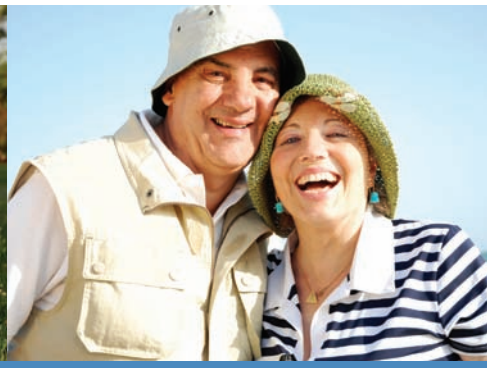
Freedom
Health Plans

- HSA-Qualified High Deductible Health Plans
- Choice PPO





Health insurance with options to lower costs for working Americans and their families

Available only to members of Communicating for America, Inc. (CA)

CA INC. COMMUNICATING for AMERICA

Underwritten by Companion Life Insurance Company.
This brochure must be accompanied by brochure insert number IHCHS 041 0708

Companion Life

Features and benefit coverage (included in all plans)

Features
$5 million lifetime maximum ($2 million per calendar year) Lifetime and calendar year maximum is per person while coverage is inforce.
Children only coverage Children only coverage is available for ages two months to 19 years, or 25 years if a full-time student.
12-month initial rate guarantee The company guarantees that rates will not change for the initial 12 months of coverage from your effective date unless during that time you move to a new residence, change your benefit options, modify the number of covered dependents or the plan administrative or PPO fees change.
10% family discount Automatically applied when up to three children are added to primary insured and spouse's coverage under the same certificate.
24-hour coverage You will have coverage for work-related injuries or illnesses unless you are covered by Workers' Compensation or you are required by law to be covered by Workers' Compensation.
Billing audit program If you find an overcharge of $200 or more on covered expenses paid on your medical bills, the company will pay you a benefit not to exceed one-half of the overcharge up to $1,000 per person per year.
Generation to generation benefit Your covered dependents have the option when they reach age 19, or up to 25 while a full-time student, to purchase their own plan without evidence of insurability.

Benefit coverage
Inpatient and outpatient medical care
Physician office visits
Intensive care unit
Semi-private hospital room
Air, water and land ambulance
X-ray, laboratory and diagnostic tests
Prostate cancer screening
Blood tests and blood transfusions
Mammogram and pap smear coverage Not subject to the plan deductible or coinsurance.
Transplants - You have access to Centers of Excellence (COE) for organ transplants. Choosing a COE gives you expertise, advocacy and case management services so that you are assured the highest level of care. - When using a COE provider, covered transplant services are subject to any applicable copays, deductibles or coinsurance amounts up to the calendar year or lifetime maximum. You will also have an allowance of up to $5,000 available for necessary travel, room and board for a companion, or two companions if the transplant recipient is a minor. - If services are not provided by a COE provider, benefits will be significantly reduced.
Forced providers in-network (Applies to the PPO High Deductible Health Plan and Choice PPO) Certain providers such as radiologists, pathologists, anesthesiologists and assistant surgeons may have relationships with network facilities but are not included in the PPO 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 usual and reasonable charges if both the hospital and admitting physician participate in your selected PPO network.

Benefits, exclusions and limitations may vary by state. The group policy, which is issued to CA, Inc., determines all rights and benefits of persons who are accepted by Companion Life and who are issued evidence of coverage through individual certificates of insurance.

Plan specifics	Freedom Choice PPO	Freedom PPO High Deductible Health Plan	Freedom Traditional High Deductible Health Plan
Physician office visit	After $25 copay, plan covers 100% of the Covered Charges(1) for in-network physician office visits including: examination, evaluation, 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 and coinsurance.	Copay is not available. Covered Charges(1) are subject to deductible and coinsurance.	Copay is not available. Covered Charges(1) are subject to deductible and coinsurance.
Deductible *For Choice PPO and PPO High Deductible Health Plan:* The deductible amounts listed are in-network deductibles. The out-of-network deductible is two times the in-network deductible and accumulates separately. *For both the High Deductible Health Plans:* You and your covered dependents share one common calendar year deductible amount for Covered Charges.	**You choose:** - $1,500 - $2,500 - $5,000 - $10,000 Once three covered persons within a family meet their individual deductibles, no additional calendar year deductibles apply.	**You choose:** **Individual** - $2,000 - $2,600 - $5,000(2) **Family** - $4,000 - $5,200 - $10,000	**You choose:** **Individual** - $2,000 - $2,600 - $5,000(2) **Family** - $4,000 - $5,200 - $10,000
Coinsurance Coinsurance applies after your selected deductible is met for the calendar year	In-Network 80% of the next $10,000 Out-of-Network 60% of the next $20,000 Thereafter, the plan pays 100% of Covered Charges for the calendar year. In-network and out-of-network expenses accumulate separately. Once two covered persons within a family meet their individual coinsurance maximum, no additional calendar year coinsurance amounts apply.	**You choose:** - 100% In-network/70% Out-of-network up to the maximum out-of-pocket amount of $3,000. - 80% In-network up to the maximum out-of-pocket amount of $1,000/50% Out-of-network up to the maximum out-of-pocket amount of $5,000.(3) Thereafter, the plan pays 100% of Covered Charges for the calendar year. In-network and out-of-network expenses accumulate separately. You and your covered dependents share one common out-of-pocket maximum amount for Covered Charges.	100% of Covered Charges

(1) For a description of Covered Charges, see page 7 of this product guide.
(2) When the individual deductible of $5,000 is selected with the 80% coinsurance option the plan no longer meets HSA guidelines due to the total out-of-pocket amount.
(3) Available with the individual $2,000 or $5,000 deductibles and family $4,000 and $10,000 deductibles.

Plan specifics	Freedom Choice PPO	Freedom PPO High Deductible Health Plan	Freedom Traditional High Deductible Health Plan
Prescription drugs An Express Scripts prescription drug card is included which offers discounts on most prescription drugs.	$250 deductible[4] on covered outpatient prescription drugs, then $15 copay for generic drugs or $25 copay then 80% coinsurance for name-brand drugs.	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.
Hospital or skilled nursing deductible per confinement[5]	$250	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.
Emergency room deductible per visit[5]	$100	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.	Same as any other illness. Covered Charges are subject to the plan deductible and coinsurance.
Emergency care	Emergency care received from an out-of-network provider will be considered as in-network. However, you must arrange for transfer to a network hospital within 48 hours or as soon as the transfer can take place without detriment to your health.		

(4) Deductible does not accumulate toward the calendar year deductible or out-of-pocket amounts. When three individual covered persons in a family satisfy their outpatient prescription calendar year deductible, the remaining outpatient prescription deductibles in the family are satisfied for the remainder of the calendar year.

(5) Hospital or skilled nursing or emergency room deductibles do not apply to out-of-pocket.

Optional benefits

Wellness coverage

Optional wellness coverage is a benefit of $250 maximum per calendar year per insured person.

Coverage includes:

- A physical examination by a physician;
- Diagnostic services that are required as part of the exam;
- An evaluation of the insured's general health status;
- Newborn's first exam after hospital discharge when the exam is billed by a physician;
- Exams that review normal growth and development of a child, oral and injectible immunizations; and
- Lab tests normally performed for a well child.

Services and supplies must conform with the guidelines of the American Academy of Pediatrics for all children. These benefits are limited to one visit per age interval. Wellness coverage requires additional premium.

Freedom Choice PPO	Freedom PPO High Deductible Health Plan	Freedom Traditional High Deductible Health Plan
One benefit of $250 is available for each insured person within the calendar year. This benefit is paid differently for in-network and out-of-network providers. In-Network: There is a $25 office visit copay; then Covered Charges are paid at 100% up to the $250 per calendar year maximum per insured. Out-of-Network: Covered Charges are subject to the out-of-network deductible and coinsurance and subject to the $250 per calendar year maximum per insured.	One benefit of $250 is available for each insured person within the calendar year. This benefit is paid differently for in-network and out-of-network providers. In-Network: Covered Charges are paid at 100% up to the $250 per calendar year maximum per insured. Out-of-Network: Covered Charges are subject to the coinsurance up to $250 per calendar year maximum per insured.	Covered Charges are paid at 100% up to the $250 per calendar year maximum per insured (no deductible or coinsurance apply).

Outpatient supplemental accident coverage

This benefit applies to covered medical charges incurred on an outpatient basis for treatment of a covered accidental bodily injury. Treatment must begin within 72 hours of the accident. This benefit also applies for subsequent follow-up care received within 90 days from the date of accident. **This benefit is available for an unlimited number of covered accidents while coverage is inforce.** Outpatient supplemental accident coverage requires additional premium.

Benefit amount options per accident	Deductible* per accident
$500	$50
$1,000	$50
$2,000	$150

* Deductible does not accumulate toward the calendar year deductible or out-of-pocket amounts.

Term life insurance

The primary insured has the option to select an amount of life insurance up to a total of $50,000 in increments of $10,000. This life insurance benefit is payable as long as the Freedom Health Plan is inforce on the date of the primary insured's death. Life insurance requires additional premium.

Limited benefits

Benefits listed below are per 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, after 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% for up to 6 months. The plan will also cover bereavement support service for the insured person's family during the 3-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:
Up to $25 per visit, maximum of 50 visits or $1,250 per calendar year and subject to your medical plan deductible and coinsurance. For the Choice PPO plan these outpatient expenses do not accumulate toward your coinsurance maximum(s).

Inpatient mental, nervous and chemical dependency:
Maximum of 10 inpatient days, up to $2,500 per calendar year and 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 policy'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 $100,000.

Benefits, exclusions and limitations may vary by state. The group policy, which is issued to CA, Inc., determines all rights and benefits of persons who are accepted by Companion Life and who are issued evidence of coverage through individual certificates of insurance.

Important Information About Your Freedom Health Plans

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 Choice PPO plan 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 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 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 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 inforce 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
- The insured changes benefit options
- Administrative or PPO fee changes
- 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 inforce.
3. Pregnancy, including freestanding birthing center services, certified nurse midwives, certified nurse anesthesiologist, 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, unless covered by the 24-Hour Occupational Coverage Rider.
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, microtrognathism, 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; (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; invitro 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 who 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 chemotherapy 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 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 plan 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.
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 Choice PPO plan 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. Investigational 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 pharmaceuticals.
    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.

Companion Life Insurance Company

Companion Life Insurance Company has specialized in employee group and individual benefits for more than 35 years. The mission of Companion Life Insurance Company is to be a well-managed organization acting in the best interests of its policyholders and marketing partners, operating on a financially sound, growing and diversified basis.

Companion Life has earned an A.M. Best rating of A+ (Superior).[1]

[1] Ratings are current as of November 2007. Ratings of the A.M. Best Company reflect their current opinion of the relative financial strength and operating performance of the insurance companies. Ratings criteria and rankings can vary by rating company. Copies of ratings reports are available from each insurance company upon request.

Insurers Administrative Corporation

Insurers Administrative Corporation (IAC) administers the Freedom Health Plans. Services include individual risk selection (underwriting), claims processing, premium billing and collection, and customer service in accordance with the guidelines of Companion Life, the insuring company.

IAC is a member of the IHC Group, an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. With more than $1.3 billion in assets, the IHC Group serves over one million customers. IAC is a bonded and licensed third-party administrator with more than 400 employees serving the needs of individuals and employers in the areas of medical, dental, life and accidental death and dismemberment, 401K and Section 125 plans.

IAC, 2101 West Peoria Ave., Suite 100, Phoenix, AZ 85029-4928

Communicating for America, Inc.

Communicating for America, Inc. (CA) endorses the Freedom Health Plans. CA is a national, non-profit, non-partisan association founded in 1972 and headquartered in Fergus Falls, Minnesota.

Member benefits

- Consumer discounts, benefits and services that have saved members more than $2 million.
- Legislative voice that unites self-employed Americans:
  - Working on 100% tax deduction for all individuals paying for their own health insurance.
  - Continuing to protect family farmers.
  - Supporting private market individual health insurance.

Endorsement standards

Before endorsing any insurance or benefit plan, CA:

- Reviews the insurance carrier's profits;
- Reviews the insurance carrier's marketing and administrative costs;
- Reviews whether rate increases are justified by financial records;
- Regularly reviews financial information;
- Has the right to audit the insurance carrier's records.

Investment in youth

- Scholarships for youth—more than $1.4 million awarded so far!
- Largest international agricultural rural youth exchange in the U.S.A.

Illustration only:
This form is an advertising brochure, not an insurance policy. The coverages briefly outlined in this brochure only generally describe the coverage provided under the group insurance policy. A more detailed explanation of this coverage is provided in the certificate of insurance which an association member will receive only after he/she is accepted by Companion Life Insurance Company and issued coverage for which he/she is eligible. The group insurance policy determines all rights and benefits of persons who are accepted by Companion Life Insurance Company and issued coverage under the group insurance policy. The Coverage under the Major Medical Insurance Plan is provided to members of Communicating for America, Inc. through a certificate of insurance underwritten by Companion Life Insurance Company. The group policy holder for this association group is Communicating for America, Inc.

Group Policy Forms (may vary by state): CLI CH 3000 and CLI CH 3020 PPO with the CLI CH 3010 CERT or CLI CH 3030 PPO CERT; Validation Page CLI CH 3010 VAL; Schedule of Benefits: CLI CH 3010 SB or CLI CH 3030 PPO SB, CLI CH 3010 HDHP SB or CLI CH 3030 HDHP PPO SB; Rider Forms: CLI GOCR 3060, CLI GPDR 3070, CLI GSAR 3110, CLI GWCR 3120, CLTLR 3220.

IHCHS 539 0808

CA INC. COMMUNICATING for AMERICA

Companion Life