

Benefits	Network Services		Non-Network Services
Benefit Period Deductible Options			
Benefit Period Deductible (choose one) Network charges only apply towards the Network Deductible and out-of-pocket maximum. Non-Network charges only apply towards the Non-Network Deductible and out-of-pocket maximum. Family Deductible is 2 times the individual Deductible. Both calendar year and plan year Deductibles are available.	Option 1	\$500 (not available with 100% plan)	\$1,000 (not available with 100% plan)
	Option 2	\$1,000	\$2,000
	Option 3	\$1,500	\$3,000
	Option 4	\$2,000	\$4,000
	Option 5	\$2,500	\$5,000
	Option 6	\$3,500	\$7,000
	Option 7	\$5,000	\$10,000
	Option 8	\$7,500	\$15,000
	Option 9	\$10,000	\$20,000
	Option 10	\$15,000	\$20,000
Benefit Percentage Options			
Benefit Percentage (choose one)	Option 1	100% (not available with \$500 Deductible option)	70% (not available with \$500 Deductible option)
	Option 2	90%	60%
	Option 3	80%	50%
Out-of-Pocket Maximum Options			
The Out-of-Pocket Maximum does not include the Deductibles, Copays, charges for sleep study tests or charges for emergency ambulance other than ground ambulance. There is a separate \$2,500 out-of-pocket maximum per person, per Benefit Period for specialty drugs.			
100% Plan Family out-of-pocket maximum is 2 times the individual out-of-pocket maximum.		\$0	\$5,000
90% Plan (choose one) Family out-of-pocket maximum is 2 times the individual out-of-pocket maximum.	Option 1	\$1,000	\$2,000
	Option 2	\$2,000	\$4,000
	Option 3	\$3,000	\$6,000
	Option 4	\$4,000	\$8,000
	Option 5	\$5,000	\$10,000
80% Plan (choose one) Family out-of-pocket maximum is 2 times the individual out-of-pocket maximum.	Option 1	\$1,000	\$2,000
	Option 2	\$2,000	\$4,000
	Option 3	\$3,000	\$6,000
	Option 4	\$4,000	\$8,000
	Option 5	\$5,000	\$10,000
Office Visit Copay Options			
Office Visit Copay (choose one)	Option 1	\$20	Subject to Non-Network Deductible and Benefit Percentage
	Option 2	\$30	
	Option 3	\$40	
	Option 4	No Office Visit/Urgent Care Center Copay (all charges subject to Network Deductible and Benefit Percentage)	
Lifetime Policy Maximum per Person	\$5 Million		
Networks	AC Network ~ PHCS ~ SuperMed Plus ~ First Health (travel network)		

Benefit	Network Services	Non-Network Services
Doctor Services		
In Doctor's Office <ul style="list-style-type: none"> • Office Visits • Radiological Services (excluding Advanced Imaging) • Laboratory Tests 	Selected Copay per visit, then 100% (If no copay option selected, then all services are subject to Network Deductible and Benefit Percentage)	Subject to Non-Network Deductible and Benefit Percentage
In Urgent Care Centers <ul style="list-style-type: none"> • Office Visits • Radiological Services (excluding Advanced Imaging) • Laboratory Tests 	2 times selected Copay per visit, then 100% (If no copay option selected, then all services are subject to Network Deductible and Benefit Percentage)	Subject to Non-Network Deductible and Benefit Percentage
In Doctor's Office and Urgent Care Centers <ul style="list-style-type: none"> • Surgery • Advanced Imaging 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Allergy Injections	\$10 Copay per visit, then 100%	Subject to Non-Network Deductible and Benefit Percentage
Allergy Testing and Serums	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Dislocations and Partial Dislocations of the Vertebrae (Chiropractic) <ul style="list-style-type: none"> • 10 visits per person per Benefit Period • Maximum \$25 per visit • These spinal manipulation limitations do not apply if such services are rendered during general anesthesia, surgery, or while an Insured is Confined 	\$35 Copay, then 100%	Subject to Non-Network Deductible and Benefit Percentage
Preventive Care Services:		
Preventive Care Maximum: \$1,000 per person per Benefit Period. Includes the following services:		
<ul style="list-style-type: none"> • Routine Physical Exams • Lab tests • Pelvic exams • PSA Test • Colonoscopy (Once Preventive Care maximum is reached, charges are subject to Deductible and Benefit Percentage) • Immunizations (except HPV) • Well-Child Care 	Selected Copay, then 100% (If no copay option selected, then all services are subject to Network Deductible and Benefit Percentage)	Subject to Non-Network Deductible and Benefit Percentage
The following Preventive Care benefits are not subject to the Preventive Care Maximum:		
<ul style="list-style-type: none"> • Bone Density Tests • HPV Immunization 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
<ul style="list-style-type: none"> • Pap Smears 	Selected Copay, then 100% (If no copay option selected, then all services are subject to Network Deductible and Benefit Percentage)	Subject to Non-Network Deductible and Benefit Percentage
<ul style="list-style-type: none"> • Screening Mammograms 	Paid at 100%	Subject to Non-Network Deductible and Benefit Percentage
In Hospital Services:		
<ul style="list-style-type: none"> • Medical • Surgical • Consultations 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
<ul style="list-style-type: none"> • Radiological Services (including Advanced Imaging) • Anesthesiology • Pathology 	If Network Facility, subject to Network Deductible and Benefit Percentage for Network and Non-Network Providers	If Non-Network Facility, subject to Non-Network Deductible and Benefit Percentage

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Hospital Services		
Inpatient Services:		
Emergency Admissions	Subject to Network Deductible and Benefit Percentage	Subject to Network Deductible and Benefit Percentage
Non-Emergency Admissions	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Outpatient Services:		
<ul style="list-style-type: none"> • Pre-Admission Testing • Outpatient Surgery • Radiological Services (including Advanced Imaging) • Laboratory Tests 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Emergency Room Services:		
Emergency Illness and Injury. Non-emergency not covered.	\$250 Copay per visit, then subject to Network Deductible and Benefit Percentage (Copay waived if admitted)	\$250 Copay per visit, then subject to Network Deductible and Benefit Percentage (Copay waived if admitted)
Other Covered Services		
Outpatient Surgery Center Facility Charges	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Diagnostic Services:		
<ul style="list-style-type: none"> • Radiological Services (excluding Advanced Imaging) • Laboratory Tests 	Selected Copay per visit, then 100% (If no copay option selected, then all services are Subject to Network Deductible and Benefit Percentage)	Subject to Non-Network Deductible and Benefit Percentage
Advanced Imaging such as: <ul style="list-style-type: none"> • Nuclear Medicine • Diagnostic Mammograms • M.R.I. • CAT Scans • Ultrasounds 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Chemotherapy and Infusion Therapy	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Emergency Ground Ambulance	Subject to Network Deductible and Benefit Percentage	Subject to Network Deductible and Benefit Percentage
All Other Emergency Ambulance (Including Emergency Air Ambulance) Charges do not apply towards Out-of-Pocket maximum	Subject to Network Deductible, then 80%	Subject to Network Deductible, then 80%
Maternity <ul style="list-style-type: none"> • Included for all groups • Benefit for all females covered under the policy 	Same as any other illness	
Durable Medical Equipment \$2,500 maximum per person per Benefit Period	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Prosthetics \$2,500 maximum per person per Benefit Period for External Prosthetics	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Sleep Study Test \$1,000 maximum per person per Benefit Period. Charges do not apply towards Out-of-Pocket maximum	Subject to Network Deductible, then 50%	Subject to Non-Network Deductible, then 50%

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Other Covered Services		
Mental Health/Substance Abuse Combined maximum per person: <ul style="list-style-type: none"> • Inpatient limited to 30 days per person per Benefit Period, up to 2 admissions per lifetime • Intermediate/outpatient limited to 20 visits per person per Benefit Period • Benefit includes a minimum of \$550 per person per Benefit Period for alcoholism treatment and a minimum of \$550 per person per Benefit Period for Mental or Nervous Disorders (Limits do not apply to Biologically Based Mental Illness) 	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Biologically Based Mental Illness	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Home Health Care Limited to 60 visits per person per Benefit Period	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Physical, Occupational and Speech Therapy Limited to 25 visits per person per Benefit Period. All therapies combined.	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Skilled Nursing Facility Limited to 60 days per person per Benefit Period	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Hospice Limited to \$200 per day, \$7,500 per person per Benefit Period (\$500 maximum for bereavement services)	Subject to Network Deductible and Benefit Percentage	Subject to Non-Network Deductible and Benefit Percentage
Transplants <ul style="list-style-type: none"> • Requires pre-authorization. • \$1 million combined lifetime maximum for designated and non-designated charges. 	Subject to Network Deductible and Benefit Percentage Lifetime benefit maximum is \$1 million when performed in a designated transplant facility and includes \$10,000 for travel and lodging expenses for insured and one companion (meals and lodging are limited to \$150 per day).	Subject to Non-Network Deductible and Benefit Percentage Lifetime benefit maximum is \$150,000 when performed in a non-designated transplant facility and includes \$5,000 for Travel and Lodging for insured and one companion (meals and lodging limited to \$150 per day).
Accident Benefit	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.	
Vision Basic 1 Exam Every 12 Months	\$20 copay per exam	Not Covered
Optional Benefits		
Accident Benefit Removal Deductible is <u>not</u> waived for an injury.	Same as any other illness	
24-Hour Occupational Coverage Available to owners, sole proprietors, partners or corporate officers of the Employer Group	Covers medical expenses that result from a work-related injury	
Deductible Carry Over (Available for Calendar Year Deductible option only)	Covered charges incurred during the last 3 months of any calendar year which are applied to that year's Deductible will also be applied to the next year's Deductible.	

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Optional Benefits		
Hospital Copay Option (available with all Deductible options - Inpatient and Outpatient must be selected as a package):		
Inpatient Services:		
Emergency Admissions	\$500 Copay per admission, then subject to Network Deductible and Benefit Percentage	\$500 Copay per admission, then subject to Network Deductible and Benefit Percentage
Non-Emergency Admissions	\$500 Copay per admission, then subject to Network Deductible and Benefit Percentage	\$1,000 Copay per admission, then subject to Non-Network Deductible and Benefit Percentage
Outpatient Services: <ul style="list-style-type: none"> • Pre-Admission Testing • Outpatient Surgery • Radiological Services (including Advanced Imaging) • Laboratory Tests 	\$250 Copay per visit, then subject to Network Deductible and Benefit Percentage	\$500 Copay per visit, then subject to Non-Network Deductible and Benefit Percentage

Rx Benefits							
Drug Discount Card included; or one of the following options may be chosen:							
	Retail: 31-day Maximum Supply			Mail Order: 90-day Maximum Supply			Specialty: 31-day Maximum Supply
Tier	Generics ¹ Copay	Select Brands Copay	Additional Brands Copay	Generics ¹ Copay	Select Brands Copay	Additional Brands Copay	Specialty Drugs Copay \$2,500 Out-of-Pocket maximum per person, per Benefit Period, then 100%
Option 1	\$10	\$30	\$50	\$25	\$75	\$125	25% (\$250 maximum)
Option 2	\$3/\$20	\$35	\$60	\$7.50/\$50	\$90	\$150	25% (\$250 maximum)
Option 3	\$3/\$30	\$50	\$75	\$7.50/\$75	\$125	\$190	25% (\$250 maximum)
Option 4	\$10	\$30	\$50	\$25	\$75	\$125	25% (\$250 maximum)
Option 5	\$3/\$20	\$35	\$60	\$7.50/\$50	\$90	\$150	25% (\$250 maximum)
Option 6	\$3/\$30	\$50	\$75	\$7.50/\$75	\$125	\$190	25% (\$250 maximum)
If a Select Brand Name Drug or an Additional Brand Name Drug is chosen when a Generic Drug is available, then the Insured Individual is responsible for the Generic Drug copayment plus the difference between the cost of the Select Brand Name Drug or the Additional Brand Name Drug and the Generic Drug.							
Specialty Drug benefits only apply at a Participating Specialty Pharmacy. No Benefits are payable if a specialty drug is purchased at any other pharmacy.							
Options 4, 5 & 6—Specialty Drugs Out-of-Pocket Maximum does not include Deductible							
Diabetic Supplies are Covered							
Contraceptive drugs and devices are covered, except injectables and surgically implanted devices.							

¹If two numbers appear in this column, this indicates a split generic copay. The first number is the copay for the low-cost generic; the second number is the copay for the high-cost generic.

Latitude Copay Prescription Drug Plan

Latitude is designed to help your employees hold down their medical expenses, including their prescription drug costs. For that reason, Latitude has its own drug formulary, which includes a Step Therapy program for certain drug classes. Step Therapy ensures that the Insured Individuals use clinically appropriate drugs in a cost effective manner. Step Therapy requires the use of one or more prerequisite drugs prior to the use of another drug. Step Therapy protocols are based on established national treatment guidelines. Certain drugs are not covered unless a plan participant tries and fails a prerequisite drug first. Drugs that are subject to Step Therapy are shown in the formulary. For more information on Step Therapy, please refer to our website at www.american-community.com, select “Prescription Drugs,” then click on the link for “Latitude Step Therapy.”

Pre-Existing Condition Limitation

A pre-existing condition is an illness for which medical advice, diagnosis, care or Treatment was recommended or received within the 6-month period prior to the Insured Individual enrollment date. No benefits are payable for pre-existing conditions until the individual has been covered under the policy for 12 months if a timely enrollee, or 18 months if a late enrollee. This exclusion does not apply to pregnancy, newborn children, or adopted children under age 19, if such children become covered within 31 days of birth, adoption, or placement for adoption.

Creditable Coverage Towards Pre-Existing Condition Limitation

An employee and/or dependent who was covered under a health benefit plan before the effective date of this plan will be given credit toward satisfaction of the pre-existing condition limitation under this plan (if any applies). The credit will be for the length of time the person was covered under the prior health benefit plan(s). Such credit applies only if fewer than 63 days have elapsed since coverage under the prior health benefit plan ended. Should an individual be subject to a pre-existing condition limit after crediting prior coverage, the employer will receive a letter indicating the time each individual has left until such limitation expires.

Employer Waiting Period

The Waiting Period is the period of time, established by an employer, that must pass before an individual is eligible for benefits. The Waiting Period is not considered a gap in coverage for purposes of calculating periods of creditable coverage. American Community will not impose a Waiting Period.

Rating Guidelines

When a group is issued, American Community prices it according to the group’s demographics (i.e., number of employees, employee age, employee gender, geographical location) and the plan’s features (i.e., payment provisions, levels of benefits and limits on benefits, such as for pre-existing conditions). Further considerations may include employee and dependent health status and type of business. Rates change at the beginning of each month when an employee enters a new age bracket. The premium rate for a class will never be more than 233% of our new business rate for that class of business. American Community will not reclassify a group to a less favorable class at renewal. We must give a group 30 days notice of a rate change.

Rate Changes and Characteristics

Any increase is limited to the change in the new business rate since the group’s last increase, plus up to an additional 15% per year, assuming the group’s demographic and plan characteristics remain the same. For example, if the new business rate has increased 3% since the group’s last increase, the most the current increase could be is 3%, plus up to 15%, for a total increase of 18%. The increase over and above the new business rate could vary from group to group based on age, gender, geographic area, group size, health status and industry, unless otherwise prohibited by law.

Simplified Underwriting

Underwriting of new business is performed on a “whole group” basis. When submitting a new group, all full-time, eligible employees must submit an application. Information contained in both the employer and employee applications will be used to determine the risk and the rates to be used for the group as a whole. If the group meets the eligibility requirements, all eligible applicants will be covered. Proposed rates and actual rates may differ if the enrollment census changes from the proposal census or due to additional medical risk disclosed at enrollment. All groups are classified by industry

based on the Standard Industrial Classification. Certain industries are considered unstable, hazardous or high risk and will require an additional premium.

Renewability

This plan is renewable for insured employees and dependents at the option of the employer, except in any one of the following cases:

1. Fraud or intentional misrepresentation by the employer or for coverage of an Insured Individual, misrepresentation by the Insured Individual or the individual’s representative;
2. Non-payment of premium;
3. Failure to meet participation requirements;
4. Non-compliance with employer contribution requirements;
5. American Community elects not to renew a particular plan in the small group market in this state;
6. American Community elects not to renew all its health benefit plans delivered or issued for delivery to small group employers in this state.

Group Participation Guidelines

The employer is required to meet and maintain the following minimum participation requirements:

1. For Life Insurance, Accidental Death and Dismemberment and Weekly Income benefits, 100% of the employer’s eligible employees must apply.
2. For all other coverages:
 - Groups of 2 to 5 employees — 100% of eligible employees
 - Groups of 6 or more employees — 75% of eligible employees
 - All group sizes — At least 50% of all employees of an eligible class must enroll.

These participation requirements apply to both new groups and inforce groups.

Employee Eligibility

An eligible employee is an employee who works at least 25 hours per week (or as otherwise determined by the employer) and is receiving earnings reportable to the IRS. Owners and partners are eligible if they meet the same requirements as an eligible employee.

Dependent Eligibility

An eligible dependent is a spouse and/or an unmarried, legally dependent child from birth to age 26, if child is dependent on the employee for maintenance and support.

Group Eligibility

An eligible employer is an employer who employed an average of at least 2 but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Contract workers, commissioned salespersons with no base salary, associated professions and work-for-fee persons are not eligible.

Groups with employees located in states other than where the group is located will be considered only if certain conditions are met. If acceptable, area rating factors may apply.

Benefit Exclusions and Limitations

THE FOLLOWING EXCLUSIONS AND LIMITATIONS APPLY TO ALL BENEFITS: 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 Deductibles, Co-payments, or Benefit Percentages: An Illness or Injury which is covered under any worker’s compensation or similar law. This exclusion also applies to an Insured Individual who could be covered by worker’s

compensation or similar law, but legally chose not to be; Charges due to a Pre-existing Condition; Charges for losses which are due to war or any act of war, whether declared or undeclared, or losses which are due to participation in a riot or insurrection; Charges incurred or disability claimed while an Insured Individual is not under the direct care of a Doctor or expenses related to Treatment provided over the internet or via electronic mail; Charges for losses which are due to committing or attempting to commit a crime; Charges which are not Medically Necessary to the care or Treatment of an Illness, Injury or condition, or which are illegal, or which are Experimental, Investigational or Unproven, including complications of such care or Treatment; Charges for tests, examinations or other procedures performed in preparation of or in follow-up to Experimental, Investigational or Unproven Procedures; Charges which would not have been made if no insurance existed; Charges which an Insured Individual is not legally obliged to pay; Charges which are in excess of the Non-Network Allowable Amount; Charges by a provider which are not within the scope of their license; Charges for which benefits are not provided in the Policy, including complications of non-covered benefits; Charges for any Illness contracted or Injury received while a member of the Military, Navy, or Air Force of any country; Charges for dental services or supplies for Treatment of the teeth, gums or alveolar processes, regardless of origin or cause, except as provided in the certificate; 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 an Illness or Injury; Charges for vision related surgery or services, including, but not limited to: eye refractions, eyeglasses or contact lenses, surgery and eye training, exercises or vision therapy; Charges for Cosmetic Treatment or complications of Cosmetic Treatment, except as provided in the certificate; Charges for services of a volunteer, a person who usually lives in the same household, or a member of his or her immediate family or the family of his or her spouse; Charges for services or supplies furnished by an agency of the United States Government or a foreign government agency, unless excluding them is prohibited by law; Charges for vitamins, minerals, supplements and food; Charges for examination, diagnosis, appliances or Treatment of malocclusion, misalignment, dysfunction, deformity or defect of the jaw or TMJ; Charges for outpatient Prescription Drugs, unless the Outpatient Prescription Drug Rider is attached to the certificate; Charges for emergency contraceptive kits, contraceptive drugs and devices, and contraceptive methods or aids, except as provided in the certificate; Charges for preventive care, except as covered under the Preventive Care Benefit; Charges for Treatment of obesity, or weight loss, including surgery and complications thereof; Charges for physical, occupational or speech therapy for Developmental, educational or social reasons; Charges for transplants, except as provided in the certificate; Charges for gender reassignment or charges due to complications of gender reassignment; Charges for Custodial Care, maintenance, or homemaker services; Charges for fertility drugs, artificial insemination, infertility Treatment or in vitro fertilization, except when insurance coverage is required by law; Charges for reversal of sterilization; Charges for the diagnosis and/or Treatment of eating disorders; Charges for Treatment of smoking cessation, expenses related to nicotine addiction, caffeine addiction and non-chemical addictions; Charges for exercise programs or equipment; Charges for Treatment of hair loss or removal; Charges for Treatment of sexual function, dysfunction, inadequacy or desire including, but not limited to, treatment of erectile dysfunction and penile prostheses; Charges for performance of physical examinations or

the verification of health status for a third party; Charges for court ordered evaluations, Treatment or testing; Charges for genetic testing; Charges for inoculations or prophylactic drugs for travel; 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; Charges for services required to be made available in the community; Charges for evaluation or Treatment of learning disabilities; attitudinal disorders; or disciplinary, social or Developmental conditions; Charges for care, services, procedures or supplies that are cognitive in nature; 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; Charges for voluntary abortion; Charges for any expenses incurred outside of the United States, except for Emergency services; Charges for non-medical expenses even if recommended by a Doctor; Charges for alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health; Charges for Treatment given in a Hospital emergency room for Non-Emergency Illness or Injury; Charges for ambulance services for routine transportation to, from or between medical facilities and/or a health care practitioner's office; Charges for services or supplies for personal comfort or convenience or hygiene; Charges for education or training, except for diabetes self-management training; Charges for educational or vocational therapy, testing, services or schools; Charges for drugs, devices, products or supplies with over-the-counter equivalents and any drugs, devices, products or supplies that are therapeutically comparable to an over-the-counter drug, device, product or supply; Charges for marital counseling; Charges for replacement of an existing breast implant if the earlier breast implant was performed for Cosmetic reasons. Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy; Charges for mileage, lodging and meal costs, and other travel related expenses, except as provided in the certificate; Charges for private duty nursing; Charges for Treatment of benign gynecomastia; Charges for medical and surgical Treatment of hyperhidrosis; Charges for medical and surgical Treatment for snoring; Charges for oral appliances for snoring; Charges for care required while incarcerated or required while in custody of law enforcement authorities, including work release programs, unless otherwise required by law or regulation; Charges for stand-by charges of a health care practitioner; Charges for Sclerotherapy for the Treatment of varicose veins of the lower extremities; Charges for Treatment of telangiectatic dermal veins (spider veins) by any method; Charges for benefits in excess of any maximums or limitations shown on the Schedule.

THE FOLLOWING EXCLUSIONS APPLY TO THE PRESCRIPTION DRUG COVERAGE OPTIONS IF INCLUDED IN THE POLICY: Non-federal legend drugs; All fluoride products; Drugs for weight loss, including anorexiant and amphetamines, and weight loss products; Cosmetics, dietary supplements, health or beauty aids; Therapeutic devices or appliances; Drugs to stimulate hair growth; Immunization agents, biological sera, blood or blood plasma; Any prescription refilled after one (1) year from the Doctor's original order or in excess of number of refills specified; Medication for which the cost is recoverable under any worker's compensation or occupational disease law, or any state or governmental agency; Medication which is to be taken by or administered to the Insured Individual, in whole or in part, while they are a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled 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; Medication for which no charge is made to the Insured Individual;

Medication or drugs delivered or administered to the Insured Individual by the prescriber; Medication or drugs labeled, "Caution - Limited by Federal Law to Investigational Use," or experimental drugs even though a charge is made to the Insured Individual; All vitamins; Drugs to deter smoking; All fertility drugs; Oral, injectible or topical agents to improve physical or cosmetic appearance; Federal legend drugs for which a non-prescription equivalent is available, regardless of dose; Drugs for the Treatment of onychomycosis (nail fungus); 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; Injectable contraceptives; Contraceptives that are surgically implanted; Emergency contraceptives; Abortifacants (drugs used to induce abortion); Drugs to treat influenza or lessen its symptoms; Federal legend drugs for which a non-prescription

therapeutic alternative is available, regardless of dose; Drugs to treat a cough or cold or lessen its symptoms; Drugs not listed on the Formulary; Proton pump inhibitors; 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, and generally recognized standards of care, except where prohibited by state law. Even if a drug has not been approved for a particular disease or disorder, it will be covered if it has been recognized as a safe and effective Treatment of that particular disease or disorder by acceptable medical literature; and Drugs to treat sexual function, dysfunction, inadequacy or desire including, but not limited to, treatment of erectile dysfunction.

This benefit chart is a brief description of the highlights of the Latitude Policy Form Number SGRP09-CONT-OH. It is not intended to be a full description of coverage. The master policy is issued to a trust in the state of Ohio. Should an employee apply for coverage and be accepted, a Certificate of Insurance will be issued with a complete description of benefits and exclusions. The certificate includes complete details of all plan provisions and is the governing document in case of discrepancies.


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