

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!**

MEDICAL EXPENSE COVERAGE – Policies of this category are designed to provide, to persons insured, coverage for 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 Med HSA offers increased benefits when the Family Member uses a Network Provider. These benefit differences are illustrated under Network/Non-Network.

Network Deductibles: Only 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. UCR means a charge which We determine does not exceed the amount usually accepted by providers in the general area where the charge is incurred.

Calendar Year Deductible and Benefit Percentage apply to the following benefits:

PLAN CHOICE	100% PLAN		80% PLAN	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Calendar Year Deductible The network and non-network calendar year deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$1,500 \$2,000 \$2,600 \$3,500 \$5,000	\$3,000 \$4,000 \$5,200 \$7,000 \$10,000	\$1,000 \$1,500 \$2,000 \$2,600 \$3,500	\$2,000* \$3,000 \$4,000 \$5,200 \$7,000
Family Calendar Year Deductible The network and non-network calendar year deductibles are separate and charges incurred under one deductible will not be applied to the other deductible.	\$3,000 \$4,000 \$5,200 \$7,000 \$10,000	\$6,000 \$8,000 \$10,400 \$14,000 \$20,000	\$2,000* \$3,000 \$4,000 \$5,200 \$7,000	\$4,000* \$6,000 \$8,000 \$10,400 \$14,000

*These are adjusted annually for changes in the U.S. Consumer Price Index.

BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.	NETWORK COVERAGE	NON-NETWORK COVERAGE
Individual Benefit Percentage/Out-of-Pocket Maximum After Deductible	100%/NA 80%/\$1,000	75%/\$4,000 50%/\$4,000
Family Benefit Percentage/Out-of-Pocket Maximum After Deductible	100%/NA 80%/\$2,000	75%/\$4,000 50%/\$8,000

PHYSICIAN SERVICES

In Physician's Office and Urgent Care Centers

- Office Visits
- X-rays
- Visits for Injury*
- Office Surgery
- Laboratory Tests

In-Hospital Visits by a Physician**

Non-Surgical Care for Dislocations or Subluxation of Spine

\$500 calendar year combined maximum of network and non-network services per family member

Allergy Testing, Serums and Injections

\$500 calendar year combined maximum of network and non-network services per family member

100% or 80%

75% or 50%

**Deductible waived for expenses incurred within 30 days of an injury. After 30 days, normal plan benefits apply.

- Please note: 1. Services performed by providers other than your physician may be billed separately and may not be part of the “visit.”
 2. Some emergency local ambulance services or hospital physicians, radiologists, anesthesiologists, and pathologists rendering services at Network hospitals may not be members of the Network. In this situation, hospital charges would be covered at the Network benefit level and the ambulance and physician charges at the Non-Network benefit level.

BENEFIT PERCENTAGES APPLY AFTER THE DEDUCTIBLE IS MET.	NETWORK COVERAGE	NON-NETWORK COVERAGE
Preventive Care \$300 calendar year maximum per family member <ul style="list-style-type: none"> • Immunizations • Bone Density Test • Pap Smear • Routine Physical Exams • Inoculations or Prophylactic Drugs for Travel 	100% or 80%	75% or 50%
Hospital Services		
Inpatient Services**		
Outpatient Surgery**		
Diagnostic Services** <ul style="list-style-type: none"> • Pre-admission testing • X-rays • Nuclear medicine • Ultrasounds • Laboratory Tests • MRIs • Mammograms 	100% or 80%	75% or 50%
Emergency Room Services**	Emergency sickness or injury covered at the network benefit percentage of 100% or 80%. Non-emergency sickness is not covered.	
OTHER COVERED SERVICES		
Free-Standing Outpatient Surgery Center** Facility Charges		
Radiology or Diagnostic Services Outside of the Hospital** <ul style="list-style-type: none"> • X-rays • MRIs • Mammograms • Laboratory Tests (including lab work sent by a physician to an independent laboratory) • Nuclear medicine • Ultrasounds 	100% or 80%	75% or 50%
Outpatient Physical, Occupational and Speech Therapy** Limited to 60 visits per calendar year (this is a combined total for all therapies)	100% or 80%	75% or 50%
Home Health Care Limited to 20 visits per calendar year		
Hospice Up to \$200 per day, a lifetime maximum \$15,000 or 6 months, whichever comes first		
Skilled Nursing Facility \$75 per day, 60 visits per calendar year		
Prescription Drug Coverage Includes the discount drug card for use at network pharmacies. Maximum 30-day supply per prescription	Discount Drug Card, then 100% or 80%	75% or 50%
Accidental Death for Primary Insured Only	\$10,000	
Organ Transplants Combined maximum benefit of \$1,000,000 A designated transplant facility is a medically proven, exceptional success rate facility for organ transplants that has agreed to provide approved transplant services to our policyholders.	\$1,000,000 at a designated transplant facility 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 day. \$150,000 at a non-designated transplant facility	
OPTIONAL BENEFITS	Type I procedures: 6-month waiting period, then 80%	
Dental Benefit Calendar year maximum benefit is \$1,000	Type II procedures: 12-month waiting period, \$100 calendar year deductible, then 50%	
Maternity Benefit for All Females Covered Under the Policy 180-day waiting period from the effective date of the rider. To be covered, pregnancy must begin after the waiting period.	100% or 80%	75% or 50%

**Deductible waived for expenses incurred within 30 days of an injury.

After 30 days, normal plan benefits apply.

- 1) Daily hospital room and board:
 - a. Semi-private room and routine nursing care for Confinement in a Hospital
 - 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. Benefits are payable at the Network benefit level.
- 3) Surgical services:
 - a. Physician's or surgeon's medical care or surgery. If two or more procedures are performed through the same incision, the most American Community will consider is the Preferred Provider Network allowance or the Usual, Customary and Reasonable Charge (UCR) for the most expensive procedure and 50% of the Preferred Provider Network allowance or the UCR Charge for the remaining procedures.
 - b. Mastectomy, breast reconstructive surgery and 2 postoperative breast prostheses. Breast reconstructive surgery of the other breast to produce symmetry. Post-mastectomy care including inpatient care for a length of time determined by the attending Physician to be Medically Necessary; and one Physician office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.
 - c. Services of an assistant surgeon or technical surgical assistant, but no more than 20% of the amount allowed for the surgeon's fee.
- 4) Anesthesia services: Anesthetics and their administration
- 5) In-hospital medical services:
 - a. Prescription drugs and medicines provided while Confined, except drugs prescribed for excluded or ridered conditions.
 - b. X-rays, lab tests and other diagnostic services
 - c. Radiation therapy, chemotherapy
 - d. Services by licensed physical, occupational or speech therapists
 - e. Complications to a Pregnancy as defined in the policy. Only charges related to the distinct complication are considered Covered Charges. For example, only the difference between the cost of a vaginal delivery and the cost of an Emergency cesarean section will be considered a Covered Charge.
- 6) Out of hospital care:
 - a. **Skilled Nursing Care** – Skilled Nursing Facility room and board covered at \$75 per day, 60 days per calendar year. This is a covered charge only if the Family Member would otherwise need Confinement in a Hospital.
 - b. **Home Health Care** – Home Health Care covered at 20 visits per calendar year. Other covered charges as part of Home Health Care: home health services performed by a Registered Nurse or qualified therapist; 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 \$15,000 or 6 months, whichever comes first. Other covered charges for treatment by a Hospice for: family counseling due to the Family Member's terminal condition; respite care; support services for other Family Members during the three month period following the death of a Family Member, not to exceed a benefit of \$500.
- d. Treatment given in an outpatient section of a Hospital, Free Standing Outpatient Surgery Center, or similar facility.
- e. Services by licensed physical, occupational or speech therapists for rehabilitation of a covered sickness or injury, covered at a combined maximum of 60 visits for all therapies, per calendar year.
- 7) Other Benefits:
 - a. Artificial larynx, limb(s) or eye(s), for loss of natural larynx, limb(s) or eye(s) while insured under the policy. This does not include myo-electric prostheses replacement or maintenance of prostheses.
 - b. Casts, splints, trusses, braces (except dental), crutches, and surgical dressings
 - c. Rental up to the purchase price for a wheel chair, standard hospital bed, respirator and devices to give oxygen.
 - d. Buying or renting kidney dialysis equipment for a Family Member's own use. If purchased, the cost will be divided by 24. The result will be the monthly benefit. We will pay that amount as long as Treatment is required, for up to 24 months. We also cover charges for supplies, repairs and materials required to use the equipment. This includes the expense to train a person to use it. No benefits are paid for a Family Member on or after the day the Individual is entitle to benefits under Medicare, except as provided by law.
 - e. Emergency ambulance service to the nearest Hospital capable of treating the Family Member's condition.
 - f. Treatment of Family Members, born after the Effective Date of this policy, for congenital defects and birth anomalies. Coverage includes, but is not limited to, benefits for Inpatient or outpatient 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.
 - g. One baseline mammogram between the ages of 35 and 39, and one mammogram per year after age 39. One mammogram per calendar year for women at risk.
 - h. Approved Transplant Procedure to a Family Member up to \$1,000,000 in a Designated Transplant Facility and \$150,000 in a Non-Designated Transplant Facility. The Combined Maximum Lifetime Transplant Benefit is \$1,000,000 for charges incurred at a Designated Transplant Facility and a Non-Designated Transplant Facility. Transplants must be approved by American Community prior to the beginning of the evaluation. Benefits will be paid for Approved Transplant Procedures only. No benefits will be paid if the procedures is not approved in advance.
 - i. Prescription drugs and medicines, except drugs prescribed for medical conditions that have been excluded from coverage by amendment or rider to this policy. Coverage includes outpatient contraceptive drugs and devices approved by the Food and Drug Administration. Drugs prescribed to treat anything listed in the General Exclusions section of the policy are not covered.
 - j. Examination and testing of a victim of a sexual assault.
 - k. Non-surgical care for dislocation or subluxation of the spine up to \$500 per calendar year.
 - l. General anesthetics and Hospital or Ambulatory Surgical Treatment Center facility charges incurred when dental care is provided for the following Family Members:
 - (1) A child age 6 or under;

- (2) A person who has a medical condition which requires hospitalization or general anesthesia when dental care is provided; or
 - (3) A person who is Disabled, as defined in the policy.
 - m. 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.
 - n. Consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods, including natural family planning to prevent an unintended pregnancy. Coverage does not include services related to abortion or permanent sterilization that requires a surgical procedure.
 - o. Services related to diagnosis and Treatment of osteoporosis, including a bone mass measurement test when the test is Medically Necessary.
 - p. Breast implant removal when the removal is Medically Necessary Treatment for a Sickness or Injury. No benefits are payable for surgery performed for removal of breast implants that were implanted solely for cosmetic reasons.
- 8) Optional Maternity Coverage
- a. Available to all females insured under the policy, with a 180-day waiting period from the effective date of the rider.
 - b. To be covered, the pregnancy must begin after the waiting period.
 - c. Benefits are subject to calendar year network and non-network deductibles and benefit percentage contained in the policy.
 - d. Covered charges include routine pre-natal care, routine delivery services, in-hospital care of well newborn, and inpatient care and associated charges incurred for 48 hours after vaginal delivery and 96 hours after cesarean section.
- 9) 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.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

We will pay no benefit for charges due to any of the following. These charges are not Covered Charges and cannot be used to satisfy this policy's Deductible or Benefit Percentage.

1. Pre-existing Conditions for 2 years starting on the Effective Date of a Family Member's coverage under the Policy.
2. Charges in excess of the Usual, Customary, and Reasonable Charges for services and supplies.
3. Suicide or attempted suicide, whether or not sane, or intentionally self-inflicted Injury.
4. Injury received while committing or attempting to commit a felony.
5. War or any act of war, whether or not declared, or participation in a riot or insurrection.
6. 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.
7. Services performed by volunteers, a relative, a Family Member, a Family Member's employer, or a resident in the Family Member's household.
8. Services or supplies for personal comfort or convenience.
9. Travel or lodging expenses, except as provided under Covered Charges.
10. Maintenance care, Custodial Care or homemaker services.
11. Preventive medical care, except as provided under Covered Charges or the Preventive Care Benefit.
12. Treatment given in a Hospital emergency room for a Non-Emergency Sickness.
13. Charges for dental services or supplies 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. The Injury must occur on or after the Effective Date of the Family Member's coverage under this policy.
14. Cosmetic Treatment, or complications of cosmetic Treatment, except when required:
 - a. to correct congenital defects or birth anomalies of a Family Member born after the Effective Date,
 - b. by an Injury to a Family Member, when provided within 12 months of the Injury. The Injury must occur on or after the Effective Date of the Family Member's coverage under this policy, or
 - c. to treat a Medically Necessary complication of cosmetic Treatment.
15. Vision related surgery or services, including, but not limited to:
 - a. Eye refractions.
 - b. Examinations for eye refractions.
 - c. Eyeglasses or their fitting.
 - d. Contact lenses or their fitting.
 - e. Surgery to correct nearsightedness, farsightedness, astigmatism or vision conditions.
 - f. Eye training, exercises or vision therapy.
16. Hearing aids or their fitting, routine hearing tests and audiograms that are not performed in connection with a Sickness or Injury.
17. Vitamins, minerals, supplements, herbals, botanicals, food, special diets, specially grown or prepared foods or diets, even if prescribed to treat an illness.
18. 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.
19. Care of a well, newborn child, except when insurance coverage is required by law.
20. Emergency contraceptive kits, sterilization or the reversal of sterilization; voluntary abortion by any means, complications from abortion or attempted abortion.
21. 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.
22. Gender reassignment or charges due to complications of gender reassignment.
 23. Treatment of “quality of life” or “lifestyle” concerns including but not limited to eating disorders; weight loss programs, drugs or surgery, except for the Medically Necessary Treatment of morbid obesity; smoking cessation; expenses related to nicotine addiction, caffeine addiction and non-chemical addictions; exercise programs or equipment; hair loss; hair restoration or removal; sexual function, dysfunction, inadequacy or desire.
 24. Treatment of a Mental or Nervous Disorder or Illness, or emotional conditions, even if court ordered.
 25. Treatment of Substance Abuse including Alcoholism, Alcohol Abuse, Chronic Alcoholism and Alcohol Dependence, even if court ordered.
 26. Physical, occupational or speech therapy for Developmental reasons.
 27. Transplants, except as provided under Covered Charges.
 28. Appliances or dental Treatment of malocclusion, misalignment of the jaw, dysfunction, deformity or defect of the jaw or temporomandibular joint dysfunction, unless caused by an Injury that occurred on or after the Effective Date of the Family Member’s coverage under this policy.
 29. Charges which a Family Member is not legally obligated to pay or which would not have been made if no insurance existed.
 30. Charges for Treatment by a Physician, which is not within the scope of his or her license.
 31. 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.
 32. 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.
 33. Court-ordered evaluation, Treatment or testing.
 34. Genetic testing, counseling and services.
 35. Growth Treatment, medication or hormones, unless Medically Necessary.
 36. Services available in the community through educational or school programs.
 37. Evaluation or Treatment of learning disabilities; Attention Deficit Hyperactivity Disorder; attitudinal disorders; or disciplinary, social or Developmental conditions.
 38. Care, services, procedures or supplies that are cognitive in nature.
 39. Tests, examinations or other procedures performed which are not Medically Necessary to the care and Treatment of a Sickness, Injury or condition, or which are:
 - a. illegal; or
 - b. Experimental, Investigational, Unproven and/or for Research.
 40. Foot care in connection with corns, calluses, toenails, flat feet, fallen arches, weak feet, or chronic foot strain; shoes, shoe accessories, and orthotics.
 41. Treatment or removal of nevi, keratoses, skin tags or warts, except refractory plantar warts.
 42. Treatment of nail fungus.
 43. Drugs to prevent Sickness and drugs to prevent, treat or lessen the symptoms of influenza or respiratory virus.
 44. Non federal legend drugs.
 45. Amphetamines.
 46. Drugs labeled “Caution - limited by Federal Law to investigational use”, or experimental drugs, even though a charge is made to the individual.
 47. 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.
 48. Any expenses incurred outside of the United States for elective care, testing, procedures or services, except for Emergency care.
 49. Treatment and testing of sleep disorders.
 50. Expenses related to Treatment, diagnosis, or care provided over the Internet or via electronic mail.
 51. 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.
 52. Expenses related to an injury sustained while the Family Member is participating in a professional sporting event for which they receive money or any other compensation.
 53. Charges for services for which You have failed to provide reasonable proof of loss.
 54. Charges for which benefits are not provided in this policy.
- If You or Your Physician/Provider have any questions regarding the Covered Charges, policy exclusions, limitations and benefit maximums expressed in the policy, please call American Community at 800-991-2642.
- MATERNITY EXCLUSIONS**
- No benefits will be paid for any of the following:
1. Vitamins including pre-natal vitamins;
 2. In vitro fertilization;
 3. Drugs, tests, treatments or procedures to aid or assist conception.
- 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.
- ELIGIBILITY**
- The following persons are eligible to be Family Members:
1. You;
 2. Your spouse;
 3. Your and Your spouse’s children and adopted children, provided they are:
 - a. not married,
 - b. dependent on You for at least 50% of their support, and
 - c. less than 22 years old.
- We consider a child in Your custody, pursuant to an interim court order 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 this policy if We change the premium for all other policies in Your state which are issued using this form. In addition, We may also change the premium in accordance with the Change of Residence provision in the policy. The renewal premium is calculated from the table of rates We use for this 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.

PREMIUM REFUND

If you die while this policy is in force We will prorate the refund of premium paid from the date following the date of your death to the end of the period for which premium has been paid.

The premium will be paid as follows: (1) if You paid the premium, the refund will be issued to your surviving spouse. If there is no surviving spouse, the premium will be paid to your estate; (2) if a person other than you paid the premium, the refund will be issued to that person. Proof of payment of the premium must be provided to Us before the refund will be issued.

RENEWAL CONDITIONS

You may renew this policy each month by paying 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 Premium Due Date after Your marriage is dissolved.
2. Your child's coverage ends on the first Premium Due Date after the earliest of the following:
 - a. the date the child marries,
 - b. the date the child ceases to be dependent on You for at least 50% of their support, or
 - c. the date the child attains age 23.
3. A Family Member's coverage ends:
 - a. If the Family Member enters a branch of the Military of any country and requests that it end. Upon written request We will refund the premium for that Family Member. The refund will be prorated.
 - b. When the sum of benefits paid for that Family Member equals or exceeds the Maximum Lifetime Benefit.
 - c. If the Family Member commits fraud or intentional misrepresentation of material facts in applying for benefits under this policy.
4. All coverage ends for all Family Members if:
 - a. You fail to pay a premium when due, or
 - b. We end all policies in Your state which are issued using this form.

Insurance under the optional maternity 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.

CHILD WITH A HANDICAPPED CONDITION

Your child's coverage will not end due to age while the child is incapable of earning their own living because of a handicapped condition or is actually dependent on You or other care providers for a majority of their support and is covered by the policy on the date immediately preceding the day their coverage would have ended due to age. A handicapped child is one who because of a handicapped condition that occurred before attainment of the limiting age, is incapable of self-sustaining employment and is dependent on their parents or other care providers for lifetime care and supervision. "Dependent on other care providers" means the handicapped child would require a community integrated living arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Mental Health and Developmental Disabilities, the Department of Public Health or the Department of Public Aid. We will inquire as to the status of the child within 2 months prior to the date their coverage would end due to age. You must furnish Us proof of incapacity within 31 days of Our inquiry. Coverage for a mentally or physically handicapped child will end on the earliest of the following dates: (1) the 61st day after we requested you were 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 2 months from the date the child reaches the attainment of the limiting age, and you do not furnish us proof of disability and dependence within 60 days of the request; (3) the date the child becomes capable of self-support; or (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 item 1. and 2. in the End of Coverage provision. 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 within 31 days after the coverage ends or in the case of divorce, within 60 days from the date of the judgement granting the divorce, whichever is later. The new policy will take effect when the coverage under this policy ends. The Time Limit on Certain Defenses and the Pre-existing Condition Exclusion on the new policy will be measured from the Effective Date of the Family Member's coverage under this policy. The new policy will be issued on this policy form.

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 promptly refund the premium paid.

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

An illness or disease that was diagnosed or treated by a Physician within 24 months prior to the Effective Date of coverage or produced symptoms within 12 months prior to the Effective Date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or Treatment. An illness or disease which appeared 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.