

American Community Mutual Insurance Company

Medalist

INDIANA

Benefits Chart

GENERAL INFORMATION	Network	Non-Network
Benefit Percentages <i>Following fulfillment of the Calendar Year Deductible, Benefit Percentage applies to the next \$5,000 or \$10,000 in Network Covered Charges, then 100% thereafter (\$10,000 or \$20,000 of Non-Network Covered Charges). The Network and Non-Network Benefit Percentage maximums are not combined.</i>	80% 70%	50% 50% (of the Usual, Customary, and Reasonable charges)
Calendar Year Deductibles <i>(Network charges apply to the Network deductible only. Non-Network charges apply to both the Network and Non-Network deductible).</i>	\$500 \$1,000 \$1,500 \$2,500 \$5,000	\$1,000 \$2,000 \$3,000 \$5,000 \$10,000
Maximum Deductible to be met per family	2	
Lifetime Maximum	\$5,000,000	
Networks	Private HealthCare Systems (PHCS), or Sagamore PLUS	

PHYSICIAN SERVICES	Network	Non-Network
In Physician's Office and Urgent Care Centers: <ul style="list-style-type: none"> • Office visits • Office Surgery • X-rays • Laboratory tests (see Other Covered Services for lab work sent to an independent laboratory) 	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
In Physician's Office and Urgent Care Centers: Visits for injury	Deductible waived, Network Benefit Percentage only for expenses incurred within 30 days of an injury	Deductible waived, Non-network Benefit Percentage only for expenses incurred within 30 days of an injury
Allergy Testing, Serums and Allergy Injections <i>\$500 maximum per Family Member per Calendar Year</i>	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
In Hospital <ul style="list-style-type: none"> • Medical Visits • Surgery • Consultations • Radiology • Anesthesiology <ul style="list-style-type: none"> • Pathology • Physical Therapy • Speech Therapy • Occupational Therapy 	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member

- Please note:**
1. Services performed by providers other than your physician may be billed separately and may not be part of the "visit."
 2. Some emergency local ambulance services or hospital physicians, radiologists, anesthesiologists, and pathologists rendering services at Network hospitals may not be members of the Network. In this situation, hospital charges would be covered at the Network benefit level and the ambulance and physician charges at the Non-network benefit level.
 3. Copayments will not be applied toward the Calendar Year Deductible or Benefit Percentage per Family Member.

HOSPITAL SERVICES	Network	Non-Network
Inpatient Services	Network Calendar Year Deductible and Benefit Percentage per Family Member	\$500 Copayment per confinement then Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Outpatient Services <ul style="list-style-type: none"> • Outpatient Surgery 	Network Calendar Year Deductible and Benefit Percentage per Family Member	\$500 Copayment per visit then Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Diagnostic Services <ul style="list-style-type: none"> • Pre-admission testing • X-rays • Laboratory tests • Nuclear Medicine • MRIs • Ultrasounds • Mammograms 	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Emergency Room Services <ul style="list-style-type: none"> • Emergency Injuries • Emergency Sickness • Non-Emergency Sickness 	Deductible waived, then Network Benefit Percentage only for expenses incurred within 30 days of an injury \$50 Copayment, then Network Calendar Year Deductible and Benefit Percentage per Family Member (Copayment waived if admitted) Not Covered	Deductible waived, then Network Benefit Percentage only for expenses incurred within 30 days of an injury \$50 Copayment, then Network Calendar Year Deductible and Benefit Percentage per Family Member (Copayment waived if admitted) Not Covered

OPTIONAL BENEFITS	Network	Non-Network
Dental Benefit	See Brochure	
Preventive Care Benefit \$400 maximum of eligible charges per Family Member per Calendar Year	Deductible waived, 80% Benefit Percentage per Family Member	Not Covered
Maternity Benefit (for Insured & Spouse only) 270-day waiting period, measured from the rider effective date to the date the pregnancy began (the date the pregnancy began is determined by the attending physician)	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Doctor Office Copayment • Office visits • Office Surgery • X-rays • Laboratory tests (see Other Covered Services for lab work sent to an independent laboratory)	\$25 (\$500 Deductible) \$30 (\$1,000 Deductible) \$35 (\$1,500 Deductible) \$40 (\$2,500 Deductible) \$40 (\$5,000 Deductible)	Copayment per visit, then 100% up to \$500 per Calendar Year. After \$500 maximum, subject to Network Calendar Year Deductible and Benefit Percentage per Family Member

OTHER COVERED SERVICES	Network	Non-Network
Free Standing Surgery Center charges for outpatient surgery procedures	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Radiology or Diagnostic Imaging Center • X-rays • Nuclear Medicine • MRIs • Ultrasounds • Mammograms Laboratory (including lab work sent by a physician to an independent laboratory)	Network Calendar Year Deductible and Benefit Percentage per Family Member.	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Outpatient Physical, Occupational and Speech Therapy • Limited to 60 visits per Calendar Year (this is a combined total for all therapies)	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Home Health Care • 20 visits per Calendar Year	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Hospice • \$200 per day; \$7,500 per Hospice Benefit Period	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Skilled Nursing Facility • \$75 per day, 60 days per Calendar Year	Network Calendar Year Deductible and Benefit Percentage per Family Member	Non-network Calendar Year Deductible and Benefit Percentage per Family Member
Prescriptions • Drug Card 31 day supply plus refills	Generic: 20% Copayment per prescription or refill (<i>minimum: \$10</i>) Select Brand Name Drugs: 30% Copayment per prescription or refill (<i>minimum: \$35</i>) Additional Brand Name Drugs: 50% Copayment per prescription or refill (<i>minimum: \$50</i>)	Not Covered (no benefits are payable if the prescription is purchased at a non-participating pharmacy)
• Mail Order 90 day supply	Generic: \$20 Copayment per prescription or refill Select Brand Name Drugs : \$50 Copayment per prescription or refill Additional Brand Name Drugs: \$75 Copayment per prescription or refill	

- Prescription Drug Program
 1. Mandatory Generic Plan: If an additional Brand Name Drug or Select Brand Name Drug is chosen when a generic equivalent is available, then the insured is 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 Generic Drug.
 2. Maintenance drugs must be obtained through the Mail Order program, however, the initial supply may be obtained through a Participating Retail Pharmacy.

- **Pre-Existing Condition means an illness, disease or injury:**
 1. For which medical advice, diagnosis, care or Treatment was recommended or received during the 12 months prior to the Effective Date of a Family Member's coverage, or
 2. that produced symptoms within 12 months prior to the Effective Date of the Family Member's coverage which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or Treatment, or a pregnancy on the Effective Date.

An illness or disease which appeared 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.

We do not pay for any expense incurred due to a Pre-existing Condition for 12 months after the Effective Date of the Family Member's coverage. The 12 month period will be reduced for any Family Member by the amount of time the Family Member had continuously served under a Pre-existing Condition clause for a policy of accident and sickness insurance under the Indiana Small Employer Group Health Insurance laws, if the Family Member applies for this policy not more than 30 days after coverage issued under said laws expire.

- Mammogram - One baseline Mammogram between ages 35-39 and one Mammogram per year after age 39. One Mammogram per Calendar Year for women at risk.

This chart is a brief description of the benefits of the Medalist health plan. Refer to your policy for a complete list of benefits, limitations, and exclusions.