



Medalist

Health Insurance for Individuals & Families

Being financially prepared in the event of a serious illness is the reason you purchase health insurance. Here is how Medalist pays benefits in any Calendar Year.

For Network doctor office visits (if copayment option is chosen):

First

Then

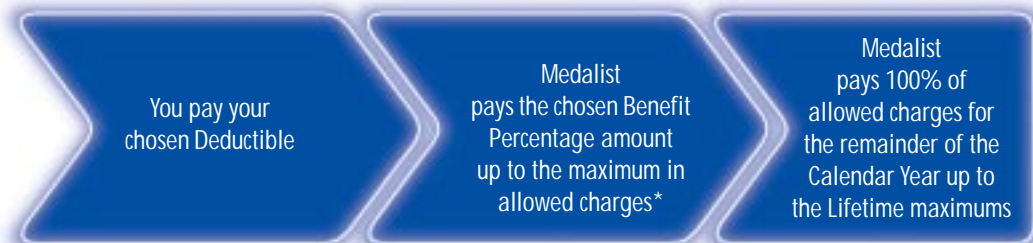


For Network doctor office visits and other Covered Services (if copayment option is not chosen):

First

Then

After That



\$5,000,000 Maximum Lifetime Benefit

Allowed charges for network are network negotiated rates. For non-network, they are the Usual, Customary, and Reasonable charges for your area.

**Network and Non-network maximums vary by state.*

Prescription Drug Program *(Varies by state. Please review your policy for details.)*

This benefit allows you to purchase generic or name brand drugs at participating pharmacies (non-participating pharmacy coverage varies by state). With participating pharmacies, there are no claim forms to be filed and no waiting for reimbursement.

A copayment is charged for each prescription. When medication is needed over an extended period, up to a 90 day supply can be obtained conveniently using the mail-order program. Mail-order medication should be received within two weeks of the order. If the medication is needed immediately, but will also be used on an ongoing basis, two prescriptions are required. One prescription for a 14-day supply of the medication (to be filled by your Prescription Drug Card), and a second prescription for the balance of the 90-day supply (to be filled by the mail service pharmacist). Authorized refills should be included with the original prescription for the 90 day supply.

Prescription drug copayments do not apply to the Calendar Year deductible or benefit percentage.

	Retail Pharmacy	Mail Order
Generic	20% (min. \$10 copay)	\$20
Select Brand Name Drugs	30% (min. \$35 copay)	\$50
Additional Brand Name Drugs	50% (min. \$50 copay)	\$75
Maximum Drug Supply	up to 31 days	up to 90 days

Generic Drug: A generic drug contains the same active ingredients and is subject to the same standards for quality and purity as a brand name drug. 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 the select brand name drug and generic drug.

Select Brand Name Drug: A list of commonly prescribed brand name medications that have been selected based on their clinical effectiveness and opportunities for cost savings.

The pharmacist may ask your permission to contact the physician for approved 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.

Additional Brand Name Drug: A brand name drug is the product name under which a drug is advertised and sold.

Other Provisions

Pre-existing Conditions Limitation

The Medalist Plan does **not** pay for any expense incurred due to any Pre-existing Condition during the 12 months following your effective date. A Pre-existing Condition which was fully disclosed on the application and was not excluded from coverage by a rider is not considered a Pre-existing Condition and will be covered (See state Benefits Chart for definition of Pre-existing Condition).

Organ Transplants

With prior approval from American Community, the maximum lifetime benefit is \$1,000,000 for organ transplants in a designated transplant facility (\$150,000 for non-designated transplant facilities) including anti-rejection drugs. When a designated transplant facility is used, an additional benefit of up to \$10,000 is included for travel and lodging expenses for one companion to the designated transplant facility. A designated transplant facility is a medical facility with a proven, exceptional success rate for organ transplants that has agreed to provide approved transplant services to our policyholders. Animal to human transplants and artificial or mechanical organs are excluded.

Covered Charges associated with an Approved Transplant procedure for a Family Member are reimbursed subject to the applicable deductible and benefit percentage per Family Member, up to benefit and policy lifetime maximums.

Renewability

Renewability is guaranteed in accordance with state and federal law as shown in the policy.

Rates

The premium is guaranteed for the first 12 months of coverage. After 12 months, American Community may modify, at any time,

the applicable premiums for all Medalist policies issued in your state.

Optional Benefits

If an optional benefit is selected, it applies to all Family Members and can only be added at time of application (except Maternity; see State Benefit Chart).

Doctor Office Visit Copay

Any time you visit your PPO provider due to sickness or injury, you pay your Copayment (see chart below). American Community then pays 100% up to \$500, then subject to Deductible and Benefit Percentage. Copayments will not be applied toward the Deductible or Benefit Percentage per Family Member.

For Non-Network Services, the Deductible and Benefit Percentage applies.

Deductible	Doctor Office Copayment
\$500	\$25
\$1,000	\$30
\$1,500	\$35
\$2,500 or \$5,000	\$40

Dental Benefit

The Dental Deductible and Benefit Percentage are separate from the Medical Deductible and Benefit Percentage. Orthodontics are not covered. The maximum benefit per person per Calendar Year is \$1,000 (Type 1 & 2 combined).

Type 1: No deductible required; charges for covered services are covered at 80% after a six month waiting period. Benefits include office visit and examinations, cleaning, x-rays, diagnostics, space maintainers and pathology.

Type 2: Charges for covered services are subject to a \$100 Calendar Year Deductible, then 50% after a 12 month waiting period. Benefits include fillings, oral surgery, extractions, root canals, endodontics, periodontics, crowns, inlays, bridges, and dentures.

Preventive Care *(Included in Michigan)*

Your deductible is waived, then 80% benefit percentage up to \$400 of eligible Covered Charges per person per Calendar Year. Covered Charges include routine physical exams, immunizations, and related lab tests or x-rays. The maximum annual benefit paid by American Community is \$320.

Maternity Benefit

The chosen Deductible and Benefit Percentage apply and coverage includes prenatal, delivery, inpatient and routine newborn care. There is a 270-day (180-day in IL) waiting period from the effective date of the policy/date rider added. The pregnancy must begin after the waiting period, for it to be covered.

Third Party Reimbursement and Subrogation

The Plan contains Third Party Reimbursement and Subrogation provisions that may reduce benefits under the Plan, a full description is contained in the policy.

End of Coverage

- Your spouse's coverage ends on the first premium due date after your marriage is dissolved.
- Your child's coverage ends on the first premium due date after:
 1. The child attains 23,
 2. The child marries, or
 3. The child is no longer dependent upon you for 50% of his or her support; whichever is earliest.
- Your or your dependent's coverage ends:
 1. If you or your dependent enter the Military Service, or
 2. When the Maximum Lifetime Benefit has been paid to you or your dependent.
- All coverage ends if you fail to pay the premium when due.

Customize Your Plan

Medalist allows you to choose a plan design that is right for your health care needs and budget. It also offers you increased benefits when a Family Member uses a Network Provider.

Deductibles

Choose from five network deductible amounts. The deductible is the amount of covered charges a Family Member must incur in a Calendar Year before the plan begins to pay benefits for that person. For services performed outside the network the deductible is two times the Network deductible.

- **Family Maximum-** Once two Family Members meet their Deductibles in a Calendar Year, the Deductible for all remaining Family Members is waived for the remainder of the year.
- **Accident Benefit-** Your deductible is waived and benefit percentage is applied for services incurred within 30 days of an injury. The deductible for the injured Family Member will not apply until the 31st day after the accident.

Deductibles					
Network	\$500	\$1,000	\$1,500	\$2,500	\$5,000
Non-Network	\$1,000	\$2,000	\$3,000	\$5,000	\$10,000

Benefit Percentage

After the Deductible has been met, you and American Community begin sharing expenses. The Benefit Percentage will determine the percentage of the expenses American Community pays and the amount you are required to pay to the maximum of allowed charges (network and non-network maximums vary by state). Allowed charges for network are network negotiated rates; for non-network, they are the Usual, Customary, and Reasonable charges for your area.

Benefit Percentage	
In-Network	Non-Network
80%	50%
70%	50%

Maximum	
In-Network	Non-Network
\$5,000	\$10,000
\$10,000	\$10,000 (MI only)
\$10,000	\$20,000 (not available in MI & NE)

After That

American Community pays 100% of allowable charges for the rest of the Calendar Year up to the lifetime per person maximum of \$5,000,000.

Preferred Provider Option

The Preferred Provider Option (PPO) gives you the freedom to choose your own physician or hospital. You can minimize your share of the health care costs by seeking medical services from a doctor who has contracted with the network. If your physician or hospital is not a member of the network, you share in more of the cost of your medical expenses. What makes our PPO plan so desirable is that it allows you to choose your own network physician and allows you access to a specialist when *you* feel it is necessary. A referral is not required. Your primary PPO network is shown on the front of your medical ID card.

In addition, you can receive the same network level of benefits when traveling outside your policy issue state through a coordinated program with National Preferred Provider Network (NPPN). There is no additional fee for this value-added benefit and a toll-free number is provided on the back of your medical ID card to locate network providers within the continental United States.

Inpatient and Outpatient Coverage

Highlights of the Medalist covered charges include:

Covered Hospital Charges

- Semi-Private room
- Intensive care
- Surgery
- Anesthesia
- Emergency room, emergency visits
- Physician visits
- Miscellaneous tests, services and medical supplies
- Nursing care
- Prescription drugs while confined

Covered Outpatient Charges

- Pre-admission testing
- Ambulance
- Surgery and anesthesia
- Second surgical opinions
- Physician services
- Mammogram
- Speech, physical and occupational therapy*
- Prescription drugs
- X-rays and lab tests
- Chemotherapy
- Hospital type equipment for kidney dialysis
- Radiation treatment
- Oxygen, blood and plasma
- Durable medical equipment
- Skilled nursing facilities*
- Home health care*
- Hospice care*
- Allergy testing*

* Please refer to the State Benefit Chart.

Benefits may be limited. Please review your policy for details.

General Exclusions and Limitations

We will not pay benefits for charges due to any of the following, except as otherwise provided in the policy. (May vary by state.)

■ Pre-existing conditions are not covered during the 12 months immediately following the effective date ■ Charges in excess of the Usual, Customary, and Reasonable Charges for services and supplies ■ Any sickness contracted or injury sustained while a member of the military of any country ■ Services or supplies not listed in the Covered Charges provision of the policy ■ Experimental, Investigational, or Unproven Procedures or Treatments including tests, examinations, or other procedures performed in preparation of or in follow-up to the procedure or treatment ■ Suicide or attempted suicide, whether or not sane, or intentionally self-inflicted injury ■ Auto related injuries (Michigan only) ■ Charges covered by Worker's Compensation or similar laws ■ Services by a volunteer, family member or resident in the insured's household ■ Services or supplies for personal comfort or convenience ■ Travel expenses ■ Homemaker expenses ■ Preventive care ■ Dental treatment or supplies ■ Cosmetic Treatment ■ Surgery to correct nearsightedness or farsightedness ■ Hearing aids and their fittings ■ Outpatient prescription drugs ■ Vitamins, herbals, botanicals and food supplements ■ Out of Hospital, non-surgical services as a result of or related to distortion, misalignment or subluxation of the vertebral column (Not applicable in Michigan or Nebraska) ■ Pregnancy (unless maternity benefit is chosen) ■ Well-baby care (unless maternity benefit is chosen) ■ Sterilization or reversal of sterilization ■ Contraceptives, contraceptive methods or aids ■ Fertility drugs and procedures ■ Gender reassignment, or charges due to complications of gender reassignment ■ Rest cure maintenance or custodial care ■ Treatment for hair restoration ■ Treatment for acne (unless medically necessary in Illinois) ■ Treatment of "quality of life" or "life-style" concerns including but not limited to eating disorders; weight loss programs, drugs or surgery; exercise programs or equipment; hair loss; sexual function, dysfunction, inadequacy or desire ■ Treatment for Mental or Nervous Disorders ■ Treatment for Substance Abuse (Not applicable in Michigan) ■ Physical, occupational or speech therapy for developmental reasons ■ Examination, diagnosis or treatment of malocclusion or misalignment of the jaw ■ Care covered under a government plan or program. Services covered by Medicare or eligible for coverage by Medicare ■ Services that are not provided under the direct care of a physician, or outside the scope of a physician's license ■ Charges arising from war, commission of a felony, or participation in a riot or insurrection ■ Transplants ■ Routine soft tissue foot care including but not limited to treatment of flat feet or other structural misalignment, toe nails, callus, or orthotic appliances. Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts ■ Routine or court ordered physical examinations ■ Genetic testing, counseling and services ■ Inoculations or prophylactic drugs for travel ■ Food, special foods or diets ■ Growth treatment, medication or hormones ■ Eye training, exercises or vision therapy ■ Services available in the community through educational or school programs ■ Learning disabilities, attitudinal disorders or disciplinary problems ■ Evaluation or treatment of learning disabilities; attitudinal disorders; or disciplinary, social or developmental conditions ■ Care, services, procedures, or supplies that are cognitive in nature

Prescription Drug Card Program Exclusions

The following drugs are not considered Covered Drugs, except as otherwise provided in the policy. (May vary by state.)

■ Non-federal legend drugs ■ Contraceptive medications or devices ■ Fertility agents and medications ■ Injectables; except insulin ■ Emergency contraception kit ■ Antidepressants ■ Tranquilizers ■ Psychotherapeutic agents ■ Benzodiazepines ■ Antimanic agents ■ Drugs to treat attention deficient hyperactivity disorder ■ Substance abuse treatment agents ■ Oral and topical acne treatments ■ Smoking deterrents ■ Antiobesity preparations ■ Amphetamines ■ Vitamins and fluoride products, ■ Drugs to treat influenza ■ Therapeutic devices or appliances ■ Drugs to stimulate or inhibit hair growth or for cosmetic purposes ■ Immunization agents and vaccines ■ Biologicals, blood or blood plasma ■ Drugs labeled "Caution - limited by Federal Law to investigational use", or experimental drugs ■ Medication for which the cost is recoverable under any Workers Compensation or Occupational Disease Law ■ Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is an in-patient in a hospital or other facility ■ Prescriptions filled in excess of the number of refills specified by the physician ■ Federal legend drugs for which a non-prescription equivalent is available ■ Growth hormones or medications ■ Drugs for treatment of nail fungus ■ Drugs for treatment of impotency

Dental Exclusions (if option is chosen)

We will not pay benefits for charges due to any of the following, except as otherwise provided in the policy. (May vary by state.)

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

This brochure is a description of the Medalist health plan-Policy Form PMED. This brochure is not your policy.

Your policy provides a complete list of benefits, limitations, and exclusions.