

# Freedom Health Plans

When it comes to health insurance, you want choice, value and dependability.

The Freedom Health Plan offers four quality options, including an HSA-qualified high-deductible health plan.



This brochure must be accompanied by insert IHCHS 041 0609 EH.  
IHCHS 539 1109

The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 25 years. For information about the IHC Group, visit [www.ihcgroup.com](http://www.ihcgroup.com).

The Freedom Health Plans are available only to members of Communicating for America, Inc. Membership is optional for residents of Kansas and Montana.

The Freedom Health Plans are underwritten by Companion Life Insurance Company. Companion Life is not a member of the IHC Group.

# Freedom

## Features and Benefits



### **\$5 million lifetime maximum**

Each covered person has a \$5 million lifetime maximum benefit and a \$2 million calendar year maximum benefit.

### **24-hour coverage**

Coverage is available 24 hours per day and includes work-related injuries or illnesses, unless those charges are covered by workers' compensation or you are required by law to be covered by workers' compensation.

### **Air, water and land ambulance**

Coverage includes ambulance services by air, water and land subject to the plan deductible and coinsurance.

### **Waiver of pre-existing condition limitation**

If you fully disclose an existing medical condition on the application that is not specifically excluded from coverage, the Freedom Health Plan will consider a claim for that condition without applying the pre-existing condition limitation.

### **Wellness**

Mammograms and Pap tests are covered at 100 percent with no waiting periods. Coverage for prostate cancer screening is included subject to your selected deductible and coinsurance. Additional wellness coverage is available through the optional wellness benefit.

### **Generation to generation**

Covered dependents have the option to purchase their own similar plan, regardless of their health history, when they reach 18 years of age or when they can no longer be considered a dependent on your plan. If your child develops a chronic condition, this important benefit will allow him or her to keep health insurance coverage.

### **Centers of Excellence for transplant services**

All plans include access to a national Center of Excellence network for organ transplants. This specialized network consists of top-rated providers in terms of the number of specific transplants performed and their success rates. The network ensures that if you need these services, you receive the highest level of care through expertise, patient advocacy and care management.

# PPO and Traditional



All Freedom Health Plans allow you to choose your health care providers. However, benefits are paid differently based on your selection of either a PPO plan or a traditional indemnity plan.

## PPO plans

Office visit copays and negotiated discounts are available through PPO network plans. Network providers have agreed to offer services at a reduced or discounted price. You realize these savings through a lower monthly premium, higher benefits and reduced out-of-pocket costs.

**Forced providers** – Certain providers such as radiologists, pathologists, anesthesiologists and assistant surgeons may have relationships with network facilities but have chosen not to join the network. Understanding that you are not always able to select these providers when admitted to an in-network hospital, the Freedom Health Plan will consider charges for these “forced providers” at the in-network benefit level. Covered charges will be based on reasonable and customary charges, if both the hospital and admitting physician participate in your selected PPO network.

**Emergency care** – If emergency medical attention is needed, you can receive care without worrying about finding an in-network provider. Charges resulting from emergency services received from an out-of-network provider will be considered in-network. Transfer to an in-network facility or provider must be arranged within 48 hours or as soon as the transfer can take place without detriment to your health.

## Traditional plans

Offering the greatest freedom in provider choice, traditional indemnity plans allow you to visit any health care provider without network restrictions. While benefits are not subject to different in-network or out-of-network limits, covered charges are subject to a reasonable and customary amount. The reasonable and customary amount is determined by the typical amount charged for a certain procedure within a geographic area. If the amount charged for a covered service is above the reasonable and customary amount, you are responsible for the excess charges.

# High-Deductible Health Plans

The deductible, coinsurance and out-of-pocket amounts apply per calendar year (January 1–December 31).

| Plan specifics   | PPO High-Deductible Health Plan  | Traditional High-Deductible Health Plan          |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
|--|--|--|--------|--|---|--|----------------------------------|---|-----------------------------------|--|------------|--------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <b>Deductible</b><br>On a family plan, you and all of your covered dependents share one common calendar year deductible amount for covered charges.  | <b>In-network:</b><br><table><tr><th>Individual</th><th>Family</th></tr><tr><td><input type="checkbox"/> \$2,000</td><td><input type="checkbox"/> \$4,000</td></tr><tr><td><input type="checkbox"/> \$2,600</td><td><input type="checkbox"/> \$5,200</td></tr><tr><td><input type="checkbox"/> \$5,000*</td><td><input type="checkbox"/> \$10,000</td></tr></table><br><b>Out-of-network:</b> The out-of-network deductible is two times the in-network deductible and accumulates separately. | Individual                                       | Family | <input type="checkbox"/> \$2,000         | <input type="checkbox"/> \$4,000                              | <input type="checkbox"/> \$2,600         | <input type="checkbox"/> \$5,200 | <input type="checkbox"/> \$5,000*                                       | <input type="checkbox"/> \$10,000 | <table><tr><th>Individual</th><th>Family</th></tr><tr><td><input type="checkbox"/> \$2,000</td><td><input type="checkbox"/> \$4,000</td></tr><tr><td><input type="checkbox"/> \$2,600</td><td><input type="checkbox"/> \$5,200</td></tr><tr><td><input type="checkbox"/> \$5,000</td><td><input type="checkbox"/> \$10,000</td></tr></table> | Individual | Family | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$2,600 | <input type="checkbox"/> \$5,200 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 |
| Individual   | Family   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$2,000   | <input type="checkbox"/> \$4,000   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$2,600   | <input type="checkbox"/> \$5,200   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$5,000*  | <input type="checkbox"/> \$10,000  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| Individual   | Family   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$2,000   | <input type="checkbox"/> \$4,000   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$2,600   | <input type="checkbox"/> \$5,200   |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> \$5,000   | <input type="checkbox"/> \$10,000  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <b>Coinsurance and out-of-pocket maximum</b><br>The coinsurance is the percentage paid by the plan after the deductible has been satisfied. The out-of-pocket maximum is the amount you pay, after satisfaction of your deductible.<br><br>On a family plan, you and all of your covered dependents share one common out-of-pocket maximum amount for covered charges. | <table><tr><td><input type="checkbox"/> <b>In-network:</b> 100%</td><td rowspan="3"></td></tr><tr><td><b>Out-of-network:</b> 70% up to \$3,000</td></tr><tr><td><input type="checkbox"/> <b>In-network:</b> 80% up to \$1,000</td></tr><tr><td><b>Out-of-network:</b> 50% up to \$5,000</td><td></td></tr></table><br>In-network and out-of-network out-of-pocket amounts accumulate separately.   | <input type="checkbox"/> <b>In-network:</b> 100% |        | <b>Out-of-network:</b> 70% up to \$3,000 | <input type="checkbox"/> <b>In-network:</b> 80% up to \$1,000 | <b>Out-of-network:</b> 50% up to \$5,000 |                                  | <table><tr><td><input type="checkbox"/> 100%</td><td></td></tr></table> | <input type="checkbox"/> 100%     |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> <b>In-network:</b> 100%   |  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <b>Out-of-network:</b> 70% up to \$3,000   |  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> <b>In-network:</b> 80% up to \$1,000  |  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <b>Out-of-network:</b> 50% up to \$5,000   |  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <input type="checkbox"/> 100%  |  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |
| <b>Outpatient prescription drugs</b>   | Same as any other illness; covered charges for outpatient prescription drugs are subject to the plan deductible and coinsurance  |  |        |  |   |  |                                  |   |                                   |  |            |        |                                  |                                  |                                  |                                  |                                  |                                   |

\* The individual deductible of \$5,000 cannot be selected with the 80% coinsurance option since the plan no longer meets HSA federal guidelines due to the total out-of-pocket amount.



# Choice PPO Plan

The deductible, coinsurance and out-of-pocket amounts apply per calendar year (January 1–December 31).

| Plan specifics   | Choice PPO   |
|--|--|
| <b>Physician office copay</b><br>After copay, plan covers 100% of the covered charges for in-network physician office visits including: examination, consultation and minor office surgery. Diagnostic tests, lab and X-rays are subject to the plan deductible and coinsurance. Copays do not accumulate toward satisfaction of your deductible or out-of-pocket maximum. | <b>In-network:</b><br>\$25<br><br><b>Out-of-network:</b> Covered charges are subject to the out-of-network deductible and coinsurance  |
| <b>Deductible</b><br>The family deductible is a maximum of three individual deductible amounts.<br><br>The out-of-network deductible is two times the in-network deductible and accumulates separately.  | <b>In-network:</b><br><input type="checkbox"/> \$1,500<br><input type="checkbox"/> \$2,500<br><input type="checkbox"/> \$5,000<br><input type="checkbox"/> \$10,000  |
| <b>Coinsurance and out-of-pocket maximum</b><br>The coinsurance is the percentage paid by the plan after the deductible has been satisfied. The out-of-pocket maximum is the amount you pay, after satisfaction of your deductible.  | <b>In-network:</b><br>80% to \$2,000<br><br><b>Out-of-network:</b><br>60% to \$8,000   |
| <b>Hospital or skilled nursing deductible,<sup>1</sup> per confinement</b>   | \$250  |
| <b>Emergency room deductible,<sup>1</sup> per visit</b>  | \$100<br>(Waived if admitted to the hospital immediately following emergency room visit.)  |
| <b>Outpatient prescription drugs</b>   | \$250 deductible* then \$15 copay for generic drugs or \$25 copay and 80% coinsurance for name brand drugs<br><br>* Maximum of three prescription deductibles per family, per calendar year. This deductible does not accumulate toward satisfaction of the plan deductible or out-of-pocket maximums. |

<sup>1</sup> Confinement and emergency room deductibles do not accumulate toward satisfaction of the plan deductible or out-of-pocket maximum.

# Optional Benefits

## Wellness coverage

If selected, this optional benefit provides up to \$250 for routine wellness services per calendar year for each family member covered by your Freedom Health Plan. Coverage includes:

- A physical examination by a physician, along with diagnostic services required as part of the exam to evaluate your general health status
- Exams that review normal growth and development of a child, along with lab tests and immunizations (Based on state mandated benefits, these child health supervision charges may be considered covered expenses without purchasing the optional wellness benefit. Please refer to the brochure insert for details.)

Services and supplies for children must conform to the American Academy of Pediatrics guidelines. These benefits are limited to one visit per age interval.

### *PPO plans –*

- In-network:** Covered charges are subject to your office visit copay, for the Choice PPO plan, then paid at 100 percent up to the \$250 calendar year benefit maximum.
- Out-of-network:** Covered charges are applied to your out-of-network deductible and coinsurance subject to the \$250 calendar year benefit maximum.

**Traditional plan –** Covered charges are paid at 100 percent up to the \$250 calendar year benefit maximum.

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## Outpatient supplemental accident coverage

Accidents happen, even to the most careful among us. Additional first-dollar coverage is available through this optional accident benefit. Select one of three benefit amounts for coverage of an accident that is treated within 72 hours, on an outpatient basis. Follow-up care is also included for up to 90 days. This benefit is available for an unlimited number of covered accidents.

| Benefit amount per accident      | Deductible* per accident |
|----------------------------------|--------------------------|
| <input type="checkbox"/> \$500   | \$50                     |
| <input type="checkbox"/> \$1,000 | \$50                     |
| <input type="checkbox"/> \$2,000 | \$150                    |

\* Deductible does not accumulate toward satisfaction of the plan deductible or out-of-pocket maximum.

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## Term Life Insurance

The primary insured has the option to select an amount of life insurance in increments of \$10,000 up to a total of \$50,000. This life insurance benefit is payable as long as the Freedom Health Plan is in force at the time of death.

# Limited Benefits

Benefits listed below are per covered person, per calendar year.

## **Non-surgical back treatment (including chiropractic care)**

Covered charges for non-surgical back treatment are payable up to \$500 per calendar year and are subject to your medical plan deductible and coinsurance.

## **Skilled nursing facility care**

After your deductible has been satisfied, covered medical charges will be paid at the coinsurance level up to a maximum of \$100 per day and 50 days per calendar year.

## **Home health care**

Covered charges are payable up to a maximum of 21 visits per calendar year, subject to your medical plan deductible and coinsurance.

## **Hospice care**

After your deductible has been satisfied, covered medical charges for hospice care will be paid at 100 percent for up to six months. The plan will also cover bereavement support services for the insured person's family during the three-month period following death, up to \$250.

## **Mental, nervous and chemical dependency disorders**

The maximum lifetime benefit for mental, nervous and chemical dependency is \$10,000 combined per insured.

### **Outpatient mental, nervous and chemical dependency**

Maximum benefit of \$25 per visit, up to 50 visits or \$1,250 per calendar year subject to your medical plan deductible and coinsurance. Outpatient detoxification services and supplies are not covered.

### **Inpatient mental, nervous and chemical dependency**

Maximum benefit of 10 inpatient days, up to \$2,500 per calendar year subject to your medical plan deductible and coinsurance. For inpatient chemical dependency, benefits are limited to inpatient detoxification in connection with a therapy program and rehabilitative services.

## **Organ transplants**

### **If a Center of Excellence is utilized:**

Covered transplant charges are subject to the plan's calendar year maximum of \$2,000,000 and lifetime maximum of \$5,000,000. Also, a travel expense allowance is included for up to \$5,000 for one companion, or two companions if the insured is a minor.

### **If a Center of Excellence is not utilized:**

*For the PPO High-Deductible Health Plan and Choice PPO:*

In-network covered organ transplant charges will be subject to a lifetime maximum benefit of \$250,000. Out-of-network covered transplant charges will be subject to a lifetime maximum benefit of \$100,000.

*For the Traditional High-Deductible Health Plan:*

Covered organ transplant services are subject to a lifetime maximum benefit of \$250,000.

# Important information about your plan

## Pre-certification requirements

The plan requires that the following services and supplies be pre-certified:

- all proposed inpatient hospital confinements
- all proposed stays in an extended care or skilled care nursing facility
- all proposed home health services
- all proposed hospice services
- complications of pregnancy (must be pre-certified within 7 days of diagnosis)

For the Choice PPO plan:

- prescription drug orders for growth hormones, immunosuppressants, AZT or HIV antiretroviral medication, “off label” use, orphan drugs, investigative new drugs and Group C cancer drugs.
- outpatient prescription drugs that require pre-certification are also subject to the pre-existing condition limitation. See the certificate for full details.

In non-emergency situations you must contact the pre-certification service at least 7 days before incurring expenses on account of any of the above occurrences. You simply call the pre-certification service listed on your health plan identification card. They will contact your physician for up to any necessary additional information. In an emergency, you should go directly to the hospital to receive immediate care. If you are then admitted as an inpatient in the hospital, you must contact the pre-certification service within 48 hours of admission, or as soon as reasonably possible. Your physician must verify that an emergency existed.

If you do not pre-certify an inpatient hospital stay as outlined above or complications of pregnancy, you will be responsible for up to an additional \$500 deductible per occurrence. If you do not pre-certify any of the medications listed above, then no benefits are payable toward their cost. If you follow pre-certification requirements, these additional deductible amounts will be waived.

## Definition of a pre-existing condition

A pre-existing condition means a bodily injury or sickness for which the individual received medical treatment (including the taking of medicine prescribed by a Physician), advice or consultation, or which produced distinct symptoms which would have caused an ordinarily prudent person to seek medical diagnosis or treatment during the twelve

(12) months immediately preceding the effective date of the covered person’s insurance.

## Coordination of benefits

Coordination of benefit (“COB”) applies to the plan when an insured or the insured’s covered dependent has health care coverage under more than one plan. If the COB provision applies, the order of benefit determination rules should be looked at first according to the policy. The rules state whether the plan is a primary plan or secondary plan as to another plan covering the person. When the plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan’s benefits. When the plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan’s benefits. With respect to covered persons who are eligible for coverage under Medicare, a benefit otherwise payable under the policy shall be reduced by the amount of any similar Medicare benefit so that the total reimbursements with respect to an insured person or his eligible dependents shall not exceed one hundred percent (100%) of such person’s approved Medicare expenses otherwise reimbursable under the policy.

## Dependent coverage

Eligible dependents include an insured’s spouse and all unmarried children from birth to age 19 (age 25 if a full-time student at an accredited school) not employed on a regular or full-time basis who is chiefly dependent on the insured for support and maintenance. Coverage will not terminate for a child who is or becomes, prior to the date insurance would normally terminate, mentally retarded or physically handicapped to the extent that the child is unable to maintain self-sustaining employment and remains chiefly dependent upon the insured for support, provided satisfactory proof of such dependent’s capacity is submitted to the company not later than 31 days after attainment of the limiting age.

## Termination of insurance

Coverage will terminate on the earliest of the following:

1. The date of termination of the policy;
2. The next premium due date after the company receives written request to terminate coverage of the insured

person under the policy;

3. The last premium due date prior to a grace period, if the premium then due is not paid within the grace period;
4. The date the insured person has been determined by the company to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the policy;
5. The date the insured reaches the lifetime maximum benefit while covered under the policy;
6. The first date following ninety (90) days advance written notice by the company to the insured when the company may lawfully discontinue offering coverage under the policy in the state where the certificate was issued;
7. The first date following one hundred eighty (180) days advance written notice by the company to the insured when the company may lawfully discontinue offering all health insurance coverage in the individual market in the state where the certificate was issued;
8. The date the coverage is determined to be a small employer health plan pursuant to governing law; or
9. The date of the insured’s death.

## Covered charges

Means expenses for medical services and supplies actually incurred as a result of a bodily injury or sickness by or on behalf of a covered person while coverage under the policy is in force with respect to such covered person and which:

1. are medically necessary for the treatment of a bodily injury or sickness and which have been recommended and prescribed by a physician;
2. are not in excess of the necessary, reasonable and customary charges made for the services performed or materials furnished, or are not in excess of such charges as would have been made in the absence of this insurance;
3. are not excluded from coverage by the terms of the policy; and
4. do not exceed any amounts payable under the terms of the policy.



### Rate guarantee

Initial monthly premiums are based on several factors, including age, spouse's age (if applicable), the number of children covered under the plan, and home address.

The company guarantees that rates will not change for the initial 12 months of coverage from the insured's effective date unless one or more of the following events occur during that time:

- A move to a new residence by the insured
- You change your benefit options
- The number of covered dependents changes

### Premium

The rates used to determine the initial premiums due under the policy will be the company's published rates. Premiums are payable to the company or its authorized administrator.

Premiums will be determined by, but not limited to, such factors as the table of premiums and applicable fees then in effect and by the current attained age, place of residence, and experience class of the covered persons.

The company reserves the right to change premiums, on a class basis, under the coverage on any premium due date by giving the insured at least thirty-one (31) days prior written notice.

### No benefits shall be payable under the policy for (may vary by state):

1. Expenses incurred by or for a covered person in connection with a pre-existing condition for twelve (12) months after the effective date as shown on the validation page for that covered person. No claim for Covered Charges incurred more than twelve (12) months after a covered person's effective date will be reduced or denied solely on the grounds that the charge is due to a pre-existing condition, unless the condition is excluded or limited by name or specific description in an amendatory endorsement that is attached to the certificate. This limitation shall not apply to a dependent child who is adopted or placed for adoption before age eighteen (18); however, expenses incurred before adoption or placement for adoption will not be covered.
2. Any confinement, treatment, service, supply or prescription which is: (a) not necessitated by a bodily injury or

sickness; (b) not authorized by a physician; (c) not medically necessary; (d) not necessary, reasonable, and customary; or (e) not incurred while coverage is in force.

3. Pregnancy, including freestanding birthing center services, certified nurse midwives, certified nurse anesthetist, midwives licensed pursuant to state law and state licensed birth centers.
4. Experimental or investigational medical treatment.
5. Voluntary abortions.
6. Bodily injury or sickness which arises out of or in the course of any employment for wage or profit for any person required to be covered under any Workers' Compensation law.
7. Any confinement, treatment, service or supply provided by a government owned or operated facility, unless the covered person is legally required to pay the charges incurred.
8. Bodily injury or sickness resulting from war or any act of war (declared or undeclared).
9. Charges incurred while on active duty with any military, naval or air force of any country or international organization.
10. Newborn nursery care.
11. Routine well baby care, unless covered by the Optional Wellness Benefit Rider.
12. Services and supplies for treatment of: (a) the teeth; and (b) the gums other than for tumors; and (c) any other associated structures primarily in connection with the treatment or replacement of natural teeth; and (d) prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, unless due to an injury which occurs while covered under the policy to sound natural teeth, provided that such treatment is received within ninety (90) days following the date of injury.
13. Treatment or surgery as the result of prognathism, retrognathism, micrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an injury, which

occurs while covered under the policy to sound natural teeth, provided that such treatment is received within ninety (90) days following the date of injury.

14. Charges for treatment of temporomandibular joint (TMJ) dysfunction.
15. Services or supplies to improve the appearance or self perception of a covered person, which does not restore a bodily function, including without limitation; cosmetic or plastic surgery, hair loss; or skin wrinkling.
16. Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery.
17. Hearing aids or the fitting thereof.
18. Charges incurred as a result of participation in a riot or insurrection or the commission of a felony or while imprisoned.
19. Charges for radial keratotomy and radial keratectomy or other similar procedures, including laser-based procedures, that are performed on the eyes.
20. Meridian therapy (acupuncture), except when used in lieu of an anesthetic.
21. Routine physical examinations, immunizations, use of prophylactic injections including gammaglobulins and flu shots, and the well-child care including immunizations, unless covered by the Optional Wellness Benefit Rider.
22. Charges for treatment, paring or removal of corns, calluses or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending physician who is treating the covered person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis, or treatment of the feet by posting or strapping, or range of motion studies, or orthotics.
23. Treatments made in connection with obesity or weight reduction including wiring of the teeth and all forms of intestinal bypass surgery.
24. Charges for services rendered by a physician, nurse or other provider if such person: (a) is a close relative of the covered person or (b) lives

- in the same household as the covered person, or (c) is the employer of the covered person, except for charges rendered while a hospital inpatient.
25. Charges incurred as the result of attempted suicide or intentionally self-inflicted bodily injury or sickness while sane or insane.
  26. Treatment for mental, nervous or chemical dependency disorders, except as provided under the Limited Major Medical benefits section of the policy.
  27. Charges related to or in connection with: (a) procedures to restore or enhance fertility; and (b) reversal of sterilization; (c) penile implants; and (d) fertility and sterility studies.
  28. Impregnation techniques such as: (a) artificial insemination, or (b) invitro fertilization, including but not limited to: artificial insemination; in-vitro fertilization, invitro zygote, intra-fallopian transfers, gamete intra-fallopian transfer; genetic counseling; and all related charges.
  29. Hospital and physician charges for weekend hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day.
  30. Congenital conditions, except with respect to children covered from birth.
  31. Sexual reassignments or sexual dysfunctions or inadequacies.
  32. Custodial care, regardless of whom prescribes or renders such care.
  33. Services or supplies for which no charge is made or for which the covered person is not required to pay.
  34. Services received or supplies purchased outside the United States unless the charges are incurred while traveling on business or for pleasure not to exceed 90 days, provided the procedure or treatment is approved for use in the United States.
  35. Charges related to or in connection with human organ or tissue transplants or high dose chemo therapy administered in connection therewith except as provided under the Limited Major Medical benefits section of the policy.
  36. Any education or training materials including, but not limited to: pain management; the management of asthma, heart disorders and other medical disorders; pre-natal screening education, unless such programs or materials are offered through our health care coordination in conjunction with a disease management program.
  37. Equipment, other than durable medical equipment, including, but not limited to: modifications to motor vehicles or homes such as to wheelchair lifts or ramps; water therapy device, such as whirlpools or hot tubs; and exercise equipment.
  38. Any service or supply to eliminate or reduce a dependency or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism or goal-oriented behavioral modification.
  39. Any surgical removal of an organ or tissue unless medically necessary.
  40. Treatment for Home Health Care Services, except as provided in the Limited Major Medical benefits.
  41. Treatment for Hospice Care Services except as provided under the Limited Major Medical benefits section of the policy.
  42. Non-Surgical Back Treatment, except as provided under the Limited Major Medical benefits section of the policy.
  43. Any service or supply in connection with the implant of an artificial organ.
  44. Personal convenience services or supplies including without limitation: beauty or barber services; radio and television; non-therapeutic massages; telephone charges; take home supplies and guest meals; and motel accommodations.
  45. For High Deductible Health Plans Any non-prescriptive medication or prescription medication that is deemed not medically necessary. For Choice PPO: Any non-prescriptive medication. For plans with no outpatient prescription drug coverage: Any outpatient prescription medication and any non-prescriptive medication.
  46. Charges for voice training for a lisp.
  47. Breast reduction surgery unless such surgery was performed as part of a mastectomy due to breast cancer.
  48. For the Choice PPO Plan, outpatient prescription drug exclusions include:
    - a. Contraceptive devices or injectables.
    - b. Over-the-counter drugs and products.
    - c. Fertility agents.
    - d. Sexual performance enhancement drugs (e.g. Viagra).
    - e. Vitamins (other than pre-natal).
    - f. Anti smoking aids (e.g. Nicorette, Nicaderm, Habitrol).
    - g. Hair loss medications (e.g. Rogaine, Minoxidil).
    - h. Immunization agents, biological sera, blood or blood plasma.
    - i. Investigation use or experimental drugs.
    - j. Any charge for administration of injectable insulin.
    - k. Drugs covered under Workers' Compensation.
    - l. Anorectic drugs for diet control.
    - m. Medication taken, prescribed or administered while an inpatient at a hospital, rest home, sanitarium, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates a facility for dispensing pharmaceutical.
    - n. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use.
    - o. Homeopathic medications.
    - p. Any drugs purchased outside the United States of America.
    - q. Any drug which requires pre-certification, which is not pre-certified as described.

Satisfaction Guaranteed: If you are not completely satisfied with the health insurance coverage and have not filed a claim, you may return the certificate of coverage within 10 days of your receipt and receive a full premium refund.

The information in this brochure is an outline of the features, plan provisions, benefits and other information about the Freedom Health Plans. Plans offered may be subject to change. This brochure is not intended to serve as legal interpretation of the benefits, which are provided under the Master Policy (CLI CH 3000 or CLI CH 3020 PPO) issued to Communicating for America, Inc. in the District of Columbia. The exact provisions governing the insurance contract are contained in the Master Policy underwritten by Companion Life Insurance Company, Columbia, South Carolina. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For complete details about the Freedom Health Plans, please refer to the health insurance Certificate of Coverage (CLI CH 3010 CERT or CLI CH 3030 PPO CERT).

Applicants should not cancel any existing insurance until they have been notified in writing that their new insurance is in effect.

Freedom Health Plans are endorsed by Communicating for America, Inc.





## Freedom Health Plans

### State-mandated benefits brochure insert

The following benefit and plan provisions replace those outlined in the Companion Life Insurance Company's Freedom Health Plans marketing brochure (IHCHS 539 1009). The descriptions below are only those that differ from the brochure and may not include all state-mandated benefits. Refer to the certificate of coverage/policy and the state's amendatory endorsement(s) for a complete description of the plan's benefits, terms and conditions.

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#### Arizona

For residents of Arizona ONLY

##### Definition of a pre-existing condition

Page 8 - The definition is deleted in its entirety and replaced with the following: A condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period before the effective date of this insurance. A genetic condition is not a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a pre-existing limitation or pre-existing condition exclusion.

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#### Colorado

For residents of Colorado ONLY

##### Colorado health plan description form

Colorado law requires carriers to make available a Colorado health plan description form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three business days, to any person who is interested in coverage or is covered by a health benefit plan of the carrier.

##### PPO providers

If a covered person obtains a PPO plan and obtains services from a non-PPO provider, the covered person may be billed by the non-PPO provider for any calendar year deductibles, coinsurance, co-payments or service deductibles and any amount that exceeds the usual, reasonable and customary charge. Reimbursement rates to non-PPO providers for specific health care services and the access plan may be obtained by sending a written request to the plan administrator. Depending upon the PPO network you choose, there may not be providers in the following counties: Crowley, Custer and Hinsdale.

##### Mental, nervous and chemical dependency disorders

Page 7 - These benefits are supplemented to cover biologically-based mental illnesses the same as any other sickness. A biologically based mental illness includes schizophrenia, schizoaffective disorder, bipolar affective disorder, specific obsessive-compulsive disorder and panic disorder.

##### Hospice care

Page 7 - This benefit description is deleted in its entirety and replaced with the following: Covered charges for hospice services are provided for up to three, three-month periods (total of nine months). Benefits for covered charges are limited to \$100 per day and are subject to the plan deductible and coinsurance. If the covered person continues to live after the exhaustion of three benefit periods, we will continue to pay for services and supplies for

hospice care prescribed by a physician and provided by licensed hospice care agent, organization or unit. Covered hospice care services include bereavement support services for the 12-month period following death. Benefits for bereavement services are limited to \$1,170 subject to the plan deductible and coinsurance.

#### Home health care

Page 7 - This benefit description is deleted in its entirety and replaced with the following: Covered charges are payable up to a maximum of 60 visits per calendar year after your medical plan deductible and coinsurance. A home health visit is defined as a visit by a member of the home health team provided on a part-time and intermittent basis as included in the plan of care. Services of up to four hours by a home health aide shall be considered as one visit.

#### Prostate cancer screening

Page 2 - This benefit is supplemented to describe that benefits are not subject to the plan deductible. Benefits are limited to the lesser of \$65 or the actual charge.

#### Mammogram and pap smear coverage

Page 2 - Mammogram and Pap smear coverage is supplemented to describe the following mammogram coverage intervals:

- a) a single baseline mammogram for women 35 years of age and under 40 years of age;
- b) once every two years for women 40 years of age and under 50 years of age but at least once each calendar year for a woman with risk factors for breast cancer as determined by her physician; and
- c) annually for women who are 50 to 65 years of age.

Benefits are subject to the lesser of \$60 or the actual charge and are not subject to the calendar year deductible.

#### Anesthesia for dental care

Page 9 (exclusion 12) - This exclusion is altered to provide benefits for general anesthesia when rendered in a hospital, outpatient surgical facility or other facility appropriately licensed in the state for dental care provided to a dependent child when:

- a. the child has a physical, mental or medically compromising condition;
- b. the child has dental needs for which the local anesthesia is ineffective because of acute infection, anatomic variations or allergy;
- c. the child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that the dental care can not be deferred;
- d. or the child has sustained extensive orofacial and dental trauma.

Benefits are provided as any other illness.

#### Well-child visits

Page 9 (exclusions 11 and 21) - These two exclusions are altered to provide the following coverage: Benefits are payable for preventive child health supervision services during the course of one visit by or under the supervision of a single physician, physician's assistant or registered nurse. Such services include the following visits and immunizations recommended by the American Academy of Pediatrics (AAP) (immunization deficient children are not bound by the "recommended ages" supplied by the AAP):

- |                      |                                  |
|----------------------|----------------------------------|
| a) Ages 1-12 months  | five well-child visits and 1 PKU |
| b) Ages 13-35 months | two well-child visits            |
| c) Ages 3-6 years    | three well-child visits          |
| d) Ages 7-12 years   | three well-child visits          |

Benefits are not subject to the plan deductible. However, copays and/or coinsurance do apply.

#### Physical, occupational and speech therapy for children

Page 10 (exclusion 30) - This exclusion is altered to provide benefits for physical, occupational and speech therapy for the care and treatment of congenital defects and birth abnormalities for a covered dependent child up to 5 years of age. Benefits may not exceed 20 visits within a calendar year subject to the plan deductible and coinsurance.

#### Pre-certification

Pages 8 and 10 (exclusion 48q) - Any reference to pre-certification is deleted in its entirety

#### Pre-existing condition limitation

Page 9 (exclusion 1) - This exclusion is supplemented to include pre-existing credit information. Covered persons will receive credit toward the pre-existing condition limitation if they were previously covered by creditable coverage and if such coverage was continuous to a date not more than 90 days prior to the effective date of this



insurance. Creditable coverage includes benefits or coverage provided under: Medicare or Medicaid; an employee welfare benefit plan or group health insurance or health benefit plan; an individual health benefit plan; a state health benefits risk pool including but not limited to CoverColorado; or a medical care program of the Federal Indian Health Services or of a tribal organization, a public health plan or a health plan under the Federal Peace Corps.

#### **Mental, nervous and chemical dependency disorders**

Page 7 – The mental, nervous and chemical dependency disorders benefit description is deleted in its entirety and replaced with the following:

Outpatient treatment for mental and nervous disorders

Up to \$25 per visit, maximum of 50 visits or \$1,250 per calendar year and subject to the plan deductible and 50 percent coinsurance

Outpatient treatment for alcoholism

Limited to \$500 per calendar year subject to the plan deductible and 50 percent coinsurance

Inpatient treatment for mental and nervous disorders and alcoholism

Inpatient or partial hospitalization in a hospital or psychiatric hospital is covered up to a maximum of 45 days of inpatient treatment or 90 days of partial hospitalization treatment. Partial hospitalization is defined as continuous treatment for at least three hours but not more than 12 hours in any 24 hour period. Each two days of partial hospitalization shall reduce by one day the 45 days available for inpatient care, and each day of inpatient care shall reduce by two the 90 days available for partial hospitalization. Each day of confinement as an inpatient in a hospital or psychiatric hospital or each two days of hospitalization shall reduce by one day the available days for alcoholism disorders. Benefits are subject to the plan deductible and coinsurance.

Benefits for alcoholism will not be payable unless the insured person receiving such treatment has completed the full continuum of care, including detoxification and rehabilitation.

Biologically based mental illnesses are covered as any other illness.

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## **Illinois**

### **For residents of Illinois ONLY**

#### **Definition of dependent**

Page 8 – The dependent coverage description is deleted in its entirety and replaced with the following: Dependent means an insured person's spouse and all unmarried children from birth to age 26, not employed on a regular or full-time basis, who is chiefly dependent on the insured for support and maintenance. Coverage will not terminate for a child who is or becomes, prior to the date insurance would normally terminate, mentally retarded or physically handicapped to the extent that the child is unable to maintain self-sustaining employment and remains chiefly dependent upon the insured for support, provided satisfactory proof of such dependent's capacity is submitted to the company not later than 31 days after attainment of the limiting age.

Also, each unmarried child who is in the military and under age 30 if the dependent (i) is an Illinois resident; (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release of discharge other than a dishonorable discharge. To be eligible for coverage the eligible dependent must submit to us a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

#### **Colorectal cancer screening**

Page 19 (exclusion 21) - This exclusion is altered to provide benefits for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing every three years for covered persons age 50 and above or for a covered person age 30 and above who is at high risk because the person or a close relative of the person has a history of colorectal cancer.

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## **Indiana**

### **For residents of Indiana ONLY**

#### **Definition of a pre-existing condition**

Page 8 - The definition of a pre-existing condition is deleted in its entirety and replaced with the following: A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six

months immediately preceding the effective date of coverage or a pregnancy existing on the effective date of coverage.

#### Pre-existing condition limitation

Page 9 (exclusion 1) - This exclusion is supplemented to include pre-existing credit information. The pre-existing condition limitation period will be reduced by the amount of time the covered person was continuously covered under a pre-existing clause for a policy of accident and health insurance issued as a small employer group health insurance policy (defined by IC 27-8-15), if the individual applies for this coverage not more than 63 days after the coverage under a small group health insurance policy is terminated.

#### Morbid obesity

Page 9 (exclusion 23) - This exclusion is altered to provide treatment for morbid obesity. Morbid obesity is defined as a weight at least two times the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables. A morbidly obese person could have a body mass index of at least 35 kilograms per meter squared, with co-morbidity or co-existing medical conditions as such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes. The person could have a body mass index of at least 40 kilograms squared without co-morbidity. Body mass index is equal to weight in kilograms divided by height in meters squared. Benefits for morbid obesity are provided an any other sickness for non-experimental surgical treatment by a health care provider of morbid obesity: a) that has persisted for five years; and b) for which non-surgical treatment that is supervised by a physician has been unsuccessful for at least 18 consecutive months.

#### Mental, nervous and chemical dependency

Page 10 (exclusion 26) - This exclusion is deleted in its entirety and replaced with the following: Treatment for mental, nervous or chemical dependency disorders. No benefits are available for mental, nervous or chemical dependency.

#### Colorectal cancer screening

Page 9 (exclusion 21) - This exclusion does not apply to colorectal cancer screening. Starting at age 50 for both men and women, one of the following test options should be used: Yearly fecal occult blood test (FOBT); or flexible sigmoidoscopy every five years; or FOBT yearly and flexible sigmoidoscopy every five years (preferred over either alone); or double contrast barium enema every five years; or colonoscopy every 10 years. Benefits for colorectal cancer screening are provided as any other illness.

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## **Iowa**

### **For residents of Iowa ONLY**

#### Contraceptive prescription drugs and devices

Page 10 (exclusion 48a) - This exclusion is deleted in its entirety. Contraceptive prescription drugs and devices are provided as any other outpatient prescription.

#### Definition of dependent

Page 8 – The dependent coverage description is modified to replace the first sentence with the following: Dependent means an insured's spouse and all unmarried children or stepchildren, including newborns who are primarily dependent for support and maintenance and are less than 25 years of age or so long as the unmarried child maintains full-time status as student in an accredited institution of postsecondary education.

#### Definition of a pre-existing condition

Page 8 - This definition is supplemented to include pre-existing credit information. The pre-existing condition limitation will be reduced by the amount of time the client has been continuously covered by creditable coverage without a lapse of more than 63 days. Creditable coverage includes but is not limited to: employer-based health plans, individual health plans, Medicare, Medicaid, risk-pool health plans, short-term major medical plans or public health plans.

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## **Kansas**

### **For residents of Kansas ONLY**

#### Individual policy

In the state of Kansas, the Freedom Health Plans are individual policies, not group association plans. Therefore, membership in Communicating for America, Inc. is not required. All references in the brochure to “certificate” are replaced with “policy.”

### **Optional benefit: Term life insurance**

Page 6 – The optional term life insurance benefit is not available for residents of Kansas.

### **Routine and necessary immunizations for all newly born children from birth to 72 months of age**

Page 9 (exclusion 21) – Benefit coverages are altered to add the following routine and necessary immunizations shall consist of:

- (i) five doses of vaccine against diphtheria, pertussis, tetanus;
- (ii) four doses of vaccine against polio and haemophilus B (Hib);
- (iii) three doses of vaccine against hepatitis B;
- (iv) two doses of vaccine against measles, mumps and rubella;
- (v) one dose of vaccine against varicella; and other vaccines and dosages as may be prescribed by the secretary of health and environment.

The child immunizations covered from birth to 72 months of age are not subject to any calendar year deductible, copays or coinsurance.

### **Inpatient treatment of chemical dependency and mental nervous disorders**

Page 7 and 10 (exclusion 26) – These items are altered to provide benefits for inpatient treatment of chemical dependency and mental nervous disorders limited to 30 inpatient days per calendar year.

### **Outpatient treatment of chemical dependency and mental nervous disorders**

Page 7 and 10 (exclusion 26) – These items are altered to provide benefits for outpatient treatment of chemical dependency and mental nervous disorders as follows:

100 percent of the first \$100,

80 percent of the next \$100,

50 percent of the next \$2,140

### **Mental, nervous and chemical dependency disorders – HSA-qualified plans**

Page 7 – If a health savings account (HSA) is to be used in conjunction with the High-Deductible Health Plan, these outpatient expenses will be first applied to the plan calendar year deductible. If the high-deductible health plan is issued with these expenses not subject to the deductible and is later used in conjunction with an HSA, a violation of the current HSA regulations may occur. Check with your tax adviser.

### **Diabetes equipment, supplies and education**

Page 10 (exclusion 36) The exclusion is altered to provide benefits for diabetes equipment, supplies and other outpatient self-management training an education including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes, when prescribed by the physician.

### **General anesthesia for dental care**

Page 9 (exclusion 12) – The exclusion is altered to provide benefit coverage for general anesthesia and medical care facility charges for dental care for the following:

- a. a child five years of age and under;
- b. a person who is severely disabled; or
- c. a person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

### **Diagnosis, treatment and management of osteoporosis**

Page 2 – Benefit coverages are altered to add the following for diagnosis, treatment and management of osteoporosis for covered persons with a condition or medical history for which bone mass measurement is medically necessary.

### **Prostate cancer screening**

Page 2 – This benefit is supplemented to provide prostate cancer screening coverage for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older.

### **Mammography and cytologic screening benefits**

Page 2 – Mammogram and cytologic screening coverage is supplemented to describe the following for a female covered person:

- a) an annual cervical cytologic screening for a female covered person;
- b) any cervical cytologic screening for a female covered person which her physician certifies to be medically necessary;
- c) a baseline mammogram and annual mammograms thereafter for a female covered person; and
- d) any mammogram for a female covered person which is certified to be medically necessary by her physician.

## Policy information

Page 11 – The master policy and certificate references are replaced with the following: This brochure is not intended to serve as legal interpretation of the benefits which are provided under the policy (CLI CH 3130 IND and CLI CH 3140 IND PPO). The exact provisions governing the insurance contract are contained in the policy underwritten by Companion Life Insurance Company, Columbia, South Carolina. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For completed details about the Freedom Health Plan, please refer to the health insurance policy.

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## **Michigan**

### **For residents of Michigan ONLY**

#### Definition of a pre-existing condition

Page 8 - This definition is deleted in its entirety and replaced with the following:

A pre-existing condition means any condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received from a physician within six months before the effective date.

#### Education or training materials

Page 10 (exclusion 36) - This exclusion is deleted in its entirety and replaced with the following:

Any education or training materials including but not limited to: modifications to programs or materials for pain management; asthma, heart disorder and other medical disorders; pre-natal screening education, unless such programs or materials are offered through Our Health Care Coordination in conjunction with a disease management program or the management of diabetes offered through diabetes self-management training.

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## **Missouri**

### **For residents of Missouri ONLY**

#### Pre-certification program/requirements

Page 8 and 10 (exclusion 48q) - All references and/or requirements to pre-certification are deleted as pre-certification is not applicable in the state of Missouri.

#### Mental and nervous disorders

Page 7 and 10 (exclusion 26) - These items are altered to provide benefits for mental illness as any other illness. Mental illness is defined as the following disorders contained in the International Classification of Diseases (ICD-9-CM):

- a) schizophrenia disorders and paranoid states (295 and 297, except 297.3);
- b) major depression, bipolar disorder and other affective psychoses (296);
- c) obsessive compulsive disorder, post traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);
- d) early childhood psychosis and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81, and item 314);
- e) alcohol and drug abuse (291, 292, 303, 304 and 305 except 305.1);
- f) anorexia nervosa, bulimia and other eating disorders (307.1, 307.51, 307.52 and 307.53); and
- g) senile organic psychotic conditions (290).

Mental disorders (those covered mental conditions not specifically listed above as mental illnesses) remain subject to the plan limitations listed on page 12 of the brochure.

#### Chemical dependency disorders

Page 7 and 10 (exclusion 26) - These items are altered to provide benefits for chemical dependency treatment as any other illness for inpatient treatment of alcoholism and drug abuse when confined in a hospital or a residential or non-residential facility certified by the Department of Mental Health. Inpatient chemical dependency disorders are limited to 30 days per calendar year. Outpatient treatment is limited to 20 days per calendar year. Inpatient treatment can be converted for use for outpatient treatment on a two-to-one basis.

#### Termination of insurance

Page 8 - "Termination of Insurance" is supplemented to include the following: Except for your written request to terminate coverage under the policy or when the premium due is not paid within the grace period, we will not

terminate a covered person's coverage under the policy prior to the first anniversary date of such person's effective date.

#### Colorectal cancer

Page 9 (exclusion 21) - This exclusion is altered to provide benefits for a colorectal cancer examination and laboratory tests for a non-symptomatic covered person. Benefits are provided as any other illness.

#### Newborn hearing assessment

Page 9 (exclusion 21) - This exclusion is altered to provide benefits for a newborn hearing screening, necessary re-screening, audiological assessment and follow-up and initial amplification.

#### Lead poisoning testing

Page 9 (exclusion 21) - This exclusion is altered to provide benefits for testing a covered pregnant women for lead poisoning. Benefits are provided as any other illness.

#### Osteoporosis

Page 9 (exclusion 42) - This exclusion is altered to provide benefits for the diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a licensed physician in Missouri, for covered persons with a condition or medical history for which bone mass measurement is medically indicated for such covered person. Benefits are provided as any other illness.

#### Well-child immunizations

Page 9 (exclusion 21) - This exclusion is deleted in its entirety and replaced with the following: Routine physical examinations, use of prophylactic injections including gammaglobulins and flu shots, unless covered by the optional Wellness Benefit Rider.

Coverage is provided for child immunizations for a dependent child from birth to 5 years of age as provided by the Department of Health Regulations. Such immunizations consist of: poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis, haemophilus influenza type B (Hib) and varicella. Benefits are not subject to the plan deductible or coinsurance.

#### Attempted suicide or self-inflicted injury

Page 10 (exclusion 25) - This exclusion is deleted in its entirety and replaced with the following: Charges incurred as the result of attempted suicide or intentionally self-inflicted bodily injury or sickness while sane.

#### Anesthesia and hospitalization for dental care

Page 9 (exclusion 12) - This exclusion is altered to provide benefits for general anesthesia and facility charges for dental care provided to a covered person who is a child under age 5, severely disabled or who has a medical or behavioral condition and requires hospitalization or general anesthesia when dental care is provided. Benefits are provided as any other illness.

#### Phenylketonuria - PKU

Page 10 (exclusion 36) - This exclusion is altered to provide benefits for formula recommended by a physician for the treatment of a covered person with phenylketonuria (PKU) or any inherited disease of amino and organic acids. Benefits are provided as any other illness.

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## Montana

### For residents of Montana ONLY

#### Individual policy

In the state of Montana, the Freedom Health Plans are individual policies, not group association plans. Therefore, membership in Communicating for America, Inc. is not required. All references in the brochure to "certificate" are replaced with "policy."

#### Freedom PPO High-Deductible Health Plan – Out-of-network charges

Page 4 – The reference to an out-of-network deductible is not applicable for residents of Montana. In-network and out-of-network charges apply to the selected deductible. An out-of-network penalty applies only when the insured has reached his/her coinsurance.



### Freedom PPO High-Deductible Health Plan – Coinsurance option

Page 4 – The second coinsurance option of 80% up to \$1,000 is not available. The first option is deleted and replaced with the following:

In-network: 100%

Out-of-network: 70% up to \$1,500

### Freedom Choice PPO: Deductible and coinsurance options

Page 5 – The out-of-network deductible is not always two-times the in-network deductible in Montana. The following chart lists the available in-network and corresponding out-of-network deductibles. The in- and out-of-network deductibles accumulate separately.

- ☐ \$1,500/\$2,000
- ☐ \$2,500/\$3,000
- ☐ \$5,000/\$5,000
- ☐ \$10,000/\$10,000

The Choice PPO coinsurance is deleted and replace with the following:

- ☐ In-network: 80% to \$2,000, Out-of-network: 60% to \$4,000

### Insurance with other insurers

Page 8 – The coordination of benefits guidelines are deleted and replaced with the insurance with other insurers provisions outlined in the policy (CLI CH 3130 IND or CLI CH 3140 PPO). Please contact IHC Health Solutions or your sales representative for complete details.

### Well-child care and immunizations

Page 9 (exclusion 21) - Benefit coverage is altered to add the following: Well-child care benefits for dependent children from the moment of birth through age 7. Well-child care includes a history, a physical examination, developmental assessments, anticipatory guidance and laboratory test according to the schedule of visits adopted under the Early and Periodic Screening, Diagnosis and Treatment Services Program. Routine immunizations are also provided according to the recommendations by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services. Such services are limited to one visit to one provider for all of the services provided at each visit and are not subject to the plan deductible.

### Severe mental illness

Page 7 – The mental, nervous and chemical dependency disorder benefit description is altered to add the following: Severe mental illness benefits are provided as any other illness. Severe mental illness means the following disorders as defined by the American Psychiatric Association: a) schizophrenia; b) schizoaffective disorder; c) bipolar disorder; d) major depression; e) panic disorder; f) obsessive-compulsive disorder; and g) autism.

### Maternity and postpartum care benefits

Page 2 - Benefit coverage is supplemented to add maternity and postpartum care benefits provided the same as any other sickness.

### Pregnancy, newborn nursery care and routine well-baby care

Page 9 (exclusions 3, 10 and 11) - These three exclusions are deleted in their entirety.

### Mammogram coverage

Page 2 - Mammogram coverage is supplemented to describe the following mammogram coverage intervals for a female covered person:

- a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;
- b) one mammogram every two years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and
- c) one mammogram every year for a woman 50 years of age or older.

### Dependent coverage

Page 8 – The dependent coverage description is deleted in its entirety and replaced with the following: Dependent means an insured person's:

- a) lawful spouse, if not legally separated from the primary insured, who resides in the same household as the insured person;
- b) unmarried children or stepchildren, including newborns, who are less than 25 years of age. A child to be covered as a dependent must not be eligible for coverage under a group health plan offered by the child's employer, be named as the primary insured on another individual health plan or be entitled to benefits under Medicare; or

- c) a child of any age who is disabled and chiefly dependent upon the primary insured for support and maintenance.

#### **Definition of a pre-existing condition**

Page 8 - This definition is deleted in its entirety and replaced with the following: Pre-existing condition means a bodily injury or sickness for which the individual received medical advice, diagnosis, care or treatment (including the taking of medicine prescribed by a physician), during the 12 months immediately preceding the effective date of the covered person's insurance.

#### **Termination of insurance**

Page 8 - The following is added to the first sentence of this provision: The policy is guaranteed renewable at the option of the insurance person. However, coverage may terminate due to the following. Termination item 8 is deleted in its entirety.

#### **Pre-certification requirements**

Page 8 - The pre-certification requirements are altered to add pre-certification is required for the treatment of a severe mental illness. The pre-certification requirements are altered to delete all references to pre-certification for complications of pregnancy and pregnancy within the pre-certification program.

#### **Policy information**

All references in the brochure to "certificate" are replaced with "policy."

Page 11 - The master policy and certificate references are replaced with the following: This brochure is not intended to serve as legal interpretation of the benefits which are provided under the policy (CLI CH 3130 IND and CLI CH 3140 IND PPO). The exact provisions governing the insurance contract are contained in the policy underwritten by Companion Life Insurance Company, Columbia, South Carolina. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For completed details about the Freedom Health Plan, please refer to the health insurance policy.

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## **New Mexico**

### **For residents of New Mexico ONLY**

#### **Dependent coverage**

Page 8 - The dependent coverage description is deleted in its entirety and replaced with the following: Eligible dependents include the insured's spouse and all unmarried and un-emancipated children under the age of 25, including natural children, legally adopted children, stepchildren living in the same household dependent upon the primary insured for maintenance and support, children for whom the primary insured has legal guardianship over, foster children living in the same household if the child is not otherwise provided health care and a child of a non-custodial parent.

#### **Routine well-baby care**

Page 9 (exclusion 11) - This exclusion is deleted in its entirety.

#### **Well-child immunizations**

Page 9 (exclusion 21) - This exclusion is altered to provide benefits for childhood immunizations as well as coverage for medically necessary booster shots of all immunizing agents in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics. Benefits are subject to the plan deductible, coinsurance and copays.

#### **Pre-existing conditions**

Page 8 - This definition is deleted in its entirety and replaced with the following: A pre-existing condition means a bodily injury or sickness for which the individual received medical treatment (including the taking of medicine prescribed by a physician), advice or consultation or which produced distinct symptoms which would have caused an ordinarily prudent person to seek medical diagnosis or treatment during the six months immediately preceding the effective date of the covered person's insurance.

Page 9 (exclusion 1) - This exclusion is deleted in its entirety and replaced with the following: Expenses incurred by or for a covered person in connection with a pre-existing condition for six months after the effective date as shown on the validation page for that covered person. No claim for covered charges incurred more than six months after a covered person's effective date will be reduced or denied solely on the grounds that the charge is due to a pre-existing condition unless the condition is excluded or limited by name or specific description in an amendatory

endorsement that is attached to the certificate. This limitation does not apply to a dependent child who is adopted or placed for adoption before age 18; however expenses incurred before adoption or placement will not be covered. The pre-existing condition limitation set forth above is satisfied to the same extent such pre-existing condition limitation would have been satisfied under a covered person's prior coverage if terminated within 31 days before the effective date of the covered person's insurance. Prior coverage may be a group or individual contract issued by an insurer, nonprofit hospital or medical services organization, or health organization or coverage under an uninsured employee benefit plan or government program such as Medicaid or the New Mexico High Risk Insurance Organization.

#### Temporomandibular joint disorder (TMJ) and craniomandibular disorder

Page 9 (exclusion 14) - This exclusion is altered to provide benefits for surgical and non-surgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as any other illness. Plan deductibles, coinsurance and copays apply. Coverage does not include orthodontic appliances and treatment for crowns, bridges and dentures unless the disorder is trauma-related.

#### Cancer clinical trials

Page 9 (exclusion 4) - This exclusion is altered to provide benefits for cancer trials that are a course of treatment provided to a covered person for the purpose of prevention of recurrence, early detection or treatment of cancer. Cancer clinical trials that meet the specific qualifications will have benefits provided as any other illness. Deductibles, coinsurance and copays will apply.

#### Acupuncture – Meridian therapy

Page 9 (exclusion 20) - This exclusion is deleted in its entirety. Benefits are provided for meridian therapy (acupuncture) as any other illness. Deductibles, coinsurance and copays will apply.

#### Test during pregnancy and newborn male circumcision

Page 9 (exclusions 3 and 11) - These exclusions are altered to provide benefits for an alpha-fetoprotein IV screening test for pregnant women generally between 16 and 20 weeks of pregnancy to screen for certain genetic abnormalities in the fetus. Benefits are also provided for circumcision for newborn males. These benefits are provided as any other illness. Deductibles, coinsurance and copays apply.

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## **North Dakota**

### **For residents of North Dakota ONLY**

#### Pre-existing conditions

Page 8 - This definition is deleted in its entirety and replaced with the following: A pre-existing condition means a condition, regardless of its cause, for which medical diagnosis, care or treatment was recommended or received within the six-month period ending on the effective date of the covered person's coverage. The pre-existing condition limitation will be reduced by the amount of time the insured has been continuously covered by qualifying previous coverage that was continuous to a date not more than 90 days prior to the covered person's effective date under this insurance. Qualifying previous coverage includes but is not limited to: a group health plan, a health benefit plan, Medicare, Medicaid, a medical care program of the Indian Health Service or a state risk-pool plan.

Page 9 (exclusion 1) - This exclusion is supplemented to include the following: However, we will credit the time the covered person was previously covered, provided the person's qualifying previous coverage was continuous to a date not more than 90 days prior to the covered person's effective date under this insurance. Such continuous period may not include waiting periods.

#### Dependent coverage

Page 8 - The dependent coverage description is deleted in its entirety and replaced with the following: Eligible dependents include an insured's spouse who resides in the same household and all unmarried children or stepchildren, including newborns, less than 22 years of age (less than 26 if a full-time student at an accredited school) and who are primarily dependent upon the insured person for support and maintenance. Full time means actively attending at least 12 hours of class per week or, if less, attending the minimum hours the school considers as full time. For summer sessions, a minimum of six hours is required if not enrolled the following semester.

#### Termination of insurance

Page 8 - Item 3 is deleted in its entirety and replaced with the following: the end of the grace period.

### Temporomandibular joint disorder (TMJ)

Page 9 (exclusion 14) - This exclusion is deleted. Coverage is provided for surgical and non-surgical treatment of TMJ and craniomandibular disorder. Benefits are limited to a lifetime maximum of \$10,000 per covered person for surgical treatment. Non –surgical treatment is limited to a lifetime maximum of \$2,500 per covered person.

### Anesthesia and hospitalization for dental care

Page 9 (exclusion 12) - This exclusion is altered to provide benefits for a child who is under age 9, is severely disabled or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Services may be provided in a hospital or an ambulatory surgical center. Benefits are provided as any other illness.

### Limited benefits

Page 7 - Limited benefits are supplemented by adding inherited metabolic disease.

Coverage is provided for medical foods and low protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease. Coverage for low-protein modified food products will not exceed \$3,000 per covered person per calendar year for a covered person with an inherited metabolic disease of amino acid or organic acid.

### Mental, nervous and chemical dependency disorders

Page 7 – The benefit description of “mental, nervous and chemical dependency disorders” is deleted in its entirety and replaced with the following:

#### Chemical dependency

Inpatient treatment for chemical dependency is limited to 60 inpatient days per calendar year. Partial hospitalization, which is defined as continuous treatment for at least three hours but not more than 12 hours in a 24-hour period, is provided up to 120 days per covered person per calendar year. Outpatient treatment for a covered person is limited to 20 visits per calendar year. The first five outpatient visits in a calendar year are not subject to deductible or coinsurance. Other than the first five outpatient visits, all covered charges for chemical dependency are subject to the plan deductible and coinsurance.

#### Mental and nervous

Inpatient treatment is limited to 45 days per covered person per calendar year. Partial hospitalization is limited to 120 days per covered person per calendar year. Residential treatment is limited to 120 days per covered person per calendar year and is only covered for insureds under 21 years of age. Outpatient treatment is limited to 30 hours per covered person per calendar year. The first five hours of outpatient treatment per covered person within a calendar are not subject to the plan deductible or coinsurance. Other than the first five hours of outpatient care, all mental and nervous treatment is subject to the plan deductible and coinsurance.

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## **Oklahoma**

### **For residents of Oklahoma ONLY**

### Dependent coverage

Page 8 - Dependent coverage is changed to read as follows: Dependent means an insured person's

- 1) lawful spouse, if not legally separated from you, who resides in the same household as the insured person; or
- 2) unmarried children or stepchildren, including newborns, who are less than 19 years of age. It also includes the insured person's unmarried children who are 19, but less than 25 years of age, and a full-time student actively attending an accredited college, vocational or high school. Full-time means actively attending at least 12 hours of class a week or, if less, attending the minimum hours of class the school considers as full-time status. For summer session a minimum of six hours is required if not enrolled in the following semester.

### Termination of insurance

Page 8 - Termination of insurance is deleted in its entirety and replaced with the following:

Guaranteed renewable at the option of the individual except for stated reasons. We will only non-renew or discontinue health insurance coverage in the individual market based on one or more of the following reasons:

1. failure to pay premiums or contributions in accordance with the terms of coverage or we have not received timely premium payments;
2. an individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

3. cessation or discontinuance of coverage in the individual market provided:
  - a) each covered individual is provided notice at least 90 days before the date of discontinuation;
  - b) each covered individual is offered like individual coverage or the option to purchase any other individual coverage currently being offered by us for individuals in such market;
  - c) in exercising the options in b) we act uniformly to any health status–related factor of enrolled individuals or individuals who may become eligible for such coverage.

If coverage is discontinued it may only be discontinued if:

- a) notice is provided to the applicable state authority at least 180 days prior to the expiration of such coverage, and
- b) all health insurance issued or delivered for issuance in the state in such market are discontinued and is not renewed.

We may not provide for the issuance of any health insurance coverage in the state during the five year period beginning on the date of discontinuation.

1. if a covered person has a PPO plan, the covered person no longer resides, lives or works in the service area (or in an area for which we are not authorized to do business) provided coverage is terminated uniformly without regard to any health status related factor of covered individuals;
2. if health insurance is made available through one or more bona fide associations, membership in the association (on the basis when coverage is provided) ceases but only if such coverage is terminated uniformly without regard to any health status–related factor of covered individuals.

#### Adopted children

Page 9 (exclusion 1) - This exclusion is supplemented to include coverage for actual and documented medical costs associated with the birth of an adopted child who is 18 months of age or younger. These costs will not be subject to the pre-existing condition limitation.

#### Bone density testing

Page 7 - The limited benefits section is supplemented to include a benefit for bone density testing. Medically accepted bone density testing for the diagnosis and treatment of a qualified covered person for osteoporosis is provided up to \$150 per test subject to the plan deductible and coinsurance.

#### Child health supervision and immunizations

Page 9 (exclusion 11 and 21) - These exclusions are altered to provide benefits for child health supervision expenses. Coverage is provided for a covered child from birth to age 18 at approximately the following age intervals: birth, 2, 4, 6, 9, 12 and 18 months, 2, 3, 4, 5, 6, 8, 10, 12, 14, 16 and 18 years. Child health supervision services which are rendered during a periodic review shall only be covered to the extent that the services are provided under the supervision of a single physician during the course of one visit. Immunizations are covered for a child who is covered from birth through the date such child is 18 years of age for diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenza type B, hepatitis A and any other immunizations required for children by the Oklahoma State Board of Health. Covered immunizations are not subject to the plan deductible or coinsurance.

#### Severe mental illness

Page 7 - The “mental, nervous and chemical depending disorders” limited benefit description is altered to provide benefits for severe mental illnesses. Severe mental illnesses include schizophrenia, bipolar disorder (manic-depressive illness), major depressive disorder, panic disorder, obsessive-compulsive disorder and schizoaffective disorder. Covered benefits for these illnesses are not subject to the \$10,000 lifetime maximum benefit or the outpatient and inpatient limitations.

#### Mammogram and Pap smear coverage

Page 2 - This benefit is altered so that these benefits are not subject to the plan’s copays. Therefore these benefits are not subject to the plan deductible, coinsurance or copays.

#### Pre-existing conditions

Page 9 (exclusion 1) - This exclusion is deleted in its entirety and replaced with the following: Expenses incurred by or for a covered person in connection with a pre-existing condition for 12 months after the effective date for that covered person. No claim for covered charges incurred more than 12 months after a covered person’s effective date will be reduced or denied solely on the grounds that the charge is due to a pre-existing condition, unless the condition is excluded or limited by name or specific description in an amendatory endorsement that is attached to this certificate. This limitation shall not apply to a dependent child who is adopted or placed for adoption before the age of 18 months; however, expenses incurred before adoption or placement for adoption will not be covered after 18 months of age.



### War/military service injury or sickness

Page 9 (exclusion 8) - This exclusion is deleted in its entirety and replaced with the following: Bodily injury or sickness resulting from war or any act of war, declared or undeclared, when serving in the military or an auxiliary unit thereto.

### Anesthesia and hospitalization for dental care

Page 9 (exclusion 12) - This exclusion is deleted in its entirety and replaced with the following: Services and supplies for treatment of: a) the teeth; and b) the gums other than for tumors; and c) any other associated structures primarily in connection with the treatment or replacement of natural teeth; and d) prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids except as provided in major medical benefits or unless due to an injury that occurs while covered under the Policy to sound natural teeth, provided such treatment is received within 90 days following the date of injury.

### Audiological services

Page 9 (exclusion 17) - This exclusion is deleted in its entirety and replaced with the following: Hearing aids or the fitting thereof, except as provided in major medical benefits. Audiological services and hearing aids for a child who is a covered person from birth up to 18 years of age.

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## **South Dakota**

### **For residents of South Dakota ONLY**

### Pre-existing conditions

Page 8 - This definition is supplemented to include pre-existing credit information. The limitation will be reduced by the amount of time the insured has been continuously covered by creditable coverage without a lapse of more than 63 days. This limitation does not apply to a newborn child within 63 days after the date of birth, a newly adopted child, or a child placed for adoption within 63 days of the adoption or the placement for adoption. Creditable coverage includes but is not limited to: employer-based health plans, individual health plans, Medicare, Medicaid, risk-pool plans, short-term major medical plans or public health plans.

Page 9 (exclusion 1) - This exclusion is deleted and replaced with: Expenses incurred by or for a covered person in connection with a pre-existing condition for 12 months after the covered person's effective date. No claim for covered charges incurred more than 12 months after a covered person's effective date will be reduced or denied solely on the grounds that the charge is due to a pre-existing condition, unless the condition is excluded or limited by name in an amendatory endorsement attached to the policy. This limitation shall not apply to a dependent child who is a newborn or adopted or placed for adoption before age 18); however, expenses incurred before adoption or placement for adoption will not be covered.

We will waive any time period applicable to a pre-existing condition limitation for the aggregate period of time a covered person was previously covered by creditable coverage, if the creditable coverage was continuous to a date not more than 63 days before the application for coverage. A period of time an insured person was previously covered may not be exaggerated if there was a break in coverage of 63 days or more.

The pre-existing condition limitation does not apply to:

1. newborn children covered by creditable coverage within 63 days after the date of birth; or
2. newly adopted children who are adopted or placed for adoption and covered by creditable coverage within 63 days after the date of adoption or placement for adoption.

Genetic information will not be treated as a condition for which a pre-existing condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

### Workers' injury or sickness

Page 9 (exclusion 6) - This exclusion is deleted and replaced with the following: Bodily injury or sickness which arises out of or in the course of employment for wage or profit, nor for a bodily injury or sickness for which the covered person has or had a right to compensation paid under any workers' compensation law or occupational disease law, unless specifically amended by the 24-hour occupational rider attached to the certificate.

### Dental surgery

Page 9 (exclusion 13) - The reference to the term "sound natural teeth" is deleted and replaced with the term "original teeth."

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## **Tennessee**

### **For residents of Tennessee ONLY**

#### **Mental, nervous and chemical dependency**

Page 7 – The benefit description of “mental, nervous and chemical dependency disorders” is deleted and replaced with the following:

##### **Chemical dependency**

Outpatient chemical dependency treatment is limited to \$25 per visit, maximum of 50 visits or \$1,250 per covered person per calendar year and subject to the plan deductible and coinsurance. These outpatient expenses do not accumulate toward the coinsurance maximum. Inpatient chemical dependency treatment benefits are limited to inpatient detoxification in connection with a therapy program and rehabilitative services. Coverage is limited to 10 inpatient days up to \$2,500 per covered person per calendar year and subject to the plan deductible and coinsurance. The maximum lifetime benefit for chemical dependency is \$10,000 while insured.

##### **Mental and nervous disorders**

Outpatient mental and nervous disorders are limited to 25 visits per covered person per calendar year and are subject to the plan deductible and coinsurance. Inpatient mental and nervous disorders are limited to 20 inpatient days and are subject to the plan deductible and coinsurance.

#### **Dependent coverage**

Page 8 - Dependent coverage is deleted in its entirety and replaced with the following:

Eligible dependents include an insured's spouse and all unmarried children or stepchildren, including newborns, who are primarily dependent for support and maintenance and are less than 25 years of age.

#### **Spinal adjustments and manipulation**

Page 7 and 10 (exclusion 42) – The non-surgical back treatment limited benefit and exclusion 42 are deleted in their entirety. Spinal adjustments and manipulation are covered as any other illness. Physiological therapeutics used as an adjunct therapy prior to or in conjunction with spinal treatment is also a covered expense. Covered benefits are subject to the plan deductible, coinsurance and copays.

#### **Newborn nursery care**

Page 9 (exclusion 10) - This exclusion is deleted in its entirety. Newborn nursery care is covered as any other illness and is subject to the plan deductibles, coinsurance and copays.

#### **Temporomandibular (TMJ) or craniomandibular joint disorder**

Page 9 (exclusion 14) - This exclusion is deleted in its entirety. Diagnostic and/or surgical treatment of conditions affecting the temporomandibular (jaw or craniomandibular) joint are covered expenses and are subject to the plan deductibles, coinsurance and copays.

#### **Artificial organ implant**

Page 10 (exclusion 43) - This exclusion is deleted in its entirety.

#### **Additional exclusions**

Page 10 - The following exclusions are added to the list:

- 49. Thermography
- 50. Orthomolecular therapy
- 51. Contact reflux analysis
- 52. Bioenergetical synchronization techniques (BEST)
- 53. Iridology
- 54 Three dimensional contour studies

#### **Anesthesia for dental care**

Page 9 (exclusion 12) - This exclusion is altered to provide benefits for anesthesia administered while performing dental care for insureds under age 5 or an insured who is severely disabled or otherwise suffers from a developmental disability, determined by a licensed physician, which places such person at serious risk. Coverage applies regardless of whether the services are provided in a hospital or dental office. Pre-certification is required as any other hospitalization. Benefits are provided as any other illness.

#### **Biologically based mental illness**

Page 10 (exclusion 26) - This exclusion is altered to provide benefits for mental illness caused by neurological disorders of the brain which substantially impair perception, cognitive function, judgment and emotional stability and limits the life activities of the covered person. Such mental illnesses include: schizophrenia and other

psychotic disorders, bipolar disorders, major depression and obsessive-compulsive disorder. Benefits for biologically based mental illnesses are provided as another illness and are not subject to the mental, nervous and chemical dependency disorders limitations on page 12 of the brochure.

#### Phenylketonuria - PKU

Page 10 (exclusion 36) - This exclusion is altered to provide benefits for the testing, diagnosis and treatment of PKU, including dietary management, formulas, case management, intake and screening assessment, comprehensive care planning and service referral. Benefits are provided as any other illness.

#### Alcoholism treatment

Page 7 – The “Mental, nervous and chemical dependency disorders” benefit description is altered to provide benefits for inpatient alcoholism treatment as any other illness up to a maximum of 30 days within any six-month period and up to a lifetime maximum of 90 days.

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## **Texas**

### **For residents of Texas ONLY**

#### Dependent definition is revised as follows

Page 8 – The dependent coverage description is deleted in its entirety and replaced with the following: Eligible dependents include an insured’s spouse and all unmarried children or stepchildren less than 25 years of age. Eligibility includes a child for whom the insured is party to a lawsuit and seeking adoption and a grandchild who is dependent on the insured for federal income tax purposes at the time application for coverage of the child is made or for whom the insured must provide medical support as required by the state of Texas (coverage for a grandchild may not be terminated solely because the covered child is no longer a dependent for federal income tax purposes). The insured’s natural born or adopted child, for whom the insured must provide medical support as required by the state of Texas, is also considered an eligible dependent.

#### Definition of a pre-existing condition

Page 8 - The pre-existing condition definition is deleted and replaced with the following: A bodily injury or sickness for which the individual received medical treatment (including the taking of medicine prescribed by a physician), advice or consultation during the 12 months immediately preceding the effective date of this insurance.

#### Mastectomy

Page 9 (exclusion 15) – The exclusion is modified to include benefits for a covered person who, in connection with a mastectomy, elects breast reconstruction. Covered charges include those incurred for:

- a) reconstruction of the breast on which the mastectomy was performed;
- b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c) prostheses and physical complications from all stages of the mastectomy, including lymphedemas.

#### Prostate cancer screening

Page 2 and 9 (exclusion 2a and 21) - These benefits and exclusions are modified to provide coverage for the following:

Expenses incurred in conducting an annual medically-recognized diagnostic examination for the detection of prostate cancer, including:

1. a physical examination for the detection of prostate cancer; and
2. a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is:
  - a. at least 50 years of age and asymptomatic; or
  - b. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

#### Chemical dependency disorders

Page 7 - The mental, nervous and chemical dependency disorders description is modified to coverage for inpatient and outpatient treatment of a chemical dependency disorder with benefits paid the same as any other illness.

#### Temporomandibular or craniomandibular joint disorders

Page 9 (exclusion 14) - This exclusion is deleted in its entirety. Coverage for medically necessary diagnostic and/or surgical treatment of conditions affecting temporomandibular (jaw) or craniomandibular joint disorder is provided if the condition is a result of: (1) an accident; (2) a trauma; (3) a congenital defect; (4) a developmental defect; or (5) a pathology.

### **Childhood immunizations**

Page 9 (exclusions 11 and 21) - These exclusions are altered to provide benefits for a covered child from birth through 6 years of age for immunizations against: diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetnus, varicella, and any other immunization that is required by law for the child. This benefit is paid at 100 percent and is not subject to the plan deductible or copay.

### **Hearing impairment**

Page 9 (exclusion 2a) – The exclusion is modified to include coverage for a screening test for hearing impairment of a covered child from the date of birth through the date the child is 30 days old and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. This benefit is not subject to the plan deductible.

### **Colorectal cancer screening**

Page 9 (exclusion 2a and 21) - These benefits and exclusions are modified to provide benefits for the following:

- a. an annual fecal occult blood test; and
- b. a flexible sigmoidoscopy every five years; or
- c. a colonoscopy every 10 years.

### **Craniofacial abnormalities**

Page 9 (exclusion 15) - Benefits are provided for a covered child age 18 or younger for surgery to improve the function of or to attempt to create a normal appearance of a craniofacial abnormality caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

### **Serious mental illness benefit**

Page 7 – The mental, nervous and chemical dependency disorder limited benefit is altered to provide benefits for diagnosis and treatment of a serious mental illnesses. Benefits may not be available for a mental illness resulting from use or an addiction to a controlled substance or marijuana that is used in violation of the law.

Benefits payable under this provision will also be payable when a covered person receives necessary care and treatment for such disorders in a psychiatric day treatment facility which is accredited by the Program for Psychiatric Facilities, its successor, or the Joint Commission on Accreditation of Hospitals provided, however, that:

1. treatment in such facility shall not exceed eight hours in any 24-hour period;
2. each full day of treatment in such facility shall be considered equal to one-half day of hospital confinement; and
3. the attending Physician certifies that such treatment is in lieu of hospital confinement.

Coverage will also be provided for treatment rendered in crisis stabilization unit or a residential treatment center for children and adolescents, subject to the following:

1. treatment must be based on an individual treatment plan;
2. treatment must be provided in state licensed or operated facilities; and
3. the condition must substantially impair the person's thought, perception of reality, emotional process or judgement or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital if care and treatment were not provided in the crisis stabilization unit or residential treatment center for children and adolescents.

For purposes of benefit payment, two days of treatment in a crisis stabilization unit or residential treatment center for children and adolescents will equal one day of treatment in a hospital.

### **Centers of Excellence**

Page 2 – All references to Centers of Excellence are not applicable in Texas. For a PPO plan, in-network transplants are subject to the lifetime maximum benefit of \$500,000 and out-of-network transplants are subject to a lifetime maximum benefit of \$350,000. For a traditional plan, all covered organ transplant services are subject to the \$500,000 lifetime maximum benefit.

### **Contraceptive devices**

Page 10 (exclusion 48a) – This exclusion is modified to provide coverage for contraceptive devices as any other covered outpatient prescription.

### **Out-of-network care**

Page 4 – The description of in-network and out-of-network care is supplemented by the following: If a covered person has to use an out-of-network provider because an in-network provider is unable to render the necessary services, benefits will be paid as if services were rendered by an in-network provider.

### Premium changes

Page 9 – The last paragraph in the premium section is deleted and replaced with the following: The company reserves the right to change premiums under the policy on any premium due date by giving the policyholder and the insured at least 60 days prior written notice.

### Home health care

Page 12 – The maximum number of home health care visits per calendar year is 60.

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## Wyoming

### For residents of Wyoming ONLY

### Pre-existing conditions

Page 8 - This definition is deleted in its entirety and replaced with the following: A pre-existing condition means a bodily injury or sickness for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the insured's effective date of coverage. The above stated definition is further supplemented to include pre-existing credit information. The six-month limitation period will be reduced by the amount of time the insured has been covered by public or private health insurance or other health insurance arrangements if the coverage was continuous to a date not more than 90 days prior to the effective date of the Freedom Health Plan, not including any applicable waiting periods. Benefit levels in this situation will be the lesser of; 1) the new coverage without the pre-existing conditions limit or, 2) the benefits of the prior health plan.

### Pap smears, colorectal cancer screening, prostate cancer screening and mammograms

Page 9 (exclusion 2a and 21) - These benefits and exclusions are modified to provide benefits for the following:

1. A cervical cancer examination including a pelvic examination and Pap smear for any non-symptomatic woman;
2. A colorectal cancer examination and laboratory tests for cancer for any non-symptomatic person;
3. A prostate examination and laboratory tests for cancer for any non-symptomatic man; and
4. A breast cancer examination including a screening mammogram and clinical breast examination for any non-symptomatic person.

The benefits are subject to an 80 percent coinsurance up to a calendar year maximum combined benefit of \$250. The plan deductibles and copays do not apply.