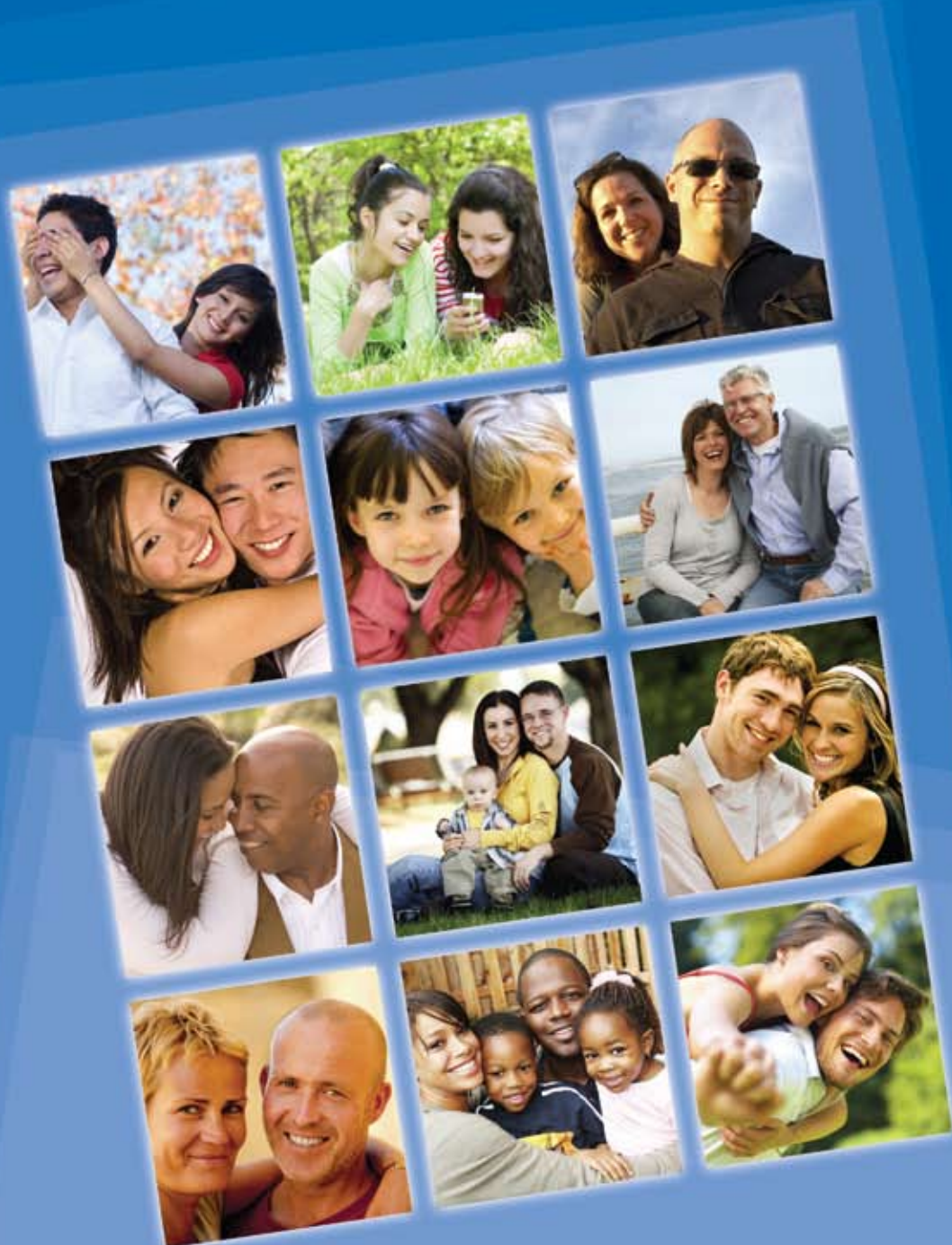


# Community Flex™

Health Insurance for  
Individuals and Families



# Community Flex

## Community Flex™— The Freedom to Choose

These days, meeting the demands of rising medical expenses requires a flexible approach—protection and choice without a hefty price tag. But many health insurance plans limit your options so you end up paying a higher premium for coverage you may never need. Instead, you should be able to design a health plan that's just right for you. Now you can, with American Community's unique new product for individuals and families—Community Flex™.

### Back to Basics

Now more than ever, the right protection—at the right price—is important for your health, your wallet, and your peace of mind. Community Flex allows you to choose from a variety of deductibles and benefit percentages. That way, you can save on premium while benefiting from the coverage that's just right for you.

### Upgrade to Gold

Unique to Community Flex is the option to upgrade to our Gold Benefits package. With the Gold package, you receive richer benefits for covered services. When you upgrade to Gold, you get even more protection for widely used services, like preventive care, allergy injections, urgent care, and emergency room services.

### The Freedom to Choose

Whether you need basic coverage or a richer health plan, Community Flex gives you the freedom to choose what's right for you. With it, you get personalized protection, value, and peace of mind. Now that's real flexibility.

## The Flex Advantage

### Immediate Coverage for Accidents

Accidents are often unavoidable, and the expenses they create can be financially devastating. At American Community, we believe you should focus on recovery when a family member is injured. That's why Community Flex includes an accident benefit offering the utmost in protection—immediate coverage. Within the first 30 days of an injury, your deductible is waived and covered charges are paid at the network or non-network benefit percentage (after any applicable copayment). After the 30-day period, covered charges are paid or applied to your deductible as appropriate.

### Other Advantages

- ✓ Extensive PPO network
- ✓ \$5 million lifetime policy maximum per person
- ✓ Accidental Death & Dismemberment for primary insured, spouse and dependents
- ✓ 24-month premium rate guarantee on deductibles of \$5,000 or higher<sup>1</sup>

<sup>1</sup>See the Premium Rates section for more details.

### Included With the Plan

- ✓ Accident Benefit
- ✓ Physician Services
- ✓ Preventive Care
- ✓ Hospital Services
- ✓ Emergency Room Services
- ✓ Value Discount Drug Card
- ✓ Vision Exam Benefit<sup>2</sup>
- ✓ Maternity Coverage with specific maternity deductible<sup>3</sup>

<sup>2</sup>Not available in Arkansas, Missouri or Texas.

<sup>3</sup>Not available in Arkansas, Iowa, Missouri or Texas.

### Optional Benefits

- ✓ Gold Benefits (enhanced coverage)
- ✓ Prescription Drug Coverage
- ✓ Dental Coverage<sup>4</sup>

<sup>4</sup>Not available in Tennessee.



## Covered Expenses

- |                             |  |   |
|-----------------------------|--|---|
| ✓ Allergy testing           | ✓ Mammograms   | ✓ Radiation treatment                       |
| ✓ Ambulance                 | ✓ Miscellaneous tests, services and medical supplies | ✓ Second surgical opinions                  |
| ✓ Chemotherapy              | ✓ Nursing care                                       | ✓ Semi-private room                         |
| ✓ Durable medical equipment | ✓ Organ transplants                                  | ✓ Skilled nursing facilities                |
| ✓ Emergency room            | ✓ Oxygen, blood and plasma                           | ✓ Speech, physical and occupational therapy |
| ✓ Home healthcare           | ✓ Physician visits                                   | ✓ X-rays and lab tests                      |
| ✓ Hospice care              | ✓ Preventive care                                    |   |
| ✓ Intensive care            |  |   |

## Calendar Year Deductibles

The deductible is the amount of covered charges you incur in a calendar year before the plan begins to pay benefits. With Community Flex, you can select from multiple network deductible amounts within the plan. For services performed outside the PPO network, the deductible amount is two times the applicable network deductible. Network charges apply to the network deductible only. Non-network charges apply to the non-network deductible only.

**Family Deductible:** The family deductible is 2 times the single deductible, met collectively by 2 or more persons. A family member begins receiving benefits after his/her single deductible amount has been met. All family members on the policy begin receiving benefits once the family deductible has been met.

## Benefit Percentage

The benefit percentage is the percentage of cost you pay for covered medical services after you meet your deductible. For example, once your deductible is met, you might pay 20% of your healthcare expenses, up to the out-of-pocket maximum you select, while your plan pays the remaining 80%, up to the out-of-pocket maximum you select.

After you meet your deductible and out-of-pocket maximum, American Community pays 100% of eligible covered charges<sup>5</sup> for the rest of the calendar year, up to a lifetime per person maximum of \$5 million.

<sup>5</sup>Certain exceptions apply; see additional information on page 8.

## Copayment

The copayment, or copay, is the set amount you pay each time you receive medical services, such as visiting the doctor or filling a prescription. You make your copayment before benefits

are paid. Copays are not credited to your deductible or out-of-pocket maximum.

## Your Provider Network

With Community Flex, you have the freedom to choose your own doctor or hospital. You can minimize your share of the healthcare costs by using doctors and hospitals that are part of your preferred provider organization (PPO) network. American Community has contracted with the leading PPO networks across the country, offering access to high-quality hospitals, primary care physicians, specialists and other providers.

Your PPO network is shown on the front of your medical identification (ID) card. If your doctor is not a member of the PPO, you still have the freedom to see your provider, but you share in more of the costs of your medical expenses. What makes our PPO plan so desirable is that it allows you access to a specialist when you feel it is necessary—a referral is not required.

## Travel Network – Added Value, No Additional Cost

We encourage you to use your designated PPO network whenever possible to receive the best discounts on provider services. However, we realize staying in-network is not always possible if you're traveling out-of-state or you have children attending college outside your PPO network area. For those instances, American Community offers you the use of a nationwide PPO travel network, at no additional fee, so you can still receive the network level of benefits when you're away from home. A toll-free number is provided on the back of your medical ID card to help you locate available providers within this travel network.

| Community Flex Plan Choice | Individual Network Calendar Year Deductible | Network Benefit Percentage You Pay | Individual Network Maximum You Will Pay Per Calendar Year, Including Deductible |
|----------------------------|---|------------------------------------|---|
|----------------------------|---|------------------------------------|---|

Family Deductible is 2 times the individual deductible, met collectively by 2 or more persons.

Non-Network deductible is 2 times the Network deductible.

|   |          |    |          |
|---|----------|----|----------|
| <b>Flex 100</b><br>Non-Network Benefit Percentage is 70% <sup>6</sup><br><sup>6</sup> 75% in Arkansas | \$5,000  | 0% | \$5,000  |
|   | \$7,500  |    | \$7,500  |
|   | \$10,000 |    | \$10,000 |

|  |         |                                       | 20% of \$10,000 | 20% of \$20,000 |
|--|---------|---------------------------------------|-----------------|-----------------|
| <b>Flex 80</b><br>Non-Network Benefit Percentage is 50% <sup>7</sup><br><sup>7</sup> 55% in Arkansas | \$1,000 | 20% of \$10,000 or<br>20% of \$20,000 | \$3,000         | \$5,000         |
|  | \$1,500 |                                       | \$3,500         | \$5,500         |
|  | \$2,500 |                                       | \$4,500         | \$6,500         |
|  | \$3,500 |                                       | \$5,500         | \$7,500         |
|  | \$5,000 |                                       | \$7,000         | \$9,000         |
|  | \$7,500 |                                       | \$9,500         | \$11,500        |

|   |         |                                       | 40% of \$10,000 | 40% of \$20,000 |
|---|---------|---------------------------------------|-----------------|-----------------|
| <b>Flex 60</b><br>Non-Network Benefit Percentage is 50% | \$500   | 40% of \$10,000 or<br>40% of \$20,000 | \$4,500         | \$8,500         |
|   | \$1,000 |                                       | \$5,000         | \$9,000         |
|   | \$1,500 |                                       | \$5,500         | \$9,500         |
|   | \$2,500 |                                       | \$6,500         | \$10,500        |
|   | \$3,500 |                                       | \$7,500         | \$11,500        |
|   | \$5,000 |                                       | \$9,000         | \$13,000        |
|   | \$7,500 |                                       | \$11,500        | \$15,500        |

**Premium is guaranteed for 24 months for network deductibles of \$5,000 or higher.<sup>8</sup>**

|                                |                        |
|--------------------------------|------------------------|
| <b>Lifetime Policy Maximum</b> | \$5 million per person |
|--------------------------------|------------------------|

| Type of Service   | Flex (100%, 80% or 60%)  | Gold Benefits Option  |
|---|--|---|
| <b>Office Visits/Urgent Care Centers</b> <ul style="list-style-type: none"> <li>Office Visit/Urgent Care Center evaluation and management services</li> <li>X-Ray and Laboratory performed on site</li> </ul> | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Non-network deductible and benefit percentage | <b>Network: Copay</b> per visit then we pay <b>100%</b><br><b>Non-network:</b> Non-network deductible and benefit percentage<br>For deductibles of \$500-\$3,500, copay is \$30 for Office Visit/\$60 for Urgent Care<br>For deductibles of \$5,000-\$10,000, copay is \$40 for Office Visit/\$80 for Urgent Care |
| <ul style="list-style-type: none"> <li>Injections</li> <li>Diagnostic Services</li> <li>Surgical Procedures</li> <li>Chemotherapy and radiation therapy</li> </ul>  | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Non-network deductible and benefit percentage |   |

<sup>8</sup>For network deductibles of \$500-\$3,500, the premium rate is guaranteed for the first 12 months of coverage. The rate guarantee may become invalid as a result of plan changes, change in residence, or dependent child attaining adult status.

| Type of Service  | Flex (100%, 80% or 60%)   | Gold Benefits Option   |
|--|---|--|
| <b>Preventive Care</b> <ul style="list-style-type: none"> <li>• HPV Immunizations</li> <li>• Bone Density Test</li> <li>• Colorectal Cancer Screening</li> </ul> | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Not covered  |  |
| \$1,000 maximum per family member: Immunizations, except for HPV; Lab work; Routine Physical Exams; PSA Testing & PAP Smears<br>Mammograms (Screening)           | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Not covered  | <b>Network:</b> Office visit copay and <b>100%</b><br><b>Non-network:</b> Not covered  |
| <b>Allergy Treatment</b> (12-month waiting period)<br>Injections   | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Non-network deductible and benefit percentage  | <b>Network:</b> 100%<br><b>Non-network:</b> Non-network deductible and benefit percentage  |
| Testing and Serums \$500<br>Calendar Year Maximum per Family Member  | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Non-network deductible and benefit percentage  |  |
| <b>Emergency Room</b><br>Sickness and Injury. Non-emergency not covered.   | <b>Network and Non-network:</b> \$250 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours.  | <b>Network and Non-network:</b> \$150 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours. |
| <b>Accident Benefit</b>  | Deductible is waived and covered charges related to the injury are paid at the network or non-network benefit percentage (after any applicable copayment) 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. |  |
| <b>Hospital</b>  |   |  |
| Emergency admissions   | <b>Network and Non-network:</b> Network deductible and benefit percentage   |  |
| Non-Emergency admissions   | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> \$500 copay, then Non-network deductible and benefit percentage  |  |
| Outpatient Surgery   | <b>Network:</b> Deductible and benefit percentage<br><b>Non-network:</b> Non-network deductible and benefit percentage  |  |
| In-Hospital Services   |   |  |
| <b>Maternity</b><br>Benefit for policyholder or spouse only, if spouse is covered under the policy (not available in Arkansas, Iowa, Missouri or Texas)          | <b>Advantage:</b> Network discounts apply when network providers are used.<br><b>Coverage:</b> \$12,000 maternity-specific deductible and paid at network or non-network benefit percentage.<br>90-day waiting period from the effective date. To be covered, pregnancy must begin after the waiting period.      |  |
| <b>Prescription Drugs</b>  | Value discount drug card for preferred pricing on select generic and brand name prescription drugs at network retail outlets.   |  |
| <b>Prescription Drug Options</b>   | <b>Retail 31-day supply</b>   | <b>Mail Order 90-day supply</b>  |
| <b>Option 1 - Generic Only</b>   | 20% copayment, \$15 minimum   | 20% copayment, \$35 minimum  |
| <b>Option 2 - Four-Tier Option</b>   | \$250 deductible (waived for Generic)   |  |
| Generic  | 20% copayment, \$15 minimum   | 20% copayment, \$40 minimum  |
| Select Brand   | 30% copayment, \$30 minimum   | 30% copayment, \$80 minimum  |
| Additional Brand   | 50% copayment, \$60 minimum   | 50% copayment, \$150 minimum   |
| Specialty  | 25% copayment, no minimum, 31-day supply<br>\$250 copay maximum per prescription<br>\$2,500 out-of-pocket maximum per person, per calendar year   |  |
| <b>Dental Option (not available in Tennessee)</b>  |   |  |
| <b>Dental Benefit</b><br>\$1,000 maximum per person per calendar year  | Type 1 procedures: 6-month waiting period and we pay 80%<br>Type 2 procedures: 12-month waiting period, \$100 calendar year deductible and we pay 50%   |  |

# Community Flex

## Coverage Highlights

### Accident Benefit

You have enough to worry about when you or a family member is injured. The Community Flex Accident Benefit provides immediate coverage for the injured member of your family within 30 days of the injury:

- ✓ Deductible is waived
- ✓ Covered charges related to the injury are paid at the applicable benefit percentage after any applicable copayment

After 30 days, the deductible will be applied for any covered services related to the injury.

### Accidental Death and Dismemberment (AD&D)

An accident can strike suddenly, usually when you're not prepared financially. Community Flex provides the comfort of knowing that you or your designated survivor(s) can receive a monetary benefit in the event of your accidental death or dismemberment.

Our AD&D benefit provides funds in the event of a fatal accident or an accident that results in the loss of a hand or foot or eyesight of the primary insured, spouse, and dependent children:

- ✓ Primary insured: \$10,000
- ✓ Spouse: \$2,500
- ✓ Dependent child: \$1,000

### Preventive Care Benefits

At American Community, we subscribe to the notion that an ounce of prevention is worth a pound of cure. That's why Community Flex covers several potentially life-saving preventive services at the chosen benefit percentage in-network after the deductible:

- ✓ HPV immunizations
- ✓ Bone density test
- ✓ Routine mammograms
- ✓ Colorectal cancer exams

A \$1,000 calendar year maximum benefit per family member applies for these preventive services:

- ✓ Immunizations, except for HPV
- ✓ Routine physical exams
- ✓ PSA testing & exam
- ✓ Pap smears
- ✓ Lab work

### Value Discount Drug Card

Included with Community Flex medical coverage is a value discount drug card. This card can be used at network retail pharmacies for preferred pricing on select generic and brand name prescription drugs. This is a discount card only. There are no benefits paid under the policy.

### Vision Exam Benefit<sup>9</sup>

Included with Community Flex is a Vision Exam benefit at VSP member facilities. This benefit covers one eye exam every 12 months with a \$10 copay. Discounts are available on eyeglasses and physician services for contact lenses.

<sup>9</sup>Not available in Arkansas, Missouri or Texas.

### Savings on Maternity Expenses<sup>10</sup>

When you're expecting, it's normal to have a lot of concerns, including how you're going to pay for everything. Doctor visits, tests, hospital and newborn expenses can really add up. Community Flex provides, at no additional premium, savings for maternity expenses so you have one less thing to worry about during this exciting time in your life.

### Network Discounts

The main advantage of the Community Flex maternity benefit is that it's included with the plan. That means you receive network discounts on your maternity expenses when you use providers in your PPO network. These discounts result in savings for you.

All your maternity expenses are applied to a maternity-specific deductible of \$12,000. Should your costs for a routine pregnancy and birth exceed that deductible amount, Community Flex coverage pays the excess at your specified benefit percentage.

Maternity benefits are subject to a 90-day waiting period from the policy effective date; the pregnancy must begin after that waiting period to be covered.

<sup>10</sup>Not available in Arkansas, Iowa, Missouri or Texas.

### Medical Benefit Covers Pregnancy Complications

In the unfortunate event of pregnancy complications, your medical costs for those complications are covered by the Community Flex medical benefit. That means coverage begins once your plan deductible (not the maternity deductible) has been satisfied.

## Optional Benefits

### Optional Prescription Drug Coverage

Our optional prescription drug coverage offers two types of plans—Generic Only or a Four Tier Plan option.

**Option 1 - Generic Only** – Covers generic drugs at a participating retail pharmacy up to a 31-day supply, or up to a 90-day supply for mail-order generic drugs, after the copay.

**Option 2 - Four Tier Plan** – Covers generic, select brand, and additional brand drugs at a participating retail pharmacy up to a 31-day supply, or up to a 90-day supply through the mail-order program. A \$250 prescription drug deductible per calendar year applies for select brand, additional brand, and specialty drugs. Covers specialty drugs up to a 31-day supply through a participating specialty pharmacy, subject to a maximum copay and out-of-pocket maximum per calendar year.

### Gold Benefits Option

An option with Community Flex insurance is an upgrade to our Gold Benefits package. With the Gold option, you can purchase richer benefits to suit your medical needs.

The Gold package includes, for 100% in-network coverage:

- ✓ Office Visits (after applicable copay)
- ✓ Allergy Injections (no copay)
- ✓ Urgent Care (after applicable copay)
- ✓ Preventive Care (after applicable copay; \$1,000 maximum per calendar year)
- ✓ Routine Mammograms (part of Preventive Care; \$1,000 maximum does not apply)

Other enhanced benefits that are part of the Gold package include:

- ✓ Reduced copay on Emergency Room for Emergency Sickness and Injury — \$150 copay, then network deductible and benefit percentage for both network and non-network services.

### Optional Dental Coverage<sup>11</sup>

Dental coverage is another option with Community Flex. The dental deductible and benefit percentage are separate from the medical deductible and benefit percentage. The maximum dental 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 6-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.

<sup>11</sup>Not available in Tennessee.

## Premium Rates and Renewability

### Premium Rates

Your premium rate is guaranteed<sup>12</sup> for the first 24 months of coverage when a deductible of \$5,000 or higher is chosen. For network deductibles of \$500 - \$3,500, the premium rate is guaranteed for the first 12 months of coverage. After the initial premium rate guarantee period, American Community may modify, at any time, the applicable premium rates for all Community Flex policies in your state. Modification of premium rates is based on claims experience of ALL Community Flex policies within the same state, not just your claims experience.

<sup>12</sup>The rate guarantee may become invalid as a result of certain plan changes, change in residence, or dependent child attaining adult status.

### Renewability

Renewability is guaranteed in accordance with state and federal law, as shown in the policy. Renewability is NOT based on your claims experience.



# Community Flex

## Additional Information

### Limited Benefits

- ✓ Transplant Benefit Combined Lifetime Maximum: \$1,000,000
- ✓ Designated Transplant Facility Maximum: \$1,000,000
- ✓ Non-Designated Transplant Facility Maximum: \$500,000
- ✓ 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
- ✓ Outpatient Spinal Manipulation: \$500 per Calendar Year
- ✓ Air Ambulance: Network Deductible then 80%. Does not apply to the Out-of-Pocket Maximum You Pay
- ✓ Durable Medical Equipment: Network or Non-Network Deductible then 50%. Does not apply to the Out-of-Pocket Maximum You Pay

### Covered After a Waiting Period

Treatment of the following conditions are not covered during the first 12 months the coverage is in force: Tonsils, adenoids, bunions, hemorrhoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy (unless the condition is life-threatening), carpal tunnel surgery, joint replacement, myringotomy, nasal repair (including rhinoplasty and septoplasty), retained hardware removal, amenorrhea, cataracts, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, and uterine prolapse.

*May not be applicable in all states. Please refer to the state variation page or the policy/certificate for additional information on limited benefits.*

### Community Flex™ Copay Prescription Drug Plan

Community Flex™ is designed to help individuals and families hold down their medical expenses, including their prescription drug costs. For that reason, Community Flex has its own drug formulary, which includes a Step Therapy program for certain drug classes. Step Therapy promotes safe and cost-effective drug use based on nationally accepted treatment standards and

well-documented clinical drug studies. Within selected drug classes, a member must try a generic drug for 30 days (within the past 365 days) before a brand drug is covered. For more information on Step Therapy, please refer to our website at [http://www.american-community.com/MiscForm/step\\_therapy.pdf](http://www.american-community.com/MiscForm/step_therapy.pdf).

## Individual Non-Network Benefits

The chart below illustrates your maximum out-of-pocket cost per calendar year when using non-network providers.

| Community Flex Plan Choice | Non-Network Benefit Percentage You Pay | Non-Network Maximum You Pay Per Calendar Year |
|----------------------------|--|---|
| <b>Flex 100</b>            | 30% <sup>13</sup> of \$10,000          | Non-Network deductible + \$3,000              |
| <b>Flex 80</b>             | 50% <sup>13</sup> of \$10,000          | Non-Network deductible + \$5,000              |
| <b>Flex 80</b>             | 50% <sup>13</sup> of \$20,000          | Non-Network deductible + \$10,000             |
| <b>Flex 60</b>             | 50% of \$20,000                        | Non-Network deductible + \$10,000             |
| <b>Flex 60</b>             | 50% of \$20,000                        | Non-Network deductible + \$10,000             |

*Non-Network Family Out-of-Pocket Maximum you will pay is 2 times the Individual, met collectively by 2 or more persons.*

<sup>13</sup>In Arkansas: Flex 100 is 25%, Flex 80 is 45%.



## General Exclusions

Some of the services that Community Flex does NOT cover include:

- ✓ Pre-existing conditions for the 24-month period starting on the effective date of coverage. Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of the policy/certificate, if approved, only if such sickness, injury, or condition is fully disclosed on the application and is not excluded from coverage by a rider or policy/certificate exclusion.
- ✓ Charges in excess of the usual, customary, and reasonable charges for non-network services and supplies
- ✓ Charges for services that are experimental, investigational, unproven or for research
- ✓ Charges arising from war, commission of a felony, or participation in a riot or insurrection
- ✓ Any sickness contracted or injury received while a member of the military
- ✓ Charges for sickness or injury that are covered by workers' compensation insurance or similar laws
- ✓ Treatment given in a hospital emergency room for a non-emergency sickness or injury
- ✓ Prescription Drugs, unless the prescription drug benefit is purchased
- ✓ Vitamins, supplements
- ✓ Services and supplies related to alternative and complementary medicine
- ✓ Breast reductions
- ✓ Treatment, testing, and surgical intervention of sleep disorders (e.g., sleep apnea)
- ✓ Learning disabilities, Attention Deficit Hyperactivity Disorders
- ✓ Charges for dental services or supplies, unless the dental benefit rider is purchased
- ✓ Cosmetic treatment, except as provided in the policy
- ✓ Care covered under a government program
- ✓ Eyeglasses, contact lenses, eye surgery
- ✓ Artificial hearing devices, cochlear implants
- ✓ Contraceptives, sterilization, voluntary abortion, infertility treatment
- ✓ Treatment for hair loss restoration or removal
- ✓ Treatment of acne
- ✓ Treatment for mental or nervous disorders, or emotional conditions
- ✓ Treatment for substance abuse
- ✓ Examination, diagnosis, appliances or treatment of malocclusion, misalignment, dysfunction, deformity, defect of the jaw or TMJ
- ✓ Charges for services that are not medically necessary
- ✓ Services performed by volunteers or relatives
- ✓ Services or supplies for comfort, convenience, maintenance, custodial care, or non-medical expenses
- ✓ Replacement, maintenance or repair of prosthetics or durable medical equipment
- ✓ Suicide or attempted suicide
- ✓ Gender reassignment, sexual function or dysfunction
- ✓ Treatment of eating disorders or services and supplies for weight loss
- ✓ Charges for smoking cessation
- ✓ Genetic testing
- ✓ Growth hormones
- ✓ Charges for routine foot care; shoes, shoe accessories, or orthotics
- ✓ Treatment for an injury received while engaging in a hazardous occupation or activity for which compensation is received
- ✓ Charges for which benefits are not provided in the policy
- ✓ Charges for travel or lodging expenses

# Community Flex

## Your American Community Agent

Your American Community agent is an independent health insurance specialist. Health insurance is your agent's business—dedication to the full, best interest of you, the client, is his or her specialty. You can count on it.

## American Community

American Community Mutual Insurance Company is one of the most established insurance companies in America. With beginnings dating back to 1938, American Community has a long history of insuring America's communities with an entire range of quality, affordable health insurance products. As a mutual company, American Community is owned by our policyholders who guide our products and processes, ensuring a collective understanding and focus.

At American Community, we're experienced and reliable. We take great pride in the products and services we offer to our customers, including:

- ✓ Flexible products with adaptable coverage to fit your needs, and a choice of billing options.
- ✓ Easy, toll-free access to friendly experts for your questions and concerns. We even offer assistance in Spanish from our team of bilingual representatives.
- ✓ Prompt claims payment. In fact, most claims are processed within 10 business days of receipt.
- ✓ No claim forms to file. You don't have to worry about the paperwork— we'll handle getting the appropriate claim information from your provider.







AMERICAN COMMUNITY  
MUTUAL INSURANCE COMPANY®

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

This document is an addition to the Community Flex brochure.

### Arizona

- ✓ Pre-existing condition is a medical condition for which medical advice or treatment was received or symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within 60 months before effective date.
- ✓ There is no limit on Outpatient Spinal Manipulation
- ✓ Amino Acid Based Formula: \$20,000 maximum per person per calendar year: Deductible then 75%
- ✓ Medical Foods: \$5,000 maximum per person per calendar year: Deductible then 50%
- ✓ Patient costs in connection with a Cancer Clinical Trial are covered
- ✓ Preventive Care benefits are covered at a non-network provider
- ✓ There is no limit on Home Health Care

See form IND09 for complete terms and conditions.

### Arkansas

- ✓ Pre-existing conditions are not covered for 3 years
- ✓ Exclusion for cosmetic treatment does not apply to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect
- ✓ Vision Exam benefit is not included
- ✓ Podiatric appliances for prevention of complication associated with diabetes are covered
- ✓ Well Child Care is covered with no maximum from birth through age 18
- ✓ Childhood Immunizations, except HPV, are covered at 100% with no maximum from birth through age 18
- ✓ Maternity is not covered; except for complications
- ✓ Diagnosis and treatment of Temporomandibular Joint Disorder (TMJ) is covered
- ✓ Medical foods & low protein modified foods to treat metabolic disease are covered after *expenses exceed \$2,400 per person*
- ✓ Treatment of speech and hearing disorders are covered. Coverage does not include hearing instruments or devices.
- ✓ Dental Anesthesia is covered for:
  - (1) A child under 7 years of age who two (2) licensed dentists have determined requires dental treatment for a complex dental condition;
  - (2) A person diagnosed with a serious mental or physical condition; or
  - (3) A person diagnosed with a significant behavioral problem

### Arkansas Continued

- ✓ Treatment and testing for a newborn child as required by Arkansas law are subject to your plan deductible (not the maternity deductible).
- ✓ Six-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; uterine prolapse
- ✓ Organ Transplant has a \$750,000 maximum benefit at a non-designated transplant facility
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Preventive Care covered in and out-of-network

#### Prescription Drug Coverage

- ✓ Four-Tier Option: Retail maximum day supply is 30 days. Mail Order minimum copay for Generic is \$45; Select Brand: \$90; Additional Brand: \$60
- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen.

See form IND09 for complete terms and conditions.

### Illinois

- ✓ Exclusion for cosmetic treatment, or complications of cosmetic treatment, does not apply to treat a medically necessary complication of cosmetic treatment
- ✓ Preventive Care benefits are covered at a non-network provider
- ✓ Appliances or dental treatment of malocclusion, misalignment, dysfunction, deformity, defect of the jaw or TMJ are not covered
- ✓ Exclusions for growth hormones and breast reductions do not apply to medically necessary charges
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen
- ✓ Maternity benefits apply to all females covered under the policy
- ✓ Charges for weight loss or exercise programs, equipment, drugs or surgery (including complications of surgery) are covered for Medically Necessary Treatment of morbid obesity
- ✓ Clinical breast exam is covered
- ✓ Examination & testing of a victim of a sexual assault is covered at 100%

## Illinois Continued

- ✓ Amino Acid-Based Formulas are covered at 50% after the deductible
- ✓ Dental Anesthesia charges incurred and anesthetics provided in conjunction with dental care provided in a hospital or ambulatory surgical center are covered if:
  - (1) child age 6 and under,
  - (2) medical condition that requires hospitalization or general anesthesia for dental care, or
  - (3) the individual is disabled
- ✓ 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)
- ✓ Exclusion for prescriptions filled at a non-network pharmacy does not apply

See form IND09 for complete terms and conditions.

## Indiana

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ Pre-existing condition is a medical condition for which medical advice, diagnosis, care or treatment was recommended or received or symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within 12 months before effective date.
- ✓ The 12-month pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Spinal Manipulations are not covered
- ✓ PSA Testing is not subject to the \$1,000 preventive care maximum

See form OTC-IND09-IN for complete terms and conditions.

## Iowa

- ✓ The 2-year pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage.
- ✓ Organ Transplant has a \$700,000 maximum benefit at a non-designated transplant facility
- ✓ Dental Anesthesia is covered for:
  - (1) a child under 5 years of age with a dental condition or developmental disability
  - (2) a person with one or more medical conditions that create undue medical risk if the necessary dental treatment is not rendered in a hospital or ambulatory surgical center
- ✓ 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; uterine prolapse
- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen

## Iowa Continued

- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Maternity is not a covered benefit, except for complications

See form IND09 for complete terms and conditions.

## Michigan

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ Charges for treatment of injuries arising out of ownership, operation, maintenance or use of a motor vehicle as a motor vehicle are excluded
- ✓ Exclusion for treatment of Substance Abuse does not apply
- ✓ Exclusion for an injury received while engaging in a hazardous occupation or activity does not apply

See form IND09 for complete terms and conditions.

## Missouri

- ✓ Pre-existing conditions are not covered
- ✓ Pap Smears, Pelvic Exam, PSA Testing & Exam are not subject to Preventive Care maximum
- ✓ Childhood Immunizations are covered at 100% birth through age 5 and are not subject to the calendar year deductible
- ✓ Preventive Care is covered at a non-network provider
- ✓ Maternity is not covered, except for complications
- ✓ Human Leukocyte Antigen testing is covered, limited to one test per lifetime, up to \$75
- ✓ Dental Anesthesia is covered for:
  - (1) a child under age 5;
  - (2) a person who is severely disabled; or
  - (3) a person with a medical or behavioral condition that requires anesthesia when dental care is provided
- ✓ Patient costs in connection with a Cancer Clinical Trial are covered
- ✓ Inpatient treatment of Alcoholism is covered for 30 days per calendar year
- ✓ Metabolic Diseases: Formula and low protein modified food products for treatment of a person with phenylketonuria (PKU) or any inherited disease of amino and organic acids are covered. Limited to children under age 6. \$5,000 maximum per person per calendar year.
- ✓ Contraceptive drugs and devices are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Vision Exam benefit is not available

See form OTC-IND09-MO for complete terms and conditions.

## Nebraska

- ✓ Childhood Immunizations: Birth through age 5 are subject to network benefit percentage, deductible does not apply

### Prescription Drug Coverage

- ✓ Four-Tier Option: Retail maximum day supply is 30 days. Mail Order minimum copay for Generic is \$45; Select Brand: \$90; Additional Brand: \$180

See form IND09 for complete terms and conditions.

## Ohio

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ The 12-month pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Outpatient mental health services covered for up to \$550 per person per calendar year
- ✓ Biologically based Mental Illness is covered
- ✓ Maternity benefits apply to all females covered under the policy
- ✓ Alcoholism treatment is covered up to a \$550 maximum per person per calendar year
- ✓ Pap Smears are not subject to the Preventive Care maximum
- ✓ Well Child Care benefits provided for birth through age 9, including coverage for hearing screening are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Preventive Care is covered at a non-network provider

See form OTC-IND09-OH for complete terms and conditions.

## Oklahoma

- ✓ PSA testing and exams are subject to a \$65 maximum reimbursement amount per service, however they are not subject to the Deductible or Preventive Care maximum
- ✓ Preventive care benefits are covered at a non-network provider
- ✓ Pre-existing conditions are not covered for 2 years
- ✓ Bone Density Test is subject to a \$150 maximum reimbursement amount per service
- ✓ Immunizations for ages 0 through 18 are covered at 100%
- ✓ Mammogram maximum benefit is \$115 per service
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Exclusion for foot care does not apply to medically necessary charges
- ✓ There is no separate maximum for non-designated transplant facilities. These charges are subject to the combined lifetime maximum of \$1,000,000
- ✓ 6-month waiting period for the following when received on a non-emergency basis: varicose veins; inguinal hernia (other than a strangulated or incarcerated hernia); elective hysterectomy; amenorrhea; cystocele; dysmenorrhea; enterocele; rectocele; urethrocele; uterine prolapse

## Oklahoma Continued

- ✓ A \$1,000 lifetime maximum applies to the following:
  - (1) Weight loss surgery, including complications of surgery.
  - (2) Charges for treatment of TMJ (temporomandibular joint dysfunction).
  - (3) Charges for growth hormone therapy.
  - (4) Charges for breast reduction (other than those due to a mastectomy).
- ✓ Hospital or Free Standing Outpatient Surgery Center charges incurred, including anesthetics, for dental care provided if the Family Member:
  - (1) Is severely disabled; or
  - (2) Is a child under the age of 8 years old and has a medical or emotional condition that requires hospitalization or general anesthesia for dental care.

See form IND09 for complete terms and conditions.

## South Carolina

- ✓ Pap smears and prostate cancer testing are not subject to the \$1,000 preventive care maximum
- ✓ The waiting period for allergy does not apply
- ✓ The waiting period is 6 months for the following surgical procedures: Tonsillectomy; adenoidectomy; surgical treatment of varicose veins including vein stripping and sclerotherapy; surgical hernia repair; elective hysterectomy; surgical repair of cystocele, rectocele, enterocele, urethrocele, uterine prolapse or any other disorder of reproductive organs
- ✓ Congenital defects and birth abnormalities of newborn and adopted children are covered
- ✓ Off-label use of prescription drugs for the treatment of cancer are covered if the optional Outpatient Prescription Drug benefit is chosen

See form OTC-IND09-2-SC for complete terms and conditions.

## Tennessee

- ✓ Bone Density Tests, Colorectal Cancer Exams, Chlamydia Screening, PSA Testing & Exam, Newborn Hearing Screening are not subject to the Preventive Care maximum
- ✓ Treatment for Autism Spectrum Disorder for children under 12 years of age is covered
- ✓ Optional Dental benefit is not available
- ✓ Newborn hearing screening is covered
- ✓ Treatment of PKU Medical Services is covered including special dietary formulas
- ✓ General Anesthesia for Dental treatment in a hospital for children 8 years old and younger is covered
- ✓ Audiology and Speech Language Pathology—subject to the Speech Therapy calendar year maximum is covered
- ✓ Bone Mass Measurement for diagnosis and treatment of osteoporosis is covered

## Tennessee Continued

- ✓ Outpatient spinal manipulation is not subject to the \$500 maximum
- ✓ Treatment of TMJ is covered (limited to Phase I treatment and surgery)
- ✓ Maternity benefits apply to all females covered under the policy

See form IND09 for complete terms and conditions.

## Texas

- ✓ The 2-year pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Maternity is not a covered benefit, except for complications
- ✓ PSA Testing, Pap Smears and newborn hearing screening are not subject to Preventive Care maximum
- ✓ Immunizations up to age 6 are covered at 100%
- ✓ Newborn Hearing Screening is covered
- ✓ Preventive Care is covered at a non-network provider
- ✓ Telehealth/Telemedicine is covered
- ✓ Organic Brain Disease is covered
- ✓ Developmental Delays limited to children less than 3 years of age are covered (not subject to policy maximums)
- ✓ Reconstructive surgery for craniofacial abnormalities under age 18 is covered
- ✓ 6-month waiting period for treatment of the following when received on a non-emergency basis: tonsils; adenoids; hemorrhoids; varicose veins; inguinal hernia (other than a strangulated or incarcerated hernia); elective hysterectomy; amenorrhea; cystocele; dysmenorrhea; enterocele; rectocele; urethrocele; uterine prolapse
- ✓ Transplant services at a non-designated transplant facility are covered up to \$700,000
- ✓ The 12-month waiting period for allergy benefits does not apply
- ✓ Contraceptives drugs and devices are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Vision Exam benefit is not included

See form IND09 for complete terms and conditions.

## Wisconsin

- ✓ Home Health Care is limited to 40 visits per person per calendar year
- ✓ Lead Poisoning Screening is covered for children under age 6
- ✓ Dental Anesthesia is covered if the person:
  - (1) Is a child under age 5;
  - (2) has a chronic disability; or
  - (3) has a medical condition that requires hospitalization or general anesthesia for dental care
- ✓ Routine patient care associated with a person's participation in a Cancer Clinical Trial is covered
- ✓ Surgical treatment of TMJ is covered. Diagnosis and non-surgical treatment is covered up to \$1,250 per calendar year.

See form IND09 for complete terms and conditions.

This state variations booklet is intended to highlight certain provisions of the plan described. It is not a contract, an insurance policy or a summary plan description booklet. Please see the policy for complete details, terms, conditions and full provisions of coverage.



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

0378 R5  
8/09