AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY®

Medalist II

For Individuals & Families

Arizona Benefit Chart

Calendar Year Deductibles

The deductible is the amount of covered charges an individual must incur in a calendar year before the plan begins to pay benefits. Network charges apply to the network deductible only. Non-network charges apply to both the network and non-network deductible.

	PLAN CHOICE:					
	Gold		Silver		Bronze	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Individual 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.	$500 $750 $1,000 $1,500 $2,500	$1,000 $1,500 $2,000 $3,000 $5,000	$1,000 $1,500 $2,500 $3,500 $5,000	$2,000 $3,000 $5,000 $7,000 $10,000	$1,500 $2,500 $3,500 $5,000	$3,000 $5,000 $7,000 $10,000

Benefit Percentages & Out-of-Pocket Maximums (Includes deductible)

Network charges apply to the network benefit percentage maximum only. Non-network charges apply to both the network and non-network benefit percentage maximums. Benefit percentages apply after the deductible is met.

	PLAN CHOICE:					
	Gold		Silver		Bronze	
	Network 80% of $10,000	Non-Network 50% of $20,000	Network 70% of $15,000	Non-Network 50% of $30,000	Network 70% of $20,000	Non-Network 50% of $40,000
Individual Family out-of-pocket maximum is 2 times the individual out-of-pocket maximum, met collectively by 2 or more persons. After the out-of-pocket maximum is met, American Community pays 100% of covered charges.	$2,500 $2,750 $3,000 $3,500 $4,500	$11,000 $11,500 $12,000 $13,000 $15,000	$5,500 $6,000 $7,000 $8,000 $9,500	$17,000 $18,000 $20,000 $22,000 $25,000	$7,500 $8,500 $9,500 $11,000	$23,000 $25,000 $27,000 $30,000
	Network 80% of $15,000	Non-Network 50% of $30,000				
	$3,500 $3,750 $4,000 $4,500 $5,500	$16,000 $16,500 $17,000 $18,000 $20,000				
Lifetime Policy Maximum	$5 million per person					
Networks Available	Arizona Foundation ~ Foundation Plus ~ Foundation Select					

ACCIDENT BENEFIT

Accident	If a family member sustains an injury, we will waive the deductible and/or copayment 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 and/or copayment will be applied to any covered charges incurred after the 30-day limit has been met.
Common Accident	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.

PHYSICIAN SERVICES	Gold	Silver	Bronze
In Office & Urgent Care Centers • Visits for sickness • Injury • Surgery, or follow-up including lab tests • X-rays • Consultations • Equipment • Supplies • Injections (except allergy injections)	Network: $30 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: $40 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: $50 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 70% Non-Network: Deductible, then we pay 50%

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PHYSICIAN SERVICES	Gold	Silver	Bronze
Preventive Care $1,000 calendar year maximum per family member • Immunizations • Routine Physical Exams • PSA Testing • Routine Mammograms • Pap Smear	Network: $30 copay per visit, then we pay 100% Non-Network: Deductible, then we pay 50%	Network: $40 copay per visit, then we pay 100% Non-Network: Deductible, then we pay 50%	Network: $50 copay per visit, then we pay 100% Non-Network: Deductible, then we pay 50%
In-Hospital Services • Surgery • Consultations • Radiology • Anesthesiology • Pathology • Physical, occupational and speech therapy	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%
Outpatient Spinal Manipulation Professional charges	Network: $30 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: $40 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: $50 copay per visit, then we pay 100% up to $500 per person per calendar year. After $500 maximum, deductible, then we pay 70% Non-Network: Deductible, then we pay 50%
Allergy Testing, Serums & Injections $500 calendar year maximum per family member	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network & Non-Network: Not covered
HOSPITAL SERVICES	**Gold**	**Silver**	**Bronze**
Inpatient Non-emergency Admissions	Network: Network deductible, then we pay 80% Non-Network: $500 copay, then deductible, then we pay 50%	Network: Network deductible, then we pay 70% Non-Network: $500 copay, then deductible, then we pay 50%	Network: Network deductible, then we pay 70% Non-Network: $500 copay, then deductible, then we pay 50%
Emergency Admissions	Network & Non-Network: Network deductible, then we pay 80%	Network & Non-Network: Network deductible, then we pay 70%	Network & Non-Network: Network deductible, then we pay 70%
Outpatient Surgery	Network: Network deductible, then we pay 80% Non-Network: $500 copay, then deductible, then we pay 50%	Network: Network deductible, then we pay 70% Non-Network: $500 copay, then deductible, then we pay 50%	Network: Network deductible, then we pay 70% Non-Network: $500 copay, then deductible, then we pay 50%
Diagnostic Services • Pre-admission testing • X-Rays • Nuclear medicine • Ultrasounds • MRIs • Non-routine Mammograms • Laboratory tests	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%
EMERGENCY ROOM SERVICES	**Gold**	**Silver**	**Bronze**
Emergency - Injury (see Accident Benefit on page 1)	Network & Non-Network: Network deductible, then we pay 80%	Network & Non-Network: Network deductible, then we pay 70%	Network & Non-Network: Network deductible, then we pay 70%
Emergency - Sickness Copay waived if admitted to hospital within 24 hours	Network & Non-Network: $50 copay per visit, then network Deductible, then we pay 80%	Network & Non-Network: $100 copay per visit, then network Deductible, then we pay 70%	Network & Non-Network: $150 copay per visit, then network Deductible, then we pay 70%
Non-Emergency Sickness	Network & Non-Network: Not covered	Network & Non-Network: Not covered	Network & Non-Network: Not covered
OTHER COVERED SERVICES	**Gold**	**Silver**	**Bronze**
Ambulance	Network & Non-Network: Network deductible, then we pay 80%	Network & Non-Network: Network deductible, then we pay 70%	Network & Non-Network: Network deductible, then we pay 70%
Free-Standing Outpatient Surgery Center Facility charge	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%

OTHER COVERED SERVICES	Gold	Silver	Bronze
Radiology or Diagnostic Services Outside of Hospital • X-Rays • MRIs • CAT Scans • Mammograms • Nuclear Medicine • Ultrasounds • Laboratory tests (including lab work sent by a physician to an independent laboratory)	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%
Outpatient Physical, Occupational & Speech Therapy Limited to 60 visits per person per calendar year (this is a combined total for all therapies)			
Durable Medical Equipment			
Home Health Care			
Hospice Care Up to $200 per day, a lifetime maximum of $15,000 or 6 months, whichever comes first; Bereavement support services up to $500			
Skilled Nursing Facility $75 per day, 60 days per calendar year (room and board only)			
Mental Health Care (outpatient only) $1,000 maximum per person per calendar year	Network & Non-Network: Deductible, then we pay 50%	Network & Non-Network: Deductible, then we pay 50%	Network & Non-Network: Not covered
Medical Foods $5,000 maximum per person per calendar year	Network & Non-Network: Deductible, then we pay 50%	Network & Non-Network: Deductible, then we pay 50%	Network & Non-Network: Deductible, then we pay 50%
Amino Acid-Based Formula $20,000 maximum per person per calendar year	Network & Non-Network: Deductible, then 75%	Network & Non-Network: Deductible, then 75%	Network & Non-Network: Deductible, then 75%
Organ Transplants Combined maximum lifetime benefit of $1 million	Designated Transplant Facility: $1 million maximum lifetime benefit with up to $10,000 for travel and accommodation expenses for the insured person and one companion. Meals and lodging are limited to $150 per person per day. Non-designated Transplant Facility: $150,000 maximum lifetime benefit		
Vision Exam Only Benefit	The following benefits are available only at VSP Member Facilities: 1 eye exam per person every 12 months; $10 copay per eye exam; 20% discount for eyeglasses; 15% discount on physician's services when contact lenses are purchased.		
Accidental Death and Dismemberment for Primary Insured Only	$10,000 (Full Amount)		
OPTIONAL BENEFITS	**Gold**	**Silver**	**Bronze**
Dental Benefit $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%		
Maternity Benefit for Policyholder and Spouse only, if Spouse is covered under the policy 270-day waiting period from the effective date of the maternity coverage. To be covered, pregnancy must begin after the waiting period.	Network: Deductible, then we pay 80% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%	Network: Deductible, then we pay 70% Non-Network: Deductible, then we pay 50%
$1,000 Prescription Drug Deductible per person 2 person maximum per family	Network: Subject to Prescription Drug Deductible, then Prescription Drug Coverage copays apply Non-Network: Not Covered	Network: Subject to Prescription Drug Deductible, then Prescription Drug Coverage copays apply Non-Network: Not Covered	Option not available

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PRESCRIPTION DRUG COVERAGE*		Gold	Silver	Bronze
Calendar Year Maximum		None	None	$300 maximum benefit per person per calendar year
Mental Health Drugs		$500 maximum benefit per person per calendar year	$500 maximum benefit per person per calendar year	Not covered
Retail Pharmacy*: Up to 31-day supply	Generic & Diabetic Supplies:	20% copay, $10 minimum	20% copay, $15 minimum	Generic Drugs Only: $15 copay per prescription or refill
	Select Brand Name Drugs & Diabetic Supplies:	30% copay, $35 minimum	30% copay, $40 minimum	
	Additional Brand Name Drugs & Diabetic Supplies:	50% copay, $50 minimum	50% copay, $60 minimum	
Mail Order Pharmacy*: Up to 90-day supply	Generic & Diabetic Supplies:	$25	$35	Generic Drugs Only: $35 copay per prescription or refill
	Select Brand Name Drugs & Diabetic Supplies:	$85	$100	
	Additional Brand Name Drugs & Diabetic Supplies:	$125	$150	

Prescription Drug Benefits only apply at a Participating Pharmacy. No benefits are payable if the prescription is purchased at a Non-participating Pharmacy.

* Includes oral contraceptives

Pre-existing Conditions Limitation

The plan does not pay for any expense incurred due to a pre-existing condition during the two-year period starting on your effective date of coverage.

Pre-existing condition means:

A medical condition not fully disclosed on the application, for which, prior to the effective date of coverage:

- The Family Member received medical advice or treatment from a physician within 60 months before the effective date of the Family Member's coverage under this policy; or
- Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within 60 months before the effective date of the Family Member's coverage under this policy.

This includes any medical condition whether diagnosed or not, for which the Family Member received medical advice or treatment. Medical advice means medical treatment or consultation; medical care or services; diagnostic tests; or taking of a prescribed drug(s) or medicine(s).

Medicare Coordination and Insurance with Other Insurers

Medalist II contains certain provisions that may reduce benefits under the plan; a full description is contained in the policy.

Underwriting

The health history provided on the application determines the policy provisions and premium. Therefore, it is important that applicants answer all questions accurately and thoroughly.

If the agent assists in completing the application, the applicant should review the answers before signing. The applicant's signature attests to the completeness and accuracy of the answers.

Reviews conducted after the policy is issued may reveal health information that wasn't disclosed on the application. This may result in rescission of coverage, increased premiums, and/or exclusion riders or claims being denied under the policy's pre-existing exclusion.

General Exclusions and Limitations

Some of the services that the Medalist II Plan does NOT cover include:

Pre-existing conditions for the two-year period starting on the effective date of coverage; Charges in excess of the usual, customary, and reasonable charges for non-network services; 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; Travel expenses, except as provided in the policy; Preventive medical care, except when covered by the preventive care benefit, or if listed under covered charges; 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; Hearing aids; Contraceptives except as provided in the policy; Pregnancy, unless the maternity benefit rider is purchased; Sterilization; Abortion; Treatment for hair restoration; Treatment of acne; Treatment of a mental or nervous disorder or emotional conditions, except as provided in the policy, even if court ordered; Treatment for substance abuse; Examination, diagnosis or treatment of malocclusion or misalignment of the jaw; Vitamins; Infertility; Gender reassignment; Growth treatment; Routine footcare; Sleep disorders; Charges for services which are not medically necessary; Treatment received in a hospital emergency room for a non-emergency sickness; Charges for which benefits are not provided in the policy.

A complete list of exclusions and limitations is included in the Medalist II policy. See Policy Form PMEDII for complete terms and conditions.

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