

**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.

**COVERED CHARGES**

Community Flex 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	Flex 100		Flex 80		Flex 60					
	Network	Non-Network	Network	Non-Network	Network	Non-Network				
<b>DEDUCTIBLES</b>										
<b>Individual Calendar Year Deductibles</b>	\$5,000	\$10,000	\$1,000	\$2,000	\$500	\$1,000				
	\$7,500	\$15,000	\$1,500	\$3,000	\$1,000	\$2,000				
	\$10,000	\$20,000	\$2,500	\$5,000	\$1,500	\$3,000				
			\$3,500	\$7,000	\$2,500	\$5,000				
			\$5,000	\$10,000	\$3,500	\$7,000				
			\$7,500	\$15,000	\$5,000	\$10,000				
					\$7,500	\$15,000				
<b>Benefit Percentage Options</b>	<b>100%</b>		<b>80% of \$10,000</b>		<b>80% of \$20,000</b>		<b>60% of \$10,000</b>		<b>60% of \$20,000</b>	
	<b>Network</b>	<b>Non-Net</b>	<b>Network</b>	<b>Non-Net</b>	<b>Network</b>	<b>Non-Net</b>	<b>Network</b>	<b>Non-Net</b>	<b>Network</b>	<b>Non-Net</b>
	100%	70% of \$10,000	80% of \$10,000	50% of \$10,000	80% of \$20,000	50% of \$20,000	60% of \$10,000	50% of \$20,000	60% of \$20,000	50% of \$20,000
<b>Individual Out-of-Pocket Maximums (Includes deductible)</b>	<b>Network 100%</b>	<b>Non-Net 70% of \$10,000</b>	<b>Network 80% of \$10,000</b>	<b>Non-Net 50% of \$10,000</b>	<b>Network 80% of \$20,000</b>	<b>Non-Net 50% of \$20,000</b>	<b>Network 60% of \$10,000</b>	<b>Non-Net 50% of \$20,000</b>	<b>Network 60% of \$20,000</b>	<b>Non-Net 50% of \$20,000</b>
	\$5,000	\$13,000	\$3,000	\$7,000	\$5,000	\$12,000	\$4,500	\$11,000	\$8,500	\$11,000
	\$7,500	\$18,000	\$3,500	\$8,000	\$5,500	\$13,000	\$5,000	\$12,000	\$9,000	\$12,000
	\$10,000	\$23,000	\$4,500	\$10,000	\$6,500	\$15,000	\$5,500	\$13,000	\$9,500	\$13,000
			\$5,500	\$12,000	\$7,500	\$17,000	\$6,500	\$15,000	\$10,500	\$15,000
			\$7,000	\$15,000	\$9,000	\$20,000	\$7,500	\$17,000	\$11,500	\$17,000
		\$9,500	\$20,000	\$11,500	\$25,000	\$9,000	\$20,000	\$13,000	\$20,000	
						\$11,500	\$25,000	\$15,500	\$25,000	
<b>Family Calendar Year Deductible and Family Out-of-Pocket Maximum</b>	<p>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.</p> <p>Family Out of Pocket maximum is 2 times the individual Out-of-Pocket maximum, met collectively by 2 or more persons.</p>									

<b>Network &amp; Non-Network Charges to Deductible &amp; Benefit Percentage</b>	Network charges apply to the Network deductible and benefit percentage. Non-Network charges apply to the Non-Network deductible and benefit percentage.
<b>Lifetime Policy Maximum</b>	\$5 million per family member
<b>Network Available</b>	Midlands Choice

<b>ACCIDENT BENEFIT</b>	
<b>Accident</b>	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.
<b>Common Accident</b>	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.

	<b>Flex 100</b>		<b>Flex 80</b>		<b>Flex 60</b>	
<b>PHYSICIAN SERVICES</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
<b>In Physician's Office</b> 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 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>Urgent Care</b> 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)						
<b>Surgery, Equipment, Supplies, Injections (other than allergy injections)</b>	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>Diagnostic Services:</b> Nuclear medicine; diagnostic mammograms; M.R.I.; cat scans; ultrasounds received during an Office Visit at a Physician's office or Urgent Care Center						
<b>Chemotherapy, Infusion Therapy and Sclerotherapy (vein surgery or treatment)</b>						
<b>Allergy Testing &amp; Serums</b> \$500 Calendar Year maximum per family member	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>Allergy Injections</b>						
<b>In Hospital Services</b> Surgery; Consultations; Radiology; Anesthesiology; Pathology; Physical, Occupational, and Speech Therapy						
<b>Outpatient Spinal Manipulation</b> \$500 Calendar Year maximum per family member						

	Flex 100		Flex 80		Flex 60	
<b>PREVENTIVE CARE SERVICES</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
Routine Mammograms; 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%	Not Covered	Deductible, then we pay 80%	Not Covered	Deductible, then we pay 60%	Not Covered
\$1,000 Calendar Year maximum per family member for the following services: Immunizations (except HPV); Routine Physical Exams; PSA Testing & Exam; Pap Smears; Lab work performed in the office						
<b>HOSPITAL SERVICES</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
<b>Inpatient Non-emergency admissions</b>	Deductible, then we pay 100%	\$500 copay per admission, then Deductible, then we pay 70%	Deductible, then we pay 80%	\$500 copay per admission, then Deductible, then we pay 50%	Deductible, then we pay 60%	\$500 copay per admission, then Deductible, then we pay 50%
<b>Emergency admissions</b>	Deductible, then we pay 100%	<b>Network</b> Deductible, then we pay 100%	Deductible, then we pay 80%	<b>Network</b> Deductible, then we pay 80%	Deductible, then we pay 60%	<b>Network</b> Deductible, then we pay 60%
<b>Outpatient Surgery</b>	Deductible, then we pay 100%	\$500 copay per surgery, then Deductible, then we pay 70%	Deductible, then we pay 80%	\$500 copay per surgery, then Deductible, then we pay 50%	Deductible, then we pay 60%	\$500 copay per surgery, then Deductible, then we pay 50%
<b>Diagnostic Services</b> Pre-admission Testing; X-rays; Nuclear Medicine; Ultrasounds; M.R.I.; Diagnostic Mammograms; Lab Tests	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>EMERGENCY ROOM</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>	<b>Network</b>	<b>Non-Network</b>
<b>Emergency Injury</b> Copay waived if admitted to hospital within 24 hours See Accident Benefit on page 2	\$250 copay per visit, then Deductible, then we pay 100%	\$250 copay per visit, then <b>Network</b> Deductible, then we pay 100%	\$250 copay per visit, then Deductible, then we pay 80%	\$250 copay per visit, then <b>Network</b> Deductible, then we pay 80%	\$250 copay per visit, then Deductible, then we pay 60%	\$250 copay per visit, then <b>Network</b> Deductible, then we pay 60%
<b>Emergency Sickness</b> Copay waived if admitted to hospital within 24 hours						
<b>Non-emergency Sickness or Injury</b>	Not Covered					

OTHER COVERED SERVICES	Flex 100		Flex 80		Flex 60	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
<b>Air Ambulance</b>	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.					
<b>Ambulance (other than air ambulance)</b>	Deductible, then we pay 100%	<b>Network</b> Deductible, then we pay 100%	Deductible, then we pay 80%	<b>Network</b> Deductible, then we pay 80%	Deductible, then we pay 60%	<b>Network</b> Deductible, then we pay 60%
<b>Radiology or Diagnostic Services Outside of Hospital</b> X-rays; M.R.I.; CAT Scans; Diagnostic Mammograms; Nuclear Medicine; Ultrasounds; Lab Tests (including lab work sent by a physician to an independent lab)	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>Outpatient Physical, Occupational and Speech Therapy</b> 20 visits per family member per Calendar Year per type of therapy						
<b>Home Health Care</b> 20 visits per family member per Calendar Year						
<b>Hospice</b> Up to \$200 per day, a lifetime maximum of \$10,000 or 6 months, whichever comes first						
<b>Nursing Facility</b> 60 days per family member per Calendar Year						
<b>Durable Medical Equipment</b>	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.					
<b>Organ Transplants:</b> Combined maximum lifetime benefit of \$1 million per person <b>Designated Transplant Facility:</b> \$1 million maximum benefit <b>Non-designated Transplant Facility:</b> \$700,000 maximum benefit	Deductible, then we pay 100%	Deductible, then we pay 70%	Deductible, then we pay 80%	Deductible, then we pay 50%	Deductible, then we pay 60%	Deductible, then we pay 50%
<b>Mental Health</b>	Not Covered					
<b>Vision Exam Only Benefit</b>	The following benefits are available only at VSP Member Facilities: 1 eye exam per person every 12 months; \$10 Copayment per eye exam; 20% discount for eyeglasses; 15% discount on physicians' services when contact lenses are purchased.					
<b>Accidental Death and Dismemberment</b>	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 for HPV  
 Routine Physical Exams  
 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:  
 Routine Mammograms

Network: Office Visit Copay, then we pay 100% up to \$1,000 calendar year maximum per family member  
 Non-Network: Not Covered

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

Network: Deductible, then we pay 100%, 80% or 60% based on plan chosen.  
 Non-Network: Not Covered

**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**

	<b>Retail</b>	<b>Mail Order</b>
<b>Generic Drugs Only</b>	Up to 31-day supply 20% copay per prescription or refill \$15 Minimum	Up to 90-day supply 20% copay per prescription or refill \$35 Minimum
Prescription Drug Card Benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased from a Non-Participating Pharmacy.		
Contraceptive drugs and devices are covered unless the insured declines coverage on their application.		

**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 drug 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.

	<b>Retail</b>	<b>Mail Order</b>
	Up to 31-day supply	Up to 90-day supply
<b>Generic Drugs &amp; Diabetic Supplies:</b>	20% copay per prescription or refill \$15 Minimum	20% copay per prescription or refill \$40 Minimum
<b>Select Brand Name Drugs &amp; Diabetic Supplies:</b>	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 \$80 Minimum
<b>Additional Brand Name Drugs &amp; Diabetic Supplies:</b>	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 \$150 Minimum
<b>Specialty Drugs:</b>	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 31 day supply	

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. 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 unless the insured declines coverage on their application.

**DENTAL OPTION**

<b>Dental Benefit</b> \$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%
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## 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.
    - 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. **Nursing Care** – Room and board, nursing care, medical services and supplies while Confined in a 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 licensed 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** - To be covered under the policy, services must be performed by a Network Provider. Covered Charges subject to a maximum benefit of \$1,000 per calendar year include the following services:
    - (1) Routine physical exams including lab services not sent to an independent lab;
    - (2) Age appropriate immunizations, other than the human papillomavirus immunization;
    - (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.Covered Charges not subject to the Preventive Care Maximum include the following services:
    - (1) Routine mammograms, limited to:
      - (a) One baseline mammogram between the ages of 35 and 39, or more frequent mammograms if recommended by the woman's physician;
      - (b) One mammogram per year after age 39, or more frequently if recommended by the patient's physician.
    - (2) Colorectal cancer examinations and laboratory tests for colorectal cancer as prescribed by a Physician in accordance with the guidelines published by the American Cancer Society, or other existing colorectal cancer screening guidelines issued by the National Cancer Institute, Centers for Disease Control and Prevention, and the American College of Gastroenterology.
    - (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 a licensed physical therapist, occupational therapist, or Speech Therapist, for Rehabilitation of a covered Sickness or Injury only. 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 for dependent children who are Family Members. 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.
- h. Administration of general anesthesia and Hospital or Ambulatory Surgical Center charges incurred when dental care is provided for the following Family Members, when determined to be necessary by a licensed dentist and the Family Member's treating Physician:
  - (1) A child under five (5) years of age who has a dental condition or a developmental disability for which patient management in the dental office has proven to be ineffective;

- (2) A person who has one or more medical conditions that would create significant or undue medical risk if the necessary dental treatment is not rendered in a Hospital or Ambulatory Surgical Center.
- i. 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 Prescription Drug Program Benefit Rider included in the policy. Coverage does not apply if You decline contraceptive coverage on Your application for insurance.
- j. 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. Coverage does not apply if You decline contraceptive coverage on Your application for insurance.
- k. Equipment and supplies for the Treatment of all types of diabetes mellitus when prescribed by a licensed Physician, including blood glucose meter and glucose strips for home monitoring.
- l. Self-management training and education for the Treatment of all types of diabetes mellitus only under all of the following conditions:
  - (1) The Family Member's Physician certifies that such services are needed;
  - (2) The self-management training and education program is certified by the Iowa department of public health, and provides the following:
    - (a) Initial training for up to 10 hours of initial outpatient diabetes self-management training within a continuous 12-month period for each Family Member that meets any of the following conditions:
      - (i) A new onset of diabetes
      - (ii) Poor glycemic control as evidenced by glycosylated hemoglobin of nine and five-tenths or more in the 90 days before attending training
      - (iii) A change in treatment regimen from no diabetes medication to any diabetes medication, or from oral diabetes medication to insulin
      - (iv) High risk for complications based on poor glycemic control
      - (v) High risk based on documented complications.
    - (b) A Family Member who receives the initial training is eligible for one (1) follow-up training session of up to one (1) hour each year.

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 \$700,000.
- 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. Such expenses shall not include charges associated with attempts to save the life of the donor or to treat complications.
- f. Only approved Transplant Procedures are covered. No benefits will be paid if the transplant procedure is not approved in advance.

9) Vision Exam Only

- a. Covered Charges include one vision examination per person every 12 months. The vision examination includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities.
- b. The benefit will be the cost of the vision examination less the \$10 copayment.
- c. The vision examination must be performed by a Member Doctor which means a doctor who is contracted by Vision Service Plan.
- d. If the Family Member is prescribed corrective eyewear by the Member Doctor for a covered vision examination the Family Member can obtain materials and services related to the ordering, fitting and adjusting of the corrective eyewear from the Member Doctor at the discount of 20% for eyeglasses and 15% for contact lenses.

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; is evidenced by a bruise or wound, except in the case of internal injuries shown by autopsy, asphyxiation or drowning; and the loss occurs within 90 days after the accident 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 CONDITION LIMITATION**

We will pay no benefits for charges due to a Pre-Existing Condition for 2 years starting on the Effective Date of a Family Member's coverage under the policy.

The 2 year period will be reduced for any Family Member by the length of time the Family Member had Qualifying Previous Coverage, which was continuous to a date not more than 63 days before the Effective Date of coverage under this policy. For purposes of this provision, periods of coverage under Iowa's high risk pool (Iowa Comprehensive Health Insurance Association), the Iowa Medical Assistance Act, the Healthy and Well Kids in Iowa Program (Hawk-i) or Medicare will not be counted with respect to such 63-day requirement.

**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 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 the 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 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, and charges for Treatment of Sickness or Injury that are covered by workers' compensation insurance or similar laws.

6. 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.
7. Charges for services or supplies for personal comfort or convenience.
8. Charges for travel or lodging expenses.
9. Charges for maintenance care, Custodial Care or homemaker services.
10. Charges for Treatment given in a Hospital emergency room for Non-Emergency Sickness or Injury.
11. 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.
12. 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; or
  - b. Due to mastectomy as provided under the Medical Benefits section of the policy.
13. Charges for vision related surgery or services, including, but not limited to:
  - a. Eye refractions;
  - b. Examinations for eye refractions, except as provided under the Vision Exam Only Benefit;
  - 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.
14. 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.
15. 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.
16. 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.
17. Charges for care of a well, newborn child, except when insurance coverage is required by law.
18. Charges for contraceptives, contraceptive methods or aids, and emergency contraceptive kits, unless the Outpatient Prescription Drug Benefit Rider is included in the policy.
19. Charges for, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from voluntary abortion or attempted voluntary abortion.
20. 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.
21. Charges for gender reassignment or charges due to complications of gender reassignment.
22. Charges for the diagnosis and/or Treatment of acne.
23. Charges for the diagnosis and/or Treatment of eating disorders.
24. Charges for weight loss programs, drugs or surgery (including complications of surgery), exercise programs or equipment.
25. Charges for smoking cessation, expenses related to nicotine addiction, caffeine addiction and non-chemical addictions
26. Charges for hair loss, hair restoration or removal.
27. Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, Treatment of erectile dysfunction and penile prostheses.
28. Charges for the diagnosis and/or Treatment of a Mental or Nervous Disorder or emotional conditions, even if court ordered.
29. Charges for the diagnosis and/or Treatment of Substance Abuse.
30. Charges for physical, occupational or speech therapy for Developmental or maintenance reasons.
31. Charges for transplants, except as provided under the Medical Benefits section of the policy.
32. Charges for examination, diagnosis, appliances or Treatment of malocclusion, misalignment, dysfunction, deformity or defect of the jaw or temporomandibular joint dysfunction.
33. Charges that a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
34. Charges for diagnosis and/or Treatment by a Physician, which is not within the scope of his or her license.
35. 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.
36. Charges for court-ordered evaluation, Treatment or testing.
37. Charges for genetic testing, counseling and services.
38. Charges for inoculations or prophylactic drugs for travel.
39. 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.
40. Charges for services available in the community through educational or school programs.
41. Charges for the evaluation or Treatment of learning disabilities, Attention Deficit Hyperactivity Disorder, attitudinal disorders, or disciplinary, social or Developmental conditions.
42. 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.
43. 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.
44. Charges for Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
45. Charges for the Treatment of nail fungus.
46. Charges for any expenses incurred outside of the United States for elective care, testing, procedures or services, except for Emergency care.
47. Charges for diagnosis, Treatment, testing, and surgical intervention of sleep disorders, including complications resulting from diagnosis, treatment, testing or surgical intervention.

48. Charges for expenses related to Treatment, diagnosis, or care provided over the Internet or via telephone or electronic mail.
49. 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.
50. 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.
51. Charges for Prescription Drugs provided while the Family Member is not Confined, unless the Outpatient Prescription Drug Benefits Rider is included in the policy.
52. Charges for private duty nursing service rendered during Hospital Confinement and charges for standby health care practitioners.
53. Charges for breast reductions, except when due to a mastectomy as provided under the Medical Benefits section of the policy.
54. 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, reiki therapy, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.
55. Charges for myo-electric or microprocessor Prosthetics.
56. 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.
57. 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.
58. 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.
59. 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 this policy;
3. Prescription Drugs used to treat anything listed in the General Exclusions section of the policy;
4. Non-federal legend drugs;
5. All contraceptive medications or devices if You declined contraceptive coverage on Your application for insurance;
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 kit, if You declined contraceptive coverage on Your application for insurance;
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, 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. 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.

### **VISION EXCLUSIONS**

No benefits are payable for:

1. Materials or services related to ordering, fitting, or adjusting any corrective eyewear. However, if the Family Member is prescribed corrective eyewear by the Member Doctor for a covered Vision Examination the Family Member can obtain materials and services related to the ordering, fitting and adjusting of the corrective eyewear from the Member Doctor at a discount of 20% for eyeglasses and 15% for contact lenses.
2. Services, examinations or material provided by a Non-Member Doctor.
3. Orthoptics or vision training.
4. Medical or surgical Treatment of the eyes.
5. Services or materials provided as a result of any Worker's Compensation Law or similar legislation, or obtained through or required by any government agency or program whether federal, state or any subdivision thereof.
6. Any Vision Examination required by an Employer as a condition of employment.
7. Any service or materials provided by any other vision care plan or benefit plan containing benefits for vision care.

### **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 not married and less than 25 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 policy anniversary date after the date the child marries or ceases to be a resident of the state of Iowa, or the first Renewal Date following the date the child attains age 26, whichever is earliest. If the unmarried child maintains full-time student status as a student in an accredited institution of post secondary education after age 26, coverage will end on the first Renewal Date following the date the child is no longer a full-time student. (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. You must provide to Us proof of incapacity within 31 days of the date coverage ends due to age. Proof may be required at reasonable intervals thereafter.

Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the 32nd day after We requested or You were required to provide proof of incapacity or dependence and it was not provided, and the child has attained the limiting age; (2) the date the child attains the limiting age, if We requested proof of disability and dependence at least 31 days from the date the child reaches the attainment of the limiting age, and You do not furnish Us with proof of disability and dependence within 31 days of the request; (3) the date the child becomes capable of self-support; (4) the date the child's coverage under the policy ends for any reason other than age.

## **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**

A medical condition that was diagnosed by or treated by a licensed Physician within five (5) years prior to the Effective Date of coverage or produced symptoms within five (5) years prior to the Effective Date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or Treatment.

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.