AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

Econo-Med PPO

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 Econo-Med PPO pays benefits in any calendar year.

For network doctor office visits:

First	Then
You pay your copayment	Econo-Med PPO pays 100% of allowed charges

For all other covered services:

First	Then	After That
You pay your chosen deductible	Econo-Med PPO pays the benefit percentage of the next $5,000 of allowed charges	Econo-Med PPO pays 100% of allowed charges for the remainder of the calendar year

$5,000,000 Maximum Lifetime Benefit

Allowed charges for in-network are network negotiated rates. For non-network, they are the usual, customary, and reasonable charges for your area.

Michigan

Customize Your Plan

Econo-Med PPO allows you to choose a plan design that is right for your health care needs and budget. It also offers you increased benefits when the family member uses a network provider.

Deductibles

Choose from four 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.

- Family Maximum- Once three family members meet their deductibles in a calendar year, the deductible for all remaining family members is waived for the remainder of the year.
- Common Accident- If two or more family members are injured in the same accident, only one deductible must be satisfied.

Deductible
$500 • $1,000 • $1,500 • $2,500

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 of the next $5,000 of allowed charges, up to the out-of-pocket maximum (allowed charges for in-network are network negotiated rates; for non-network, they are the described usual, customary, and reasonable charges for your area).

In-Network	Out-of-Network
80% ($1,000)*	60% ($2,000)*

*Calendar year maximum out-of-pocket expenses per person, excluding deductible, copayments, and other charges not covered by the policy.

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.

Copayment

Any time you visit a PPO provider in an office or Urgent Care Center due to sickness or injury , you only pay your copayment; the deductible and benefit percentage does not apply.

The copayment is a nominal fixed fee.

Network Doctor Office Visits	Non-Network Doctor Office Visits
$25 *(including office surgery)*	Subject to calendar year deductible and benefit percentage

Copayments will not be applied toward the calendar year deductible or benefit percentage per family member.

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 ID card.

In addition, you can receive the same network level of benefits when traveling outside your policy issue state, provided 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 the PPO ID card to locate network providers within the United States.

Inpatient and Outpatient Coverage

Highlights of the Econo-Med PPO covered charges include:

Covered Hospital Charges

- Semi-private room and board
- Intensive care
- Surgery
- Anesthesia
- Emergency room, emergency visits
- Nursing care
- Physician visits
- Miscellaneous tests, services and medical supplies
- Approved transplant services

Covered Outpatient Charges

- Emergency room, emergency visits
- Pre-admission testing
- Emergency ambulance service
- Surgery and anesthesia
- Second surgical opinions
- Physician services
- Mammogram
- Speech, physical and occupational therapy*
- Prescription drugs
- X-rays and lab tests
- Approved transplant services
- Chemotherapy
- Hospital-type equipment for kidney dialysis
- Radiation treatment
- Oxygen, blood and plasma
- Durable medical equipment
- Skilled nursing facilities*
- Home health care*
- Hospice care*
- Soft tissue foot care*
- Allergy testing*

** Please refer to the State Benefits Chart.*

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

Prescription Drug Program

This benefit allows you to purchase generic or name brand drugs at any pharmacy.

With participating pharmacies, there are no claim forms to be filed and no waiting for reimbursement. You simply pay the greater of $25 or 25% of the prescription or refill (up to $100) for a 30-day supply at the time of purchase.

For non-participating pharmacies, your benefit is the greater of your doctor office copayment or 50% of the prescription or refill (up to $100) plus the difference between the pharmacy's regular charge and the Plan Cost. The Plan Cost is the maximum reimbursement amount paid to Participating Pharmacies.

When medication is needed over an extended period, up to a 90-day supply can be obtained conveniently using the mail-order materials delivered with your Prescription Drug Card. The medication should be received within two weeks of the order.

Mail order prescriptions are subject to a charge equal to the greater of $25 or 20% of the prescription or refill (up to $100). Authorized refills should be included with the original prescription for the 90-day supply.

Other Provisions

Accident Benefit

This benefit provides up to $500 per person, per calendar year of first-dollar benefits for treatment of an injury within 48 hours of an accident.

Deductible and benefit percentage will not apply until after the maximum benefit has been reached or 48 hours following the injury. The covered charges paid can not be used to meet the deductible amount.

Pre-existing Conditions Limitation

The plan does **not** pay for any expense incurred due to any pre-existing condition during the 12 months following your effective date.

A 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 in a designated transplant facility ($150,000 for non-designated transplant facilities) including anti-rejection drugs. An additional benefit of up to $10,000 is included for travel and lodging expenses for one companion. 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 through the United Resource Network. 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 Econo-Med PPO policies issued in your state.

Survivorship Benefit

If you die while the policy is in force, coverage for your family members will continue without premium payment. Coverage will remain in force for one year or until your covered spouse remarries, if earlier.

Three Month Carry Forward of Deductible

If covered charges incurred during the calendar year do not exceed the deductible, covered charges incurred during the last three months of that calendar year shall be applied to the next calendar year's deductible.

Optional Benefits

If this benefit is selected, it applies to all family members and can only be added at time of application.

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.

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.

General Exclusions and Limitations

We will not pay benefits for charges due to any of the following, except as otherwise provided in the policy:

■ Pre-existing conditions. ■ Charges in excess of the usual, customary, and reasonable charges for services and supplies. ■ Services or supplies not listed in the Covered Charges provision of the contract. ■ Experimental, investigational, or unproven procedures or treatments. ■ Suicide or attempted suicide, whether or not sane, or intentionally self-inflicted injury. ■ Charges covered by Worker's Compensation or similar laws. ■ Services or supplies for personal comfort or convenience. ■ Cosmetic treatment, except as provided in the policy. ■ Surgery to correct nearsightedness or farsightedness. ■ Hearing aids and their fittings. ■ Vitamins and food supplements. ■ Pregnancy, except complications of pregnancy. ■ Sterilization or reversal of sterilization. ■ Contraceptive medication. ■ Preventive medical care, including physical exams, immunizations and PAP tests, except when insurance coverage is required by law. ■ Fertility drugs and procedures. ■ Gender reassignment, or charges due to complications of gender reassignment. ■ Treatment for hair restoration. ■ Treatment for acne. ■ Treatment for eating disorders; smoking cessation; exercise programs or equipment; weight loss programs, drugs, or surgery. ■ Treatment for mental or nervous disorders. ■ Treatment for substance abuse. ■ Diagnosis or non-surgical treatment of malocclusion or misalignment of the jaw. ■ Out of hospital, non-surgical services as a result of or related to distortion, misalignment or subluxation of the vertebral column. ■ Care covered under a government plan or program. ■ Services covered by Medicare or eligible for coverage by Medicare. ■ Charges arising from war, commission of a felony, or participation in a riot or insurrection. ■ Transplants, except approved transplant services as provided in the policy. ■ Outpatient prescription drugs, unless provided through the Prescription Drug Card or Mail Order programs. ■ Care of well, newborn child, except when insurance coverage is required by law. ■ Rest cure, maintenance, or custodial care. ■ Services performed by volunteers, a family member, a family member's employer, or a resident in the insured's household. ■ Any sickness contracted or injury received while a member of the military, Navy, or Air Force of any country or combination of countries. ■ Any care given by or through any government or international authority unless the family member is legally required to pay the charges. ■ Travel expenses, except for emergency local ambulance, and travel and accommodation expenses associated with approved transplant services. ■ Homemaker services, except when provided under the Hospice Benefit provision. ■ Dental examinations, x-rays, or treatment, unless the dental benefit is selected; or required as a result of and rendered within 12 months of an injury to sound, natural teeth and provided that treatment begins within 90 days following the injury. The injury must occur after the effective date of the family member's coverage under this policy.

Prescription Drug Card Program Exclusions

The following drugs are not considered covered drugs, except as otherwise provided in the policy:

■ 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:

■ 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

If you or your physician/provider have any questions regarding the covered charges, policy exclusions, limitations and benefit maximums expressed in the policy, please call American Community at (800) 991-2642.

This brochure is a brief description of the Econo-Med PPO health plan Policy Form 880. This brochure is not your policy. Your policy provides a complete list of benefits, limitations, and exclusions.

American Community Mutual Insurance Company • 39201 Seven Mile Rd., Livonia, Michigan 48152-1094
(734) 591-9000 • (800) 991-2642
www.american-community.com

2525-0116 R3
Michigan