

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.



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 nearly 30 years. For information about The IHC Group, visit 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.

IHC Freedom EH online 0811



You have **Freedom**

Create your plan

Families differ, and so do their health insurance needs. Flexibility in plan design and premium is important. Eleven deductibles and five coinsurance out-of-pocket options allow you to create a Freedom Health Plan with the coverage you need, at a price you can afford.

Choose your providers

The best providers are determined by you, not your insurance company. With the Freedom Health Plan, you choose your doctors and hospitals. With a PPO plan option, you will receive discounts and lower out-of-pocket expenses when you visit network providers.

Enhance your benefits

Go beyond the basics. Through a Premier membership in Communicating for America Inc., you can enhance your coverage with a critical illness benefit, accident medical expense insurance and disability income protection.

Maintain your coverage

You want your health insurance to provide peace of mind. Rest assured that, once issued, your Freedom Health Plan will not single you out for cancellation based on your claims.

Freedom

Features and Benefits



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.

Preferred health discount

Maintaining your health has its rewards. Qualified applicants may be eligible for a reduction in premium.

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.

Strength and security

Freedom Health Plans are underwritten by Companion Life Insurance Company of Columbia, S.C. Companion is rated A+ (Superior) as of December 23, 2010 by A.M. Best Company based on its relative strength, operating performance and a ability to meet policyholder needs.

* "January 2010 census shows 10 million people covered by HSA/High-Deductible health plans" AHIP Center for Policy and Research, November 2010

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. Because Freedom Health Plans offer numerous networks nationwide, you can choose a network in your area that includes your physicians and hospitals. 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 Necessary, Reasonable and Customary Charge. The Necessary, Reasonable and Customary Charge 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 Necessary, Reasonable and Customary Charge, 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									
Calendar-year maximum	\$2 million										
Deductible On a family plan, you and all of your covered dependents share one common calendar-year deductible amount for covered charges.	In-network: <table><tr><td>Individual</td><td>Family</td></tr><tr><td><input type="checkbox"/> \$2,000</td><td><input type="checkbox"/> \$4,000</td></tr><tr><td><input type="checkbox"/> \$2,600¹</td><td><input type="checkbox"/> \$5,200¹</td></tr><tr><td><input type="checkbox"/> \$5,000²</td><td><input type="checkbox"/> \$10,000</td></tr></table> Out-of-network: 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 ¹	<input type="checkbox"/> \$5,200 ¹	<input type="checkbox"/> \$5,000 ²	<input type="checkbox"/> \$10,000	Individual <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,600 <input type="checkbox"/> \$5,000	Family <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,200 <input type="checkbox"/> \$10,000
Individual	Family										
<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$4,000										
<input type="checkbox"/> \$2,600 ¹	<input type="checkbox"/> \$5,200 ¹										
<input type="checkbox"/> \$5,000 ²	<input type="checkbox"/> \$10,000										
Coinsurance and out-of-pocket maximum 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. On a family plan, you and all of your covered dependents share one common out-of-pocket maximum amount for covered charges.	<input type="checkbox"/> In-network: 100% Out-of-network: 70% up to \$3,000 <input type="checkbox"/> In-network: 80% up to \$1,000 Out-of-network: 50% up to \$5,000 In-network and out-of-network out-of-pocket amounts accumulate separately.	100%									
Outpatient prescription drugs	Same as any other illness; covered charges for outpatient prescription drugs are subject to the plan deductible and coinsurance										

¹ The \$2,600/\$5,200 deductibles are not available with the 80 percent coinsurance option.

² When the individual deductible of \$5,000 is selected with the 80 percent coinsurance option, 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
Calendar-year maximum	\$2 million
Physician office and urgent center copay After copay, plan covers 100 percent of the covered charges for in-network physician office or urgent care center 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.	In-network: \$25 Out-of-network: Covered charges are subject to the out-of-network deductible and coinsurance
Deductible The family deductible is a maximum of three individual deductible amounts. The out-of-network deductible is two times the in-network deductible and accumulates separately.	In-network: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
Coinsurance and out-of-pocket maximum 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. The family out-of-pocket maximum is two individual out-of-pocket maximum amounts.	<input type="checkbox"/> In-network: 80% to \$2,000 Out-of-network: 60% to \$8,000 <input type="checkbox"/> In-network: 70% to \$6,000 Out-of-network: 50% to \$20,000
Hospital or skilled nursing deductible,¹ per confinement	\$250
Emergency room deductible,¹ per visit	\$100 (Waived if admitted to the hospital immediately following emergency room visit.)
Outpatient prescription drugs	\$250 deductible* then \$15 copay for generic drugs or \$25 copay and 80% coinsurance for name brand drugs * 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.

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

Traditional Plan

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

Plan specifics	Traditional
Calendar-year maximum	\$2 million
Deductible The family deductible is a maximum of three individual deductible amounts.	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000
Coinsurance and out-of-pocket maximum 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. The family out-of-pocket maximum is two individual out-of-pocket maximum amounts.	70% to \$6,000
Hospital or skilled nursing deductible,¹ per confinement	\$250
Emergency room deductible,¹ per visit	\$100 (Waived if admitted to the hospital immediately following emergency room visit.)
Outpatient prescription drugs	\$250 deductible* then \$15 copay for generic drugs or \$25 copay and 80% coinsurance for name brand drugs * 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.

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

Preventive Benefits

In accordance with the Patient Protection and Affordable Care Act, the Freedom Health Plan will cover preventive services rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit www.uspreventiveservicestaskforce.org.

For PPO plans, in-network covered preventive services are paid at 100 percent with no required copay, deductible or coinsurance. Out-of-network preventive services are not covered.

For traditional plans, covered preventive services are paid at at 100 percent with no required deductible or coinsurance.

Optional Benefits

Outpatient supplemental accident coverage
Accidents happen, even to the most careful. 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.

Term Life Insurance

Each Freedom Health Plan includes \$10,000 in term life insurance coverage on you, the primary insured. Additional life insurance is available 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 inforce at the time of death. Protect your family with the funds to maintain their lifestyle and continue their health insurance coverage. (Term life insurance is not available for residents of Kansas.)

Limited Benefits

Benefits listed below apply per covered person.

Non-surgical back treatment (including chiropractic care)
Covered charges for non-surgical back treatment are payable up to 10 visits 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.

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
Outpatient mental, nervous and chemical dependency
Maximum benefit of \$25 per visit, 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 \$250 per day 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 million. 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:
Covered organ transplant services are subject to a maximum benefit of \$250,000 per transplant.

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 seven days of diagnosis)

For only Choice PPO and Traditional plans when a copay prescription drug option is selected:

- 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 seven 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 that would have caused an ordinarily prudent person to seek medical diagnosis or treatment during the 12 months immediately preceding the effective date of the covered person’s insurance.

The pre-existing condition limitation does not apply to any covered person under the age of 19.

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 100 percent of such person’s approved Medicare expenses otherwise reimbursable under the policy.

Dependent coverage

Eligible dependents include an insured’s spouse and all children from birth to age 26. 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:

- The date of termination of the policy;
- The next premium due date after the company receives written request to

terminate coverage of the insured person under the policy;

- The last premium due date prior to a grace period, if the premium then due is not paid within the grace period;
- 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;
- The first date following 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;
- The first date following 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;
- The date the coverage is determined to be a small employer health plan pursuant to governing law; or
- 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:

- are medically necessary for the treatment of a bodily injury or sickness and which have been recommended and prescribed by a physician;
- 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;
- are not excluded from coverage by the terms of the policy; and
- 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 31 days prior written notice.

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

- Expenses incurred by or for a covered person in connection with a pre-existing condition for 12 months after the effective date as shown on the validation page 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 the certificate. The pre-existing condition limitation does not apply to any covered person under the age of 19.
- 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.
- Pregnancy, including freestanding birthing center services, certified nurse midwives, certified nurse anesthetist, midwives licensed pursuant to state law and state licensed birth centers.
- Experimental or investigational medical treatment.
- Voluntary abortions.
- 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.
- 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.
- Bodily injury or sickness resulting from war or any act of war (declared or undeclared).
- Charges incurred while on active duty with any military, naval or air force of any country or international organization.
- Newborn nursery care and routine well baby care
- 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 90 days following the date of injury.
- 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 90 days following the date of injury.
- Charges for treatment of temporomandibular joint (TMJ) dysfunction.
- 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.

- Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery.
- Hearing aids or the fitting thereof.
- Charges incurred as a result of participation in a riot or insurrection or the commission of a felony or while imprisoned.
- Charges for radial keratotomy and radial keratectomy or other similar procedures, including laser-based procedures, that are performed on the eyes.
- Meridian therapy (acupuncture), except when used in lieu of an anesthetic.
- Routine physical examinations, immunizations, use of prophylactic injections including gammaglobulins and flu shots, and the well-child care including immunizations, unless the service is listed as an "A" or "B" by the United States Preventive Services Task Force.
- 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.
- Treatments made in connection with obesity or weight reduction including wiring of the teeth and all forms of intestinal bypass surgery.
- 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.
- Charges incurred as the result of attempted suicide or intentionally self-inflicted bodily injury or sickness while sane or insane.

- Treatment for mental, nervous or chemical dependency disorders, except as provided under the Limited Major Medical benefits section of the policy.
- 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.
- Impregnation techniques such as: (a) artificial insemination, or (b) in vitro fertilization, including but not limited to: artificial insemination; in vitro fertilization, in vitro zygote, intrafallopian transfers, gamete intrafallopian transfer; genetic counseling; and all related charges.
- 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.
- Congenital conditions, except with respect to children covered from birth.
- Sexual reassignments or sexual dysfunctions or inadequacies.
- Custodial care, regardless of whom prescribes or renders such care.
- Services or supplies for which no charge is made or for which the covered person is not required to pay.
- 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.
- 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.
- 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.
- 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.
- 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.
- Any surgical removal of an organ or tissue unless medically necessary.
- Treatment for home health care services, except as provided in the Limited Major Medical benefits.
- Treatment for hospice care services except as provided under the Limited Major Medical benefits section of the policy.
- Non-surgical back treatment, except as provided under the Limited Major Medical benefits section of the policy.
- Any service or supply in connection with the implant of an artificial organ.
- 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.
- For high-deductible health plans with prescription drug coverage and for Choice PPO and Traditional plans with prescription drug coverage the same as any other illness: Any non-prescriptive medication or prescription medication that is deemed not medically necessary. For Choice PPO, Economy PPO, and Traditional plans with the copay prescription drug option: Any non-prescriptive medication. For plans with no outpatient prescription drug coverage: Any outpatient prescription medication and any non-prescriptive medication.
- Charges for voice training for a lisp.
- Breast reduction surgery unless such surgery was performed as part of a mastectomy due to breast cancer.
- For Choice PPO and Traditional plans with a copay prescription option, 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.