claim is filed on paper, within 45 days after the date the claim is received by Us.

If the claim is not a Clean Claim, We will suspend the claim and notify the provider within 30 days after receipt of the claim of any deficiencies in the submitted claim and describe any information necessary to establish the claim as a Clean Claim.

If We fail to pay or deny a Clean Claim, or We fail to notify the provider of any deficiencies as set forth above, and We subsequently pay the claim, We will pay to the provider that submitted the claim, interest on the Covered Charges. Interest will accrue beginning on the sixty-first day after receipt of the Clean Claim and ending on the Clean Claim payment date (the delinquent payment period).

We will reopen and pay or deny a previously suspended claim within 30 days after We receive all the information We requested. If We fail to pay or deny the claim, and We subsequently pay the claim, We will pay to the provider that submitted the claim, interest on the Covered Charges. If We are not already required to pay interest as described above, interest will accrue beginning on the forty-sixth day after the last item of information requested was received and ending on the claim payment date (the delinquent payment period).

The interest will be calculated as follows:

The amount of the claim payment, times 12% per annum, times the number of days in the delinquent payment period, divided by 365.

Assignment. You authorize us to make payments directly to Network Providers who have provided Covered Charges to You or a Family Member. Regardless of whether You make an assignment, We reserve the right to make payment directly to You for Covered Charges provided by Non-Network Providers. When We pay You, You must pay the Non-Network Provider and We are not legally obligated to pay any additional amounts. You cannot assign Your right to receive payment to anyone else.

Payment of Claims for other than Loss of Life. After receiving proof of loss, We will pay any benefits due under the policy in accordance with the above Assignment provision. Any accrued benefits not paid at Your death will be paid at Our option to Your designated beneficiary or to Your estate. If benefits are payable to Your estate or a beneficiary who cannot execute a valid release, We can pay benefits up to **[**$1,000**]** to someone related to You by blood or marriage whom We consider to be entitled to the benefits. Such payment made in good faith legally discharges Us to the extent of the payment.

Payment of Claims for Loss of Life. Benefits for the loss of life of the Primary Insured will be payable in accordance with the beneficiary designation. If no such designation is in effect at the time of payment, such benefit will be paid to the Primary Insured's estate.

Benefits for the loss of life of a Family Member other than the Primary Insured will be paid to the Primary Insured. If the Primary Insured dies before the Family Member, benefits will be paid to the Family Member's estate.

Change of Beneficiary. You have the right to change the named beneficiary. The consent of the beneficiary will not be a requisite to any change of beneficiary or beneficiaries.

Physical Examination and Autopsy. We have the right to have You examined at Our cost as often as reasonably required while a claim is pending. We may require an autopsy, unless prohibited by law.

Premium Adjustments. If the Family Member's age has been misstated, his or her rate will be adjusted to the rate for his or her correct age.

Legal Actions. No legal action may be brought to recover on this policy:

1. Within 60 days after written proof of loss has been given as required, or
2. After 3 years from the time written proof of loss is required to be given.

Notices. Every notice or other document required or permitted under this policy or certificate shall be deemed to be sufficiently delivered, given, served, sent, provided and received for all purposes at such time as it is deposited in the United States mail or given to a reputable mail courier with postage properly affixed.

Conformity with Law. Any provision of this policy which, on its Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of those laws.

Signed for American Community Mutual Insurance Company at Livonia, Michigan.

[President & CEO**]**

NOTICE TO INSURED
OF ANNUAL MEETING AND ELECTION

We are a mutual insurance company. We have no stockholders. An annual meeting and election of Directors is held each year at **[**9:00 A.M. on the last Thursday in April at our home office in Livonia, Michigan.**]**

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09

Monthly Base Rate and Factors

Monthly Medical Base Rate (1/1/2009 effective date): $129.71

State Factor: Arkansas 0.77

Product Factor: IND09 1.000

Factors for Deductible Options:

Deductible (Network)	Factor
$500	1.39
$1,000	1.15
$1,500	1.00
$2,500	0.76
$3,500	0.62
$5,000	0.55
$7,500	0.48
$10,000	0.43

Factors for Benefit Percentage:

Benefit % (Network)	Factor
60%	0.91
80%	1.00
100%	1.09

Factors for Coinsurance Maximum:

Coins Max (Network)	Factor
$0 (100%)	1.00
$10,000	1.00
$20,000	0.95

Modal Factors and Fees:

Mode	Modal Factor	Billing Fee per Bill
Annual	12	$10.00
Semi-Annual	6	$10.00
Quarterly	3	$10.00
Monthly Direct	1	$10.00
Monthly EFT	1	$0
Credit Card Convenience Fee		$6.25/trans.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
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Medical Expense; Preferred Provider Option
Policy Form IND09

Age/ Gender and Status Factors

Age Last	**all deductibles**		Non-	Standard
Birthday	Male	Female	smoker	Smoker
0-17	0.83	0.83	1.00	1.00
18-24	0.83	1.16	1.00	1.10
25	0.87	1.19	1.00	1.10
26	0.90	1.22	1.00	1.11
27	0.93	1.24	1.00	1.12
28	0.95	1.27	1.00	1.13
29	0.98	1.31	1.00	1.14
30	1.00	1.35	1.00	1.15
31	1.03	1.40	1.00	1.16
32	1.06	1.45	1.00	1.17
33	1.09	1.50	1.00	1.18
34	1.13	1.55	1.00	1.19
35	1.16	1.60	1.00	1.20
36	1.20	1.65	1.00	1.21
37	1.25	1.71	1.00	1.22
38	1.30	1.77	1.00	1.23
39	1.35	1.83	1.00	1.24
40	1.40	1.87	1.00	1.25
41	1.45	1.93	1.00	1.27
42	1.52	2.00	1.00	1.29
43	1.60	2.07	1.00	1.30
44	1.70	2.12	1.00	1.32
45	1.81	2.19	1.00	1.34
46	1.92	2.28	1.00	1.36
47	2.03	2.36	1.00	1.37
48	2.14	2.43	1.00	1.39
49	2.28	2.52	1.00	1.41
50	2.45	2.63	1.00	1.43
51	2.63	2.76	1.00	1.44
52	2.81	2.87	1.00	1.46
53	3.02	2.97	1.00	1.48
54	3.22	3.07	1.00	1.50
55	3.42	3.17	1.00	1.51
56	3.62	3.27	1.00	1.53
57	3.82	3.38	1.00	1.55
58	4.02	3.49	1.00	1.57
59	4.21	3.61	1.00	1.58
60	4.38	3.72	1.00	1.60
61	4.57	3.84	1.00	1.60
62	4.75	3.96	1.00	1.60
63	4.93	4.09	1.00	1.60
64 & over	5.09	4.21	1.00	1.60
Childrider*	0.83	0.83	1.00	

* Each Child; Three or More Children at Three Children Rate

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09

County Area and Network Factors

COUNTY	Area Factor	FirstHealth Factor	AMCO Factor
Arkansas	0.95	0.64	0.67
Ashley	0.95	0.71	0.75
Baxter	0.82	0.71	0.75
Benton	0.90	0.64	0.67
Boone	0.82	0.71	0.75
Bradley	0.95	0.71	0.75
Calhoun	0.95	0.71	0.75
Carroll	0.82	0.71	0.75
Chicot	0.95	0.71	0.75
Clark	0.95	0.71	0.75
Clay	0.90	0.71	0.75
Cleburne	0.90	0.71	0.75
Cleveland	0.95	0.71	0.75
Columbia	0.95	0.71	0.75
Conway	0.95	0.64	0.67
Craighead	0.90	0.71	0.75
Crawford	0.86	0.64	0.67
Crittenden	0.82	0.71	0.75
Cross	0.82	0.71	0.75
Dallas	0.95	0.71	0.75
Desha	0.95	0.71	0.75
Drew	0.95	0.71	0.75
Faulkner	0.95	0.64	0.67
Franklin	0.86	0.64	0.67
Fulton	0.82	0.71	0.75
Garland	0.95	0.64	0.67
Grant	0.95	0.64	0.67
Greene	0.90	0.71	0.75
Hempstead	0.95	0.71	0.75
Hot Spring	0.95	0.64	0.67
Howard	0.95	0.71	0.75
Independence	0.90	0.71	0.75
Izard	0.82	0.71	0.75
Jackson	0.95	0.64	0.67
Jefferson	0.95	0.71	0.75
Johnson	0.90	0.64	0.67
Lafayette	0.86	0.71	0.75
Lawrence	0.90	0.71	0.75
Lee	0.82	0.71	0.75
Lincoln	0.95	0.71	0.75
Little River	0.95	0.71	0.75
Logan	0.86	0.64	0.67
Lonoke	0.95	0.64	0.67
Madison	0.86	0.64	0.67
Marion	0.82	0.71	0.75
Miller	0.95	0.71	0.75
Mississippi	0.82	0.71	0.75
Monroe	0.95	0.64	0.67
Montgomery	0.95	0.71	0.75
Nevada	0.86	0.71	0.75
Newton	0.82	0.71	0.75
Ouachita	0.86	0.71	0.75
Perry	0.95	0.64	0.67
Phillips	0.82	0.71	0.75
Pike	0.95	0.71	0.75
Poinsett	0.82	0.71	0.75
Polk	0.95	0.71	0.75
Pope	0.90	0.64	0.67
Prairie	0.95	0.64	0.67
Pulaski	1.05	0.64	0.67
Randolph	0.90	0.71	0.75
Saint Francis	0.82	0.71	0.75
Saline	0.95	0.64	0.67
Scott	0.86	0.64	0.67
Searcy	0.82	0.71	0.75
Sebastian	0.86	0.64	0.67
Sevier	0.95	0.71	0.75
Sharp	0.90	0.71	0.75
Stone	0.90	0.71	0.75
Union	0.95	0.71	0.75
Van Buren	0.95	0.64	0.67
Washington	0.90	0.64	0.67
White	0.95	0.64	0.67
Woodruff	0.95	0.64	0.67
Yell	0.86	0.64	0.67

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY
39201 Seven Mile Road - Livonia Michigan 48152
Medical Expense; Preferred Provider Option
Policy Form IND09 Optional Benefits and Riders

Factors for Optional Gold Benefits Package:
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	Factor
$500	0.21
$1,000	0.21
$1,500	0.22
$2,500	0.29
$3,500	0.35
$5,000	0.44
$7,500	0.47
$10,000	0.50

Factors for Optional Prescription Drug Benefits - Generics Only (Form AR-RX-GENERIC09-AR)
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	
$500	0.04
$1,000	0.05
$1,500	0.06
$2,500	0.07
$3,500	0.09
$5,000	0.13
$7,500	0.14
$10,000	0.16

Factors for Optional Prescription Drug Benefits - Four Tier Coverage (Form AR-RX-TIER09-AR)
(factor is applied to final calculated medical rate)

Medical Deductible (Network)	
$500	0.15
$1,000	0.17
$1,500	0.20
$2,500	0.25
$3,500	0.31
$5,000	0.39
$7,500	0.44
$10,000	0.50

Optional Dental Expense Rider (Form 650DR) - All Areas, All Ages

Male	$30.00
Female	$30.00
Each Child*	$15.00

* Three or more children at three children rate

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

[Olympic]
Preferred Provider Option (PPO)
Arkansas - 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. Basic hospital or basic medical insurance coverage is not provided.

COVERED CHARGES

[Olympic] 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: 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.

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

PLAN CHOICE	**[Olympic] 100**		**[Olympic] 80**		**[Olympic] 60**	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
DEDUCTIBLES						
Individual Calendar Year Deductible	[$5,000 $7,500 $10,000]	[$10,000 $15,000 $20,000]	[$1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$2,000 $3,000 $5,000 $7,000 $10,000 $15,000]	[$500 $1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$1,000 $2,000 $3,000 $5,000 $7,000 $10,000 $15,000]

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%]	[75% of $10,000]	[80% of $10,000]	[55% of $10,000]	[80% of $20,000]	[55% of $20,000]	[60% of $10,000]	[50% of $20,000]	[60% of $20,000]	[50% of $20,000]
Individual Out-of-Pocket Maximums (Includes deductible)	**Network [100%]**	**Non-Net [75% of $10,000]**	**Network [80% of $10,000]**	**Non-Net [55% of $10,000]**	**Network [80% of $20,000]**	**Non-Net [55% 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 $7,500 $10,000]	[$12,500 $17,500 $22,500]	[$3,000 $3,500 $4,500 $5,500 $7,000 $9,500]	[$6,500 $7,500 $9,500 $11,500 $14,500 $19,500]	[$5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $14,000 $16,000 $19,000 $24,000]	[$4,500 $5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]	[$8,500 $9,000 $9,500 $10,500 $11,500 $13,000 $15,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]

Family Calendar Year Deductible and Family Out-of-Pocket Maximum	Family deductible is 2 times the individual deductible, met collectively by 2 or more persons. A family member begins receiving benefits after his/her individual deductible amount has been met or the family deductible has been met, whichever occurs first. Family Out of Pocket maximum is 2 times the individual Out-of-Pocket maximum, met collectively by 2 or more persons.

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	[First Health Network]

ACCIDENT BENEFIT	
Accident	If a family member sustains an injury, we will waive the deductible (copayments 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.

	[Olympic] 100		**[Olympic] 80**		**[Olympic] 60**	
PHYSICIAN SERVICES	**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 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	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)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]						

	[Olympic] 100		[Olympic] 80		[Olympic] 60	
PREVENTIVE CARE SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Human papillomavirus (HPV) Immunizations; Bone Density Test; Colorectal Cancer Exams; Lab work sent to an independent lab; all other preventive care services not specified elsewhere in the policy	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
[$1,000 Calendar Year maximum per family member] for the following services: Immunizations (except HPV) & Routine Physical Exams (age 19 and older); PSA Testing & Exams; Routine Mammograms; Pap Smears; Lab work performed in the office						
Childhood Immunizations (except HPV) (Birth through age 18)	100%	100%	100%	100%	100%	100%
Well Child Care (from birth through age 18)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
HOSPITAL SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Inpatient **Non-emergency admissions**	Deductible, then we pay 100%	[$500] copay per admission, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per admission, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per admission, 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%	[$500] copay per surgery, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per surgery, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per surgery, then Deductible, then we pay 50%
Diagnostic Services Pre-admission Testing; X-rays; Nuclear Medicine; Ultrasounds; M.R.I.; Non-routine Mammograms; Lab Tests	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%

	[Olympic] 100		[Olympic] 80		[Olympic] 60	
EMERGENCY ROOM	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Emergency Injury Copay waived if admitted to hospital within 24 hours See Accident Benefit on page 2 **Emergency Sickness** Copay waived if admitted to hospital within 24 hours	[$250] copay per visit, then Deductible, then we pay 100%	[$250] copay per visit, then **Network** Deductible, then we pay 100%	[$250] copay per visit, then Deductible, then we pay 80%	[$250] copay per visit then **Network** Deductible, then we pay 80%	[$250] copay per visit, then Deductible, then we pay 60%	[$250] copay per visit, then **Network** Deductible, then we pay 60%
Non-emergency Sickness or Injury	Not Covered					
OTHER COVERED SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Air Ambulance	Network Deductible, then 80% Charges do not apply to out of pocket maximums and will be paid at 80% even after the out of pocket maximum has been met.					
Ambulance (other than air ambulance)	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 type of therapy] **Home Health Care** [20 visits per family member per Calendar Year] **Hospice** Up to [$200 per day, a lifetime maximum of $10,000 or 6 months, whichever comes first] **Skilled Nursing Facility** [60 days per family member per Calendar Year]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Durable Medical Equipment	Deductible, then 50% Charges do not apply to out of pocket maximums and will be paid at 50% even after the out of pocket maximum has been met.					
Organ Transplants: Combined maximum lifetime benefit of [$1 million] per person **Designated Transplant Facility:** [$1 million] maximum benefit **Non-designated Transplant Facility:** [$750,000] maximum benefit	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Maternity	Not Covered					
Mental Health	Not Covered					

OTHER COVERED SERVICES	
Accidental Death and Dismemberment	Primary Insured [$10,000]; Spouse [$2,500]; and Dependent Children [$1,000] (Full Amounts)

OPTIONAL BENEFITS	
GOLD BENEFITS	
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500-$3,500] the copay is [$30] Deductibles of [$5,000-$10,000] the copay is [$40] Non-Network: Non-Network Deductible and Benefit Percentage
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500 - $3,500] the copay is [$60] Deductibles of [$5,000 - $10,000] the copay is [$80] Non-Network: Non-Network Deductible and Benefit Percentage
Allergy Injections	Network: 100% - Office Visit Copay does not apply Non-Network: Non-Network Deductible and Benefit Percentage
Preventive Care Immunizations (except HPV) & Routine Physical Exams (age 19 and older); Routine Mammograms; PSA Testing & Exams; Pap Smears; Lab work performed in the office The following will not be applied to or limited by the [$1,000] maximum: Well Child Care from birth through age 18	Network: Office Visit Copay, then we pay 100% up to [$1,000 calendar year maximum per family member] Non-Network: Non-Network Deductible and Benefit Percentage
Childhood Immunizations (except HPV) from birth through age 18	Network & Non-Network: 100%
Human papillomavirus (HVP) immunizations; Bone Density Tests; Colorectal Cancer Exams; Lab work sent to an independent lab; All other preventive care services not specified elsewhere in the policy	Network: Deductible, then we pay 100%, 80% or 60% based on plan chosen. Non-Network: Non-Network Deductible and Benefit Percentage
Emergency Room - Emergency Sickness or Injury	[$150] Copay per visit, then Network Deductible and Benefit Percentage Copay waived if admitted to hospital within 24 hours Non-emergency sickness or injury is not covered.

PRESCRIPTION DRUG OPTIONS

GENERIC PLAN OPTION		
	Retail	**Mail Order**
Generic Drugs Only	Up to [30-day] supply [20%] copay per prescription or refill [$15] Minimum	Up to [90-day] supply [20%] copay per prescription or refill [$45] Minimum
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy.		
Contraceptive Drugs and Devices are covered		

FOUR TIER PLAN OPTION		
Individual Prescription Drug Deductible: [$250] per Calendar Year Individual Out of Pocket Maximum for Specialty Drugs: [$2,500] per Calendar Year		
Family prescription drug deductible is 2 times the individual prescription drugs deductible, met collectively by 2 or more persons. A family member begins receiving prescription drug benefits after his/her individual prescription drug deductible amount has been met or the family prescription drug deductible has been met, whichever occurs first. Family Out of Pocket maximum for Specialty Drugs is 2 times the individual Out-of-Pocket maximum for Specialty Drugs, met collectively by 2 or more persons.		
	Retail Up to [30-day] supply	**Mail Order** Up to [90-day] supply
Generic Drugs & Diabetic Supplies:	[20%] copay per prescription or refill [$15] Minimum	[20%] copay per prescription or refill [$45] Minimum
Select Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$30] Minimum	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$90] Minimum
Additional Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$60] Minimum	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$180] Minimum
Specialty Drugs:	Subject to Prescription Drug Deductible, then [25%] copayment per prescription or refill (maximum [$250]) up to the Out of Pocket Maximum shown above, then 100% Up to [30 day] supply	
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy. Specialty Drug benefits only apply at a Participating Specialty Pharmacy. No benefits are payable if a Specialty Drug is purchased at any other pharmacy.		
Mandatory Generic Provision If an Additional Brand Name Drug or Select Brand Name Drug is chosen when a Generic Drug is available, then the family member is responsible for the Generic Drug copay plus the difference between the cost of the Additional Brand Name Drug or Select Brand Name Drug and the cost of the Generic Drug and any deductible.		
Contraceptive Drugs and Devices are covered		

DENTAL OPTION

Dental Benefit [$1,000] calendar year maximum	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%

COVERED CHARGES

1) Daily hospital room and board:
   a. 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.
   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.
3) Surgical services:
   a. Surgeon's medical care or surgery. If two or more procedures are performed at the same operative session, the most We will pay:
      (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. Hospital Inpatient post mastectomy care of not less than 48 hours, however, the attending Physician after consulting with the Family Member may approve a shortened length of Hospital Inpatient stay.
   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. **Skilled Nursing Care** - Room and board, nursing care, medical services and supplies while Confined in a Skilled Nursing Facility covered at [60 days per calendar year].
   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 $10,000 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; and respite care
   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.
   e. **Preventive Care** - Covered Charges are subject to a maximum benefit of [$1,000 per calendar year] include the following:
      (1) Routine physical exams including lab services not sent to an independent lab, for a Family Member age 19 and older;
      (2) Immunizations, other than the human papillomavirus immunization for a Family Member age19 and older;
      (3) An annual Prostate-Specific Antigen (PSA) blood test and Digital Rectal Examination upon the recommendation of a licensed Physician for:
         (a) All males age 50 and over; and
         (b) Males age 40 and over with a family history of prostate cancer or men at risk;
      (4) An annual cervical smear or pap smear;
      (5) Routine mammograms, limited to:
         (a) One mammogram between the ages of 35 and 39;
         (b) One mammogram per year after age 39; and
         (c) One mammogram per year for women at risk.

      Covered Charges not subject to the Preventive Care Maximum include the following services:
      (1) Colorectal cancer screening for a Family Member who is:
         (a) Age 50 or older;
         (b) Less that age 50 who is at high risk for colorectal cancer according to the American Cancer Society guidelines for colorectal cancer screening; or
         (c) Experiencing symptoms of colorectal cancer as determined by a Physician.

         Covered Charges for colorectal cancer screening include the following:
         (a) An annual fecal occult blood test, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
         (b) A double-contract barium enema every 5 years; or
         (c) A colonoscopy every 10 years; and
         (d) Any additional medically recognized screening tests required by the Director of the Department of Health, determined in

consultation with appropriate health care organizations.

(2) Well child care benefits for a Family Member from birth through 18 years of age. Covered Charges for well child care must be rendered by or under the supervision of a single Physician during the course of one visit and include the following:
   (a) A medical history;
   (b) A complete physical exam;
   (c) A developmental assessment;
   (d) Anticipatory guidance;
   (e) *****Age appropriate immunizations, other than the Human papillomavirus (HPV) immunization; and
   (f) Appropriate laboratory test(s).

   *** Age appropriate immunizations are not subject to the Deductible, Benefit Percentage or Preventive Care maximum benefit. Immunizations will be covered at 100%.**

(3) Human papillomavirus (HPV) immunizations;
(4) Bone density tests;
(5) Lab work sent to an independent lab; and
(6) All other preventive services not specifically shown elsewhere in the policy.

f. **Physical, Occupational & Speech Therapy** - Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury. Services are limited to a maximum of [20 visits per calendar year per type of therapy].

g. **Outpatient spinal manipulation -** 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** - Services are subject to a maximum benefit of [$500 per calendar year].

i. **Allergy Injections**.

7) Other Benefits:

a. Injectable Prescription Drugs are covered subject the 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 is included in the policy and provides coverage for Generic Drugs only, then injectable Prescription Drugs are covered subject to the policy's Deductible and Benefit Percentage.
   If the Outpatient Prescription Drug Benefit Rider is included in the policy and provides coverage for Specialty Drugs, then injectable Prescription Drugs that are administered in a Physician's office are covered subject to the policy's Deductible and Benefit Percentage.

b. Prosthetics, except myo-electric or microprocessor prosthetics and dental prosthetics.

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 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. 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.

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. Coverage also includes reconstructive surgery of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

h. Contraceptive drugs and devices approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the terms, conditions and limitations contained on the Outpatient Prescription Drug Program Benefit Rider.

i. Contraceptive devices that are surgically implanted and are approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the Benefit Provisions section of the policy and are not covered under the Outpatient Prescription Drug Benefit Rider.

j. Treatment of Type 1, Type 2, and gestational diabetes, if determined to be Medically Necessary and prescribed by a licensed Physician, including the following equipment, supplies and appliances:
   (1) Blood glucose monitors and blood glucose monitors for the legally blind;
   (2) Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
   (3) Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
   (4) Insulin;
   (5) Injection aids;
   (6) Syringes, including pen-like insulin injection devices and pen needles;
   (7) Insulin pumps and appurtenances which include insulin infusion pumps and supplies such as skin

preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;

(8) Oral agents for controlling the blood sugar level, which are Prescription Drugs;

(9) Podiatric appliances for prevention of complication associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and

(10) Glucagon emergency kits and Injectable glucagon.

k. Diabetes Self-Management Training must be provided by an appropriately licensed health care professional in accordance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Covered Charges is limited to:

(1) One training session per lifetime;

(2) Additional training sessions that are Medically Necessary because of a significant change in the Family Member's symptoms or condition and are order in writing by a Physician.

l. Medically Necessary Treatment of loss or impairment of speech or hearing, including communicative disorders generally treated by a speech pathologist or audiologist. Coverage does not include hearing instruments or devices.

m. Medical Foods and Low Protein Modified Food Products that are prescribed as Medically Necessary for the therapeutic treatment of a Family Member inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism. To be covered under the policy, the food products must be administered under the direction of a licensed Physician and the cost of the food products must exceed the income tax credit of $2,400 per year per person as allowed by Arkansas law.

n. The following care and Treatment of Your newborn child, provided the child is covered under the policy from the moment of birth as described under the Addition of a Newborn Child provision contained in the policy:

(1) Testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants that may be mandated by Arkansas law in the future.

(2) Treatment related to a premature birth.

(3) Routine nursery care and pediatric charges for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

o. Medically Necessary diagnosis and Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorders. Treatment includes both surgical and non-surgical procedures whether prescribed or administered by a Physician or a dentist.

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 [$750,000].

c. Covered Charges include Approved Transplant Procedures which are 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. If any benefits remain and are available under the Policy after the recipient's expenses have been paid, medical expenses of a live donor will be reimbursed.

f. Only approved Transplant Procedures are covered. No benefits will be paid if the transplant procedure is not approved in advance.

10) Accidental Death (including dismemberment and loss of sight) provides the following full amounts of insurance:

a. Primary Insured: [$10,000]

b. Spouse: [$2,500]

c. Child: [$1,000]

Benefits are payable if the loss results from an accidental bodily injury which occurred while insured under the policy; was independent of all other causes; and the loss occurs within 90 days after the accident bodily injury. However, benefits will be paid if use of extraordinary life support systems delays the loss for more than 90 days from the date of the accidental 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.

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.

PRE-EXISTING CONDITIONS LIMITATION

We will pay no benefits for charges due to a Pre-existing Condition for 3 years starting on the Effective Date of a Family Member's coverage under the policy.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

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

We will pay no charges, including the diagnosis and/or Treatment, due to any of the following. These charges are not Covered Charges and cannot be used to satisfy the policy's Deductible, Copayments or Benefit Percentage.

1. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.
2. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
3. Charges for an Injury received while committing or attempting to commit a felony.
4. Charges caused by or contributed to by war or any act of war, whether or not declared, or participation in a riot or insurrection.
5. Charges for any Sickness contracted or Injury sustained while a member of the Military, Navy, or Air Force of any country or combination of countries.
6. Charges for any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, except for Medicaid.
7. Charges for Treatment of Sickness or Injury covered by workers' compensation insurance or similar laws.
8. 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.
9. Charges for services or supplies for personal comfort or convenience.
10. Charges for travel or lodging expenses.
11. Charges for maintenance care, Custodial Care or homemaker services.
12. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.
13. Charges for dental services, supplies, or Prosthetics 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.
14. Charges for 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.
    b. Due to mastectomy as provided under the Medical Benefits section of the policy.
    c. Due to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.
15. Charges for 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. 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, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury, except as provided under the Medical Benefits section of the policy.
17. 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.
18. 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.
19. Charges for care of a well, newborn child, except as provided under the Medical Benefits or Preventive Care Benefits section of the policy.
20. Charges for contraceptives, contraceptive methods or aids, unless the Schedule shows that the Outpatient Prescription Drug Benefit Rider is included in the policy.
21. Charges for emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
22. 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, in vitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.
23. Charges for gender reassignment or charges due to complications of gender reassignment.
24. Charges for the diagnosis and/or Treatment of acne.
25. Charges for the diagnosis and/or Treatment of eating disorders.
26. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.
27. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and nonchemical addictions.
28. Charges for hair loss, hair restoration or removal.

29. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.
30. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.
31. Charges for the diagnosis and/or Treatment of Substance Abuse.
32. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.
33. Charges for transplants, except as provided under the Medical Benefits section of the policy.
34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.
36. Charges for the 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.
37. Charges for court-ordered evaluation, Treatment or testing.
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.
41. Charges for services available in the community through educational or school programs.
42. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.
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, except podiatric appliances for prevention of complications associated with diabetes, as provided under the Medical Benefits section of the policy.
45. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
46. Charges for the 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 telephone or electronic mail.
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 Treatment of an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to the following:
    a. Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
    b. Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.
52. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.
53. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.
54. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of the policy.
55. 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, reike therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
56. Charges for myo-electric or microprocessor Prosthetics.
57. 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.
58. 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.
59. 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.
60. Charges for which benefits are not provided in the policy.

PRESCRIPTION DRUG PROGRAM EXCLUSIONS

We will pay no benefits for charges due to any of the following:

1. Brand Name Drugs (this exclusion applies to the Generic Drug Plan only).
2. Prescription Drugs used to treat medical conditions that have been excluded from coverage by amendment or rider to the policy;
3. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy;
4. Non-federal legend drugs;
5. Contraceptive medications or devices that are not approved by the United States Food and Drug Administration for use as a contraceptive;
6. Contraceptive devices that are surgically implanted;
7. Fertility agents and medications;

8. Injectable or any prescription directing parenteral administration or use, except insulin (this exclusion applies to the Generic Drug Plan only);
9. Emergency contraception kits or any drugs that are intended to induce abortion;
10. Antidepressants;
11. Tranquilizers;
12. Miscellaneous psychotherapeutic agents;
13. Benzodiazepines;
14. Anti-manic agents;
15. Drugs to treat Attention Deficit Hyperactivity Disorder;
16. Substance abuse treatment agents;
17. Oral and topical acne medications;
18. Smoking deterrents;
19. All anti-obesity preparations;
20. Amphetamines;
21. Legend vitamins and fluoride products;
22. Drugs to treat influenza or lessen its symptoms;
23. Therapeutic devices or appliances;
24. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
25. Immunization agents and vaccines;
26. Biologicals, blood or blood plasma;
27. Off-label use of prescription drugs except when insurance coverage is required by law;
28. Drugs labeled "Caution - limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
29. 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;
30. 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;
31. 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;
32. 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;
33. Charges for the administration or injection of any drug;
34. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
35. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
36. 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;
37. Drugs for Treatment of onychomycosis (nail fungus);
38. Drugs for Treatment of impotency;
39. Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose;
40. Drugs to treat a cough or cold or lessen its symptoms;
41. Drugs to treat a migraine or headache;
42. Drugs not listed on the Formulary; and
43. Proton Pump Inhibitors.

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.

ACCIDENTAL DEATH EXCLUSIONS

No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

1. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;
2. Insurrection, riot or war;
3. The committing of, or the attempt to commit, an assault or felony;
4. Disease or disorder of the body or mind;
5. Medical or surgical treatment or diagnosis, preventive care or complications of care;
6. The voluntary taking of drugs (except drugs taken as prescribed by a physician) or poison; or inhaling of gas or other inhalants;
7. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or
8. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of an accidental wound).

COORDINATION OF BENEFITS (COB)

COB may limit benefits when a Family Member is entitled to benefits from more than one source. It does this by relating the Family Member's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of a Family Member's Allowable Expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out in the policy, so that from all sources, a Family Member will not be paid for more than 100% of his or her Allowable Expenses.

ELIGIBILITY

The following persons are eligible to be Family Members:

1. You;
2. Your spouse; and
3. Your and Your spouse's children and adopted children, provided they are:

a. not married,
b. dependent on You for at least 50% of their support, and
c. less than 22 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.

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 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 Renewal Date after Your marriage is dissolved; (2) Your child’s coverage ends on the first Renewal Date after the date the child attains age 23, marries, or is no longer dependent upon you for at least 50% of their support, whichever is earliest; (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 outpatient prescription drug 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 actually dependent on You for a majority of their support, and covered by the policy on the date immediately preceding the day their coverage would have ended due to age. We may ask for proof of incapacity and dependency annually.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the date the child becomes capable of self-support, (2) the date the child's coverage under the policy ends for any reason other than age, (3) the date the policy ends; or (4) the date a Covered Charge is incurred if, as part of the required proof of loss, We ask for proof of the child's status and You fail to provide proof that as of the date the expense was incurred the child remains mentally or physically incapable of earning their own living and actually dependent on You for a majority of their support.

CONVERSION

We will issue a new policy to insure a Family Member whose coverage ends for any reason described in sections (1) and (2) of the End of Coverage provision. The new policy will be issued on this policy form. The premium will be based on the table of rates for the Family Member's age and sex.

We must receive a written request and the first premium:

1. Within 31 days after the coverage ends; or
2. In the case of dissolution of marriage, within 60 days from the date of the judgment granting the dissolution, 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

Pre-existing condition means a medical condition, for which, prior to the Effective Date of coverage: (1) the Family Member received medical advice or Treatment from a Physician within 60 months before the Effective Date of coverage, (2) medical advice or Treatment was recommended by a Physician within 60 months before the Effective Date of coverage; or (3) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or Treatment within 60 months before the Effective Date of the Family Member's coverage under this policy.

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.

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. Basic hospital or basic medical insurance coverage is not provided.

COVERED CHARGES

Olympic 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: 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.

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

PLAN CHOICE	**Olympic 100**		**Olympic 80**		**Olympic 60**	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
DEDUCTIBLES						
Individual Calendar Year Deductible	[$5,000 $7,500 $10,000]	[$10,000 $15,000 $20,000]	[$1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$2,000 $3,000 $5,000 $7,000 $10,000 $15,000]	[$500 $1,000 $1,500 $2,500 $3,500 $5,000 $7,500]	[$1,000 $2,000 $3,000 $5,000 $7,000 $10,000 $15,000]

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%]	[75% of $10,000]	[80% of $10,000]	[55% of $10,000]	[80% of $20,000]	[55% of $20,000]	[60% of $10,000]	[50% of $20,000]	[60% of $20,000]	[50% of $20,000]
Individual Out-of-Pocket Maximums (Includes deductible)	**Network [100%]**	**Non-Net [75% of $10,000]**	**Network [80% of $10,000]**	**Non-Net [55% of $10,000]**	**Network [80% of $20,000]**	**Non-Net [55% 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 $7,500 $10,000]	[$12,500 $17,500 $22,500]	[$3,000 $3,500 $4,500 $5,500 $7,000 $9,500]	[$6,500 $7,500 $9,500 $11,500 $14,500 $19,500]	[$5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $14,000 $16,000 $19,000 $24,000]	[$4,500 $5,000 $5,500 $6,500 $7,500 $9,000 $11,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]	[$8,500 $9,000 $9,500 $10,500 $11,500 $13,000 $15,500]	[$11,000 $12,000 $13,000 $15,000 $17,000 $20,000 $25,000]

Family Calendar Year Deductible and Family Out-of-Pocket Maximum	Family deductible is 2 times the individual deductible, met collectively by 2 or more persons. A family member begins receiving benefits after his/her individual deductible amount has been met or the family deductible has been met, whichever occurs first. Family Out of Pocket maximum is 2 times the individual Out-of-Pocket maximum, met collectively by 2 or more persons.

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	[First Health Network]

ACCIDENT BENEFIT	
Accident	If a family member sustains an injury, we will waive the deductible (copayments 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.

	Olympic 100		**Olympic 80**		**Olympic 60**	
PHYSICIAN SERVICES	**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 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	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)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
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]						

	Olympic 100		Olympic 80		Olympic 60	
PREVENTIVE CARE SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Human papillomavirus (HPV) Immunizations; Bone Density Test; Colorectal Cancer Exams; Lab work sent to an independent lab; all other preventive care services not specified elsewhere in the policy	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
[$1,000 Calendar Year maximum per family member] for the following services: Immunizations (except HPV) & Routine Physical Exams (age 19 and older); PSA Testing & Exams; Routine Mammograms; Pap Smears; Lab work performed in the office						
Childhood Immunizations (except HPV) (Birth through age 18)	100%	100%	100%	100%	100%	100%
Well Child Care (from birth through age 18)	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
HOSPITAL SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Inpatient **Non-emergency admissions**	Deductible, then we pay 100%	[$500] copay per admission, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per admission, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per admission, 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%	[$500] copay per surgery, then Deductible, then we pay 75%	Deductible, then we pay 80%	[$500] copay per surgery, then Deductible, then we pay 55%	Deductible, then we pay 60%	[$500] copay per surgery, then Deductible, then we pay 50%
Diagnostic Services Pre-admission Testing; X-rays; Nuclear Medicine; Ultrasounds; M.R.I.; Non-routine Mammograms; Lab Tests	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%

	Olympic 100		Olympic 80		Olympic 60	
EMERGENCY ROOM	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Emergency Injury Copay waived if admitted to hospital within 24 hours See Accident Benefit on page 2 **Emergency Sickness** Copay waived if admitted to hospital within 24 hours	[$250] copay per visit, then Deductible, then we pay 100%	[$250] copay per visit, then **Network** Deductible, then we pay 100%	[$250] copay per visit, then Deductible, then we pay 80%	[$250] copay per visit then **Network** Deductible, then we pay 80%	[$250] copay per visit, then Deductible, then we pay 60%	[$250] copay per visit, then **Network** Deductible, then we pay 60%
Non-emergency Sickness or Injury	Not Covered					
OTHER COVERED SERVICES	**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Air Ambulance	Network Deductible, then 80% Charges do not apply to out of pocket maximums and will be paid at 80% even after the out of pocket maximum has been met.					
Ambulance (other than air ambulance)	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 type of therapy] **Home Health Care** [20 visits per family member per Calendar Year] **Hospice** Up to [$200 per day, a lifetime maximum of $10,000 or 6 months, whichever comes first] **Skilled Nursing Facility** [60 days per family member per Calendar Year]	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Durable Medical Equipment	Deductible, then 50% Charges do not apply to out of pocket maximums and will be paid at 50% even after the out of pocket maximum has been met.					
Organ Transplants: Combined maximum lifetime benefit of [$1 million] per person **Designated Transplant Facility:** [$1 million] maximum benefit **Non-designated Transplant Facility:** [$750,000] maximum benefit	Deductible, then we pay 100%	Deductible, then we pay 75%	Deductible, then we pay 80%	Deductible, then we pay 55%	Deductible, then we pay 60%	Deductible, then we pay 50%
Maternity	Not Covered					
Mental Health	Not Covered					

OTHER COVERED SERVICES	
Accidental Death and Dismemberment	Primary Insured [$10,000]; Spouse [$2,500]; and Dependent Children [$1,000] (Full Amounts)

OPTIONAL BENEFITS	
GOLD BENEFITS	
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500-$3,500] the copay is [$30] Deductibles of [$5,000-$10,000] the copay is [$40] Non-Network: Non-Network Deductible and Benefit Percentage
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)	Network: Copay per visit, then we pay 100% Deductibles of [$500 - $3,500] the copay is [$60] Deductibles of [$5,000 - $10,000] the copay is [$80] Non-Network: Non-Network Deductible and Benefit Percentage
Allergy Injections	Network: 100% - Office Visit Copay does not apply Non-Network: Non-Network Deductible and Benefit Percentage
Preventive Care Immunizations (except HPV) & Routine Physical Exams (age 19 and older); Routine Mammograms; PSA Testing & Exams; Pap Smears; Lab work performed in the office The following will not be applied to or limited by the [$1,000] maximum: Well Child Care from birth through age 18	Network: Office Visit Copay, then we pay 100% up to [$1,000 calendar year maximum per family member] Non-Network: Non-Network Deductible and Benefit Percentage
Childhood Immunizations (except HPV) from birth through age 18	Network & Non-Network: 100%
Human papillomavirus (HVP) immunizations; Bone Density Tests; Colorectal Cancer Exams; Lab work sent to an independent lab; All other preventive care services not specified elsewhere in the policy	Network: Deductible, then we pay 100%, 80% or 60% based on plan chosen. Non-Network: Non-Network Deductible and Benefit Percentage
Emergency Room - Emergency Sickness or Injury	[$150] Copay per visit, then Network Deductible and Benefit Percentage Copay waived if admitted to hospital within 24 hours Non-emergency sickness or injury is not covered.

PRESCRIPTION DRUG OPTIONS

GENERIC PLAN OPTION		
	Retail	**Mail Order**
Generic Drugs Only	Up to [30-day] supply [20%] copay per prescription or refill [$15] Minimum	Up to [90-day] supply [20%] copay per prescription or refill [$45] Minimum
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy.		
Contraceptive Drugs and Devices are covered		

FOUR TIER PLAN OPTION		
Individual Prescription Drug Deductible: [$250] per Calendar Year Individual Out of Pocket Maximum for Specialty Drugs: [$2,500] per Calendar Year		
Family prescription drug deductible is 2 times the individual prescription drugs deductible, met collectively by 2 or more persons. A family member begins receiving prescription drug benefits after his/her individual prescription drug deductible amount has been met or the family prescription drug deductible has been met, whichever occurs first. Family Out of Pocket maximum for Specialty Drugs is 2 times the individual Out-of-Pocket maximum for Specialty Drugs, met collectively by 2 or more persons.		
	Retail Up to [30-day] supply	**Mail Order** Up to [90-day] supply
Generic Drugs & Diabetic Supplies:	[20%] copay per prescription or refill [$15] Minimum	[20%] copay per prescription or refill [$45] Minimum
Select Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$30] Minimum	Subject to Prescription Drug Deductible, then [30%] copay per prescription or refill [$90] Minimum
Additional Brand Name Drugs & Diabetic Supplies:	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$60] Minimum	Subject to Prescription Drug Deductible, then [50%] copay per prescription or refill [$180] Minimum
Specialty Drugs:	Subject to Prescription Drug Deductible, then [25%] copayment per prescription or refill (maximum [$250]) up to the Out of Pocket Maximum shown above, then 100% Up to [30 day] supply	
Prescription Drug Coverage benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-Participating Pharmacy. Specialty Drug benefits only apply at a Participating Specialty Pharmacy. No benefits are payable if a Specialty Drug is purchased at any other pharmacy.		
Mandatory Generic Provision If an Additional Brand Name Drug or Select Brand Name Drug is chosen when a Generic Drug is available, then the family member is responsible for the Generic Drug copay plus the difference between the cost of the Additional Brand Name Drug or Select Brand Name Drug and the cost of the Generic Drug and any deductible.		
Contraceptive Drugs and Devices are covered		

DENTAL OPTION

Dental Benefit [$1,000] calendar year maximum	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%

COVERED CHARGES

1) Daily hospital room and board:
   a. 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.
   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.
3) Surgical services:
   a. Surgeon's medical care or surgery. If two or more procedures are performed at the same operative session, the most We will pay:
      (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. Hospital Inpatient post mastectomy care of not less than 48 hours, however, the attending Physician after consulting with the Family Member may approve a shortened length of Hospital Inpatient stay.
   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. **Skilled Nursing Care** - Room and board, nursing care, medical services and supplies while Confined in a Skilled Nursing Facility covered at [60 days per calendar year].
   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 $10,000 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; and respite care
   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.
   e. **Preventive Care** - Covered Charges are subject to a maximum benefit of [$1,000 per calendar year] include the following:
      (1) Routine physical exams including lab services not sent to an independent lab, for a Family Member age 19 and older;
      (2) Immunizations, other than the human papillomavirus immunization for a Family Member age19 and older;
      (3) An annual Prostate-Specific Antigen (PSA) blood test and Digital Rectal Examination upon the recommendation of a licensed Physician for:
         (a) All males age 50 and over; and
         (b) Males age 40 and over with a family history of prostate cancer or men at risk;
      (4) An annual cervical smear or pap smear;
      (5) Routine mammograms, limited to:
         (a) One mammogram between the ages of 35 and 39;
         (b) One mammogram per year after age 39; and
         (c) One mammogram per year for women at risk.

      Covered Charges not subject to the Preventive Care Maximum include the following services:
      (1) Colorectal cancer screening for a Family Member who is:
         (a) Age 50 or older;
         (b) Less that age 50 who is at high risk for colorectal cancer according to the American Cancer Society guidelines for colorectal cancer screening; or
         (c) Experiencing symptoms of colorectal cancer as determined by a Physician.

         Covered Charges for colorectal cancer screening include the following:
         (a) An annual fecal occult blood test, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years;
         (b) A double-contract barium enema every 5 years; or
         (c) A colonoscopy every 10 years; and
         (d) Any additional medically recognized screening tests required by the Director of the Department of Health, determined in

consultation with appropriate health care organizations.

(2) Well child care benefits for a Family Member from birth through 18 years of age. Covered Charges for well child care must be rendered by or under the supervision of a single Physician during the course of one visit and include the following:
   (a) A medical history;
   (b) A complete physical exam;
   (c) A developmental assessment;
   (d) Anticipatory guidance;
   (e) *****Age appropriate immunizations, other than the Human papillomavirus (HPV) immunization; and
   (f) Appropriate laboratory test(s).
   *** Age appropriate immunizations are not subject to the Deductible, Benefit Percentage or Preventive Care maximum benefit. Immunizations will be covered at 100%.**
(3) Human papillomavirus (HPV) immunizations;
(4) Bone density tests;
(5) Lab work sent to an independent lab; and
(6) All other preventive services not specifically shown elsewhere in the policy.

f. **Physical, Occupational & Speech Therapy** - Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury. Services are limited to a maximum of [20 visits per calendar year per type of therapy].

g. **Outpatient spinal manipulation -** 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** - Services are subject to a maximum benefit of [$500 per calendar year].

i. **Allergy Injections**.

7) Other Benefits:

a. Injectable Prescription Drugs are covered subject the 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 is included in the policy and provides coverage for Generic Drugs only, then injectable Prescription Drugs are covered subject to the policy's Deductible and Benefit Percentage.
   If the Outpatient Prescription Drug Benefit Rider is included in the policy and provides coverage for Specialty Drugs, then injectable Prescription Drugs that are administered in a Physician's office are covered subject to the policy's Deductible and Benefit Percentage.

b. Prosthetics, except myo-electric or microprocessor prosthetics and dental prosthetics.

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 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. 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.

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. Coverage also includes reconstructive surgery of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

h. Contraceptive drugs and devices approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the terms, conditions and limitations contained on the Outpatient Prescription Drug Program Benefit Rider.

i. Contraceptive devices that are surgically implanted and are approved by the United States Food and Drug Administration are covered only if the optional Outpatient Prescription Drug Benefit Rider is included in the policy. Benefits are subject to the Benefit Provisions section of the policy and are not covered under the Outpatient Prescription Drug Benefit Rider.

j. Treatment of Type 1, Type 2, and gestational diabetes, if determined to be Medically Necessary and prescribed by a licensed Physician, including the following equipment, supplies and appliances:
   (1) Blood glucose monitors and blood glucose monitors for the legally blind;
   (2) Test strips for glucose monitors, which include glucose control solutions, lancet devices, and lancets for monitoring glycemic control;
   (3) Visual reading and urine test strips, which include visual reading strips for glucose, urine testing strips for ketones, or urine testing strips for both glucose and ketones;
   (4) Insulin;
   (5) Injection aids;
   (6) Syringes, including pen-like insulin injection devices and pen needles;
   (7) Insulin pumps and appurtenances which include insulin infusion pumps and supplies such as skin

preparations, adhesive supplies, infusion sets, cartridges, batteries and other disposable supplies needed to maintain insulin pump therapy. These include durable and disposable devices used to assist in the injection of insulin;

(8) Oral agents for controlling the blood sugar level, which are Prescription Drugs;

(9) Podiatric appliances for prevention of complication associated with diabetes, which include therapeutic molded or depth-inlay shoes, replacement inserts, preventive devices, and shoe modifications for prevention and treatment; and

(10) Glucagon emergency kits and Injectable glucagon.

k. Diabetes Self-Management Training must be provided by an appropriately licensed health care professional in accordance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Covered Charges is limited to:

(1) One training session per lifetime;

(2) Additional training sessions that are Medically Necessary because of a significant change in the Family Member's symptoms or condition and are order in writing by a Physician.

l. Medically Necessary Treatment of loss or impairment of speech or hearing, including communicative disorders generally treated by a speech pathologist or audiologist. Coverage does not include hearing instruments or devices.

m. Medical Foods and Low Protein Modified Food Products that are prescribed as Medically Necessary for the therapeutic treatment of a Family Member inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism. To be covered under the policy, the food products must be administered under the direction of a licensed Physician and the cost of the food products must exceed the income tax credit of $2,400 per year per person as allowed by Arkansas law.

n. The following care and Treatment of Your newborn child, provided the child is covered under the policy from the moment of birth as described under the Addition of a Newborn Child provision contained in the policy:

(1) Testing for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants that may be mandated by Arkansas law in the future.

(2) Treatment related to a premature birth.

(3) Routine nursery care and pediatric charges for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

o. Medically Necessary diagnosis and Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorders. Treatment includes both surgical and non-surgical procedures whether prescribed or administered by a Physician or a dentist.

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 [$750,000].

c. Covered Charges include Approved Transplant Procedures which are 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. If any benefits remain and are available under the Policy after the recipient's expenses have been paid, medical expenses of a live donor will be reimbursed.

f. Only approved Transplant Procedures are covered. No benefits will be paid if the transplant procedure is not approved in advance.

10) Accidental Death (including dismemberment and loss of sight) provides the following full amounts of insurance:

a. Primary Insured: [$10,000]

b. Spouse: [$2,500]

c. Child: [$1,000]

Benefits are payable if the loss results from an accidental bodily injury which occurred while insured under the policy; was independent of all other causes; and the loss occurs within 90 days after the accident bodily injury. However, benefits will be paid if use of extraordinary life support systems delays the loss for more than 90 days from the date of the accidental 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.

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.

PRE-EXISTING CONDITIONS LIMITATION

We will pay no benefits for charges due to a Pre-existing Condition for 3 years starting on the Effective Date of a Family Member's coverage under the policy.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

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

We will pay no charges, including the diagnosis and/or Treatment, due to any of the following. These charges are not Covered Charges and cannot be used to satisfy the policy's Deductible, Copayments or Benefit Percentage.

1. Charges in excess of the Usual, Customary, and Reasonable Charges for Non-Network services and supplies.
2. Charges for a Sickness or Injury caused or aggravated by suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
3. Charges for an Injury received while committing or attempting to commit a felony.
4. Charges caused by or contributed to by war or any act of war, whether or not declared, or participation in a riot or insurrection.
5. Charges for any Sickness contracted or Injury sustained while a member of the Military, Navy, or Air Force of any country or combination of countries.
6. Charges for any care given by or through any government or international authority unless the Family Member is legally required to pay the charges, except for Medicaid.
7. Charges for Treatment of Sickness or Injury covered by workers' compensation insurance or similar laws.
8. 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.
9. Charges for services or supplies for personal comfort or convenience.
10. Charges for travel or lodging expenses.
11. Charges for maintenance care, Custodial Care or homemaker services.
12. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.
13. Charges for dental services, supplies, or Prosthetics 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.
14. Charges for 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.
    b. Due to mastectomy as provided under the Medical Benefits section of the policy.
    c. Due to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect.
15. Charges for 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. 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, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury, except as provided under the Medical Benefits section of the policy.
17. 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.
18. 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.
19. Charges for care of a well, newborn child, except as provided under the Medical Benefits or Preventive Care Benefits section of the policy.
20. Charges for contraceptives, contraceptive methods or aids, unless the Schedule shows that the Outpatient Prescription Drug Benefit Rider is included in the policy.
21. Charges for emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
22. 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, in vitro fertilization, embryo transfer, fertility drugs, artificial insemination or similar procedures that augment or enhance reproduction ability.
23. Charges for gender reassignment or charges due to complications of gender reassignment.
24. Charges for the diagnosis and/or Treatment of acne.
25. Charges for the diagnosis and/or Treatment of eating disorders.
26. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.
27. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and nonchemical addictions.
28. Charges for hair loss, hair restoration or removal.

29. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.
30. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.
31. Charges for the diagnosis and/or Treatment of Substance Abuse.
32. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.
33. Charges for transplants, except as provided under the Medical Benefits section of the policy.
34. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
35. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.
36. Charges for the 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.
37. Charges for court-ordered evaluation, Treatment or testing.
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.
41. Charges for services available in the community through educational or school programs.
42. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.
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, except podiatric appliances for prevention of complications associated with diabetes, as provided under the Medical Benefits section of the policy.
45. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
46. Charges for the 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 telephone or electronic mail.
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 Treatment of an Injury received while engaging in any hazardous occupation or other activity for which compensation is received including, but not limited to the following:
    a. Participating, instructing, demonstrating, guiding, or accompanying others in parachute jumping, hang gliding, bungee jumping, competing with any motorized vehicle, skiing, or horse riding; or
    b. Practicing, exercising, conditioning, or other physical preparation for any such compensated activity.
52. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.
53. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.
54. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of the policy.
55. 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, reike therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
56. Charges for myo-electric or microprocessor Prosthetics.
57. 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.
58. 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.
59. 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.
60. Charges for which benefits are not provided in the policy.

PRESCRIPTION DRUG PROGRAM EXCLUSIONS

We will pay no benefits for charges due to any of the following:

1. Brand Name Drugs (this exclusion applies to the Generic Drug Plan only).
2. Prescription Drugs used to treat medical conditions that have been excluded from coverage by amendment or rider to the policy;
3. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy;
4. Non-federal legend drugs;
5. Contraceptive medications or devices that are not approved by the United States Food and Drug Administration for use as a contraceptive;
6. Contraceptive devices that are surgically implanted;
7. Fertility agents and medications;

8. Injectable or any prescription directing parenteral administration or use, except insulin (this exclusion applies to the Generic Drug Plan only);
9. Emergency contraception kits or any drugs that are intended to induce abortion;
10. Antidepressants;
11. Tranquilizers;
12. Miscellaneous psychotherapeutic agents;
13. Benzodiazepines;
14. Anti-manic agents;
15. Drugs to treat Attention Deficit Hyperactivity Disorder;
16. Substance abuse treatment agents;
17. Oral and topical acne medications;
18. Smoking deterrents;
19. All anti-obesity preparations;
20. Amphetamines;
21. Legend vitamins and fluoride products;
22. Drugs to treat influenza or lessen its symptoms;
23. Therapeutic devices or appliances;
24. Drugs with the primary purpose to stimulate or inhibit hair growth or for cosmetic purposes;
25. Immunization agents and vaccines;
26. Biologicals, blood or blood plasma;
27. Off-label use of prescription drugs except when insurance coverage is required by law;
28. Drugs labeled "Caution - limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual;
29. 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;
30. 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;
31. 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;
32. 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;
33. Charges for the administration or injection of any drug;
34. Medication furnished by any other drug or medical service for which no charge is made to the Family Member;
35. Federal legend drugs for which a non-prescription equivalent is available, regardless of dose;
36. 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;
37. Drugs for Treatment of onychomycosis (nail fungus);
38. Drugs for Treatment of impotency;
39. Federal legend drugs for which a non-prescription therapeutic alternative is available, regardless of dose;
40. Drugs to treat a cough or cold or lessen its symptoms;
41. Drugs to treat a migraine or headache;
42. Drugs not listed on the Formulary; and
43. Proton Pump Inhibitors.

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.

ACCIDENTAL DEATH EXCLUSIONS

No Accidental Death benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

1. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane;
2. Insurrection, riot or war;
3. The committing of, or the attempt to commit, an assault or felony;
4. Disease or disorder of the body or mind;
5. Medical or surgical treatment or diagnosis, preventive care or complications of care;
6. The voluntary taking of drugs (except drugs taken as prescribed by a physician) or poison; or inhaling of gas or other inhalants;
7. Injury or sickness arising out of or suffered during the course of employment or work related activity and duties; or
8. Ptomaines or bacterial infection (except only pyogenic infection occurring at the same time as, and as a result of an accidental wound).

COORDINATION OF BENEFITS (COB)

COB may limit benefits when a Family Member is entitled to benefits from more than one source. It does this by relating the Family Member's total benefits from various sources to his or her total expenses. The COB provision is widely used in the insurance industry. Its purpose is to keep the cost of insurance down by limiting benefits to no more than 100% of a Family Member's Allowable Expenses. Therefore, the benefits payable under this policy may be reduced, as appropriate under the rules set out in the policy, so that from all sources, a Family Member will not be paid for more than 100% of his or her Allowable Expenses.

ELIGIBILITY

The following persons are eligible to be Family Members:

1. You;
2. Your spouse; and
3. Your and Your spouse's children and adopted children, provided they are:

a. not married,
b. dependent on You for at least 50% of their support, and
c. less than 22 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.

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 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 Renewal Date after Your marriage is dissolved; (2) Your child’s coverage ends on the first Renewal Date after the date the child attains age 23, marries, or is no longer dependent upon you for at least 50% of their support, whichever is earliest; (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 outpatient prescription drug 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 actually dependent on You for a majority of their support, and covered by the policy on the date immediately preceding the day their coverage would have ended due to age. We may ask for proof of incapacity and dependency annually.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the date the child becomes capable of self-support, (2) the date the child's coverage under the policy ends for any reason other than age, (3) the date the policy ends; or (4) the date a Covered Charge is incurred if, as part of the required proof of loss, We ask for proof of the child's status and You fail to provide proof that as of the date the expense was incurred the child remains mentally or physically incapable of earning their own living and actually dependent on You for a majority of their support.

CONVERSION

We will issue a new policy to insure a Family Member whose coverage ends for any reason described in sections (1) and (2) of the End of Coverage provision. The new policy will be issued on this policy form. The premium will be based on the table of rates for the Family Member's age and sex.

We must receive a written request and the first premium:

1. Within 31 days after the coverage ends; or
2. In the case of dissolution of marriage, within 60 days from the date of the judgment granting the dissolution, 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

Pre-existing condition means a medical condition, for which, prior to the Effective Date of coverage: (1) the Family Member received medical advice or Treatment from a Physician within 60 months before the Effective Date of coverage, (2) medical advice or Treatment was recommended by a Physician within 60 months before the Effective Date of coverage; or (3) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or Treatment within 60 months before the Effective Date of the Family Member's coverage under this policy.

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.