

Community Flex Plan Choice	Individual Network Calendar Year Deductible	Network Benefit Percentage You Pay	Individual Network Maximum You Will Pay Per Calendar Year, Including Deductible
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Family Deductible is 2 times the individual deductible, met collectively by 2 or more persons.

Non-Network deductible is 2 times the Network deductible.

<b>Flex 100</b> Non-Network Benefit Percentage is 70% <sup>6</sup> <sup>6</sup> 75% in Arkansas	\$5,000	0%	\$5,000
	\$7,500		\$7,500
	\$10,000		\$10,000

			20% of \$10,000	20% of \$20,000
<b>Flex 80</b> Non-Network Benefit Percentage is 50% <sup>7</sup> <sup>7</sup> 55% in Arkansas	\$1,000	20% of \$10,000 or 20% of \$20,000	\$3,000	\$5,000
	\$1,500		\$3,500	\$5,500
	\$2,500		\$4,500	\$6,500
	\$3,500		\$5,500	\$7,500
	\$5,000		\$7,000	\$9,000
	\$7,500		\$9,500	\$11,500

			40% of \$10,000	40% of \$20,000
<b>Flex 60</b> Non-Network Benefit Percentage is 50%	\$500	40% of \$10,000 or 40% of \$20,000	\$4,500	\$8,500
	\$1,000		\$5,000	\$9,000
	\$1,500		\$5,500	\$9,500
	\$2,500		\$6,500	\$10,500
	\$3,500		\$7,500	\$11,500
	\$5,000		\$9,000	\$13,000
	\$7,500		\$11,500	\$15,500

**Premium is guaranteed for 24 months for network deductibles of \$5,000 or higher.<sup>8</sup>**

<b>Lifetime Policy Maximum</b>	\$5 million per person
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Type of Service	Flex (100%, 80% or 60%)	Gold Benefits Option
<b>Office Visits/Urgent Care Centers</b> <ul style="list-style-type: none"> <li>Office Visit/Urgent Care Center evaluation and management services</li> <li>X-Ray and Laboratory performed on site</li> </ul>	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Non-network deductible and benefit percentage	<b>Network: Copay</b> per visit then we pay <b>100%</b> <b>Non-network:</b> Non-network deductible and benefit percentage For deductibles of \$500-\$3,500, copay is \$30 for Office Visit/\$60 for Urgent Care For deductibles of \$5,000-\$10,000, copay is \$40 for Office Visit/\$80 for Urgent Care
<ul style="list-style-type: none"> <li>Injections</li> <li>Diagnostic Services</li> <li>Surgical Procedures</li> <li>Chemotherapy and radiation therapy</li> </ul>	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Non-network deductible and benefit percentage	

<sup>8</sup>For network deductibles of \$500-\$3,500, the premium rate is guaranteed for the first 12 months of coverage. The rate guarantee may become invalid as a result of plan changes, change in residence, or dependent child attaining adult status.

Type of Service	Flex (100%, 80% or 60%)	Gold Benefits Option
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• HPV Immunizations</li> <li>• Bone Density Test</li> <li>• Colorectal Cancer Screening</li> <li>• Lab work sent to an independent lab</li> </ul>	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Not covered	
\$1,000 maximum per family member: Immunizations, except for HPV; Lab work performed in the office; Routine Physical Exams; PSA Testing & PAP Smears	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Not covered	<b>Network:</b> Office visit copay and 100% <b>Non-network:</b> Not covered
Mammograms (Screening)		
<b>Allergy Treatment</b> (12-month waiting period) Injections	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Non-network deductible and benefit percentage	<b>Network:</b> 100% <b>Non-network:</b> Non-network deductible and benefit percentage
Testing and Serums \$500 Calendar Year Maximum per Family Member	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Non-network deductible and benefit percentage	
<b>Emergency Room</b> Sickness and Injury. Non-emergency not covered.	<b>Network and Non-network:</b> \$250 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours.	<b>Network and Non-network:</b> \$150 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours.
<b>Accident Benefit</b>	Deductible is waived and covered charges related to the injury are paid at the network or non-network benefit percentage (after any applicable copayment) for services incurred within 30 days of the injury. The deductible will be applied to any covered charges incurred after the 30-day limit has been met.	
<b>Hospital</b>		
Emergency admissions	<b>Network and Non-network:</b> Network deductible and benefit percentage	
Non-Emergency admissions	<b>Network:</b> Deductible and benefit percentage	
Outpatient Surgery	<b>Non-network:</b> \$500 copay, then Non-network deductible and benefit percentage	
In-Hospital Services	<b>Network:</b> Deductible and benefit percentage <b>Non-network:</b> Non-network deductible and benefit percentage	
<b>Maternity</b> Benefit for policyholder or spouse only, if spouse is covered under the policy (not available in Arkansas, Iowa, Missouri, or Texas)	<b>Advantage:</b> Network discounts apply when network providers are used. <b>Coverage:</b> \$12,000 maternity-specific deductible and paid at network or non-network benefit percentage. 90-day waiting period from the effective date. To be covered, pregnancy must begin after the waiting period.	
<b>Prescription Drugs</b>	Value discount drug card for preferred pricing on select generic and brand name prescription drugs at network retail outlets.	
<b>Prescription Drug Options</b>	<b>Retail 31-day supply</b>	<b>Mail Order 90-day supply</b>
<b>Option 1 - Generic Only</b>	20% copayment, \$15 minimum	20% copayment, \$35 minimum
<b>Option 2 - Four-Tier Option</b>	\$250 deductible (waived for Generic)	
Generic	20% copayment, \$15 minimum	20% copayment, \$40 minimum
Select Brand	30% copayment, \$30 minimum	30% copayment, \$80 minimum
Additional Brand	50% copayment, \$60 minimum	50% copayment, \$150 minimum
Specialty	25% copayment, no minimum, 31-day supply \$250 copay maximum per prescription \$2,500 out-of-pocket maximum per person, per calendar year	
<b>Dental Option (not available in Tennessee)</b>		
<b>Dental Benefit</b> \$1,000 maximum per person per calendar year	Type 1 procedures: 6-month waiting period and we pay 80% Type 2 procedures: 12-month waiting period, \$100 calendar year deductible and we pay 50%	

This document is an addition to the Community Flex brochure.

### Arkansas

- ✓ Pre-existing conditions are not covered for 3 years
- ✓ Exclusion for cosmetic treatment does not apply to a congenital disease or anomaly of a covered dependent child, which has resulted in a functional defect
- ✓ Vision Exam benefit is not included
- ✓ Podiatric appliances for prevention of complication associated with diabetes are covered
- ✓ Well Child Care is covered with no maximum from birth through age 18
- ✓ Childhood Immunizations, except HPV, are covered at 100% with no maximum from birth through age 18
- ✓ Maternity is not covered; except for complications
- ✓ Diagnosis and treatment of Temporomandibular Joint Disorder (TMJ) is covered
- ✓ Medical foods & low protein modified foods to treat metabolic disease are covered after expenses exceed \$2,400 per person
- ✓ Treatment of speech and hearing disorders are covered. Coverage does not include hearing instruments or devices.
- ✓ Dental Anesthesia is covered for:
  - (1) A child under 7 years of age who two (2) licensed dentists have determined requires dental treatment for a complex dental condition;
  - (2) A person diagnosed with a serious mental or physical condition; or
  - (3) A person diagnosed with a significant behavioral problem
- ✓ Treatment and testing for a newborn child as required by Arkansas law are subject to your plan deductible (not the maternity deductible).
- ✓ Six-month waiting period for treatment of the following when received on a non-emergency basis: tonsils, adenoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, uterine prolapse
- ✓ Organ Transplant has a \$750,000 maximum benefit at a non-designated transplant facility
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Preventive Care covered in and out-of-network

### Prescription Drug Coverage

- ✓ Four-Tier Option: Retail maximum day supply is 30 days. Mail Order minimum copay for Generic is \$45; Select Brand: \$90; Additional Brand: \$60

### Arkansas Continued

- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen.

### Illinois

- ✓ Exclusion for cosmetic treatment, or complications of cosmetic treatment, does not apply to treat a medically necessary complication of cosmetic treatment
- ✓ Preventive Care benefits are covered at a non-network provider
- ✓ Treatment for TMJ is covered
- ✓ Exclusion for injury received while operating a motorized vehicle does not apply
- ✓ Exclusions for growth hormones and breast reductions do not apply to medically necessary charges
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen
- ✓ Maternity benefits apply to all females covered under the policy
- ✓ Charges for weight loss or exercise programs, equipment, drugs or surgery (including complications of surgery) are covered for Medically Necessary Treatment of morbid obesity
- ✓ Clinical breast exam is covered
- ✓ Examination & testing of a victim of a sexual assault is covered at 100%
- ✓ Amino Acid-Based Formulas are covered at 50% after the deductible
- ✓ Dental Anesthesia charges incurred and anesthetics provided in conjunction with dental care provided in a hospital or ambulatory surgical center are covered if:
  - (1) child age 6 and under,
  - (2) medical condition that requires hospitalization or general anesthesia for dental care, or
  - (3) the individual is disabled
- ✓ 6-Month waiting period for treatment of the following when received on a non-emergency basis: tonsils, adenoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia)
- ✓ Exclusion for prescriptions filled at a non-network pharmacy does not apply

## Iowa

- ✓ The 2-year pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage.
- ✓ Organ Transplant has a \$700,000 maximum benefit at a non-designated transplant facility
- ✓ Dental Anesthesia is covered for:
  - (1) a child under 5 years of age with a dental condition or developmental disability
  - (2) a person with one or more medical conditions that create undue medical risk if the necessary dental treatment is not rendered in a hospital or ambulatory surgical center
- ✓ 6-Month waiting period for treatment of the following when received on a non-emergency basis: tonsils, adenoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, uterine prolapse
- ✓ FDA approved contraceptive drugs and devices are covered if the optional Outpatient Prescription Drug benefit is chosen
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Maternity is not a covered benefit, except for complications

## Michigan

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ Charges for treatment of injuries arising out of ownership, operation, maintenance or use of a motor vehicle as a motor vehicle are excluded
- ✓ Exclusion for treatment of Substance Abuse does not apply
- ✓ Exclusion for an injury received while engaging in a hazardous occupation or activity does not apply

## Missouri

- ✓ Pre-existing conditions are not covered
- ✓ Pap Smears, Pelvic Exam, PSA Testing & Exam are not subject to Preventive Care maximum
- ✓ Childhood Immunizations are covered at 100% birth through age 5 and are not subject to the calendar year deductible
- ✓ Preventive Care is covered at a non-network provider
- ✓ Maternity is not covered, except for complications
- ✓ Human Leukocyte Antigen testing is covered, limited to one test per lifetime, up to \$75

## Missouri Continued

- ✓ Dental Anesthesia is covered for:
  - (1) a child under age 5;
  - (2) a person who is severely disabled; or
  - (3) a person with a medical or behavioral condition that requires anesthesia when dental care is provided
- ✓ Patient costs in connection with a Cancer Clinical Trial are covered
- ✓ Inpatient treatment of Alcoholism is covered for 30 days per calendar year
- ✓ Metabolic Diseases: Formula and low protein modified food products for treatment of a person with phenylketonuria (PKU) or any inherited disease of amino and organic acids are covered. Limited to children under age 6. \$5,000 maximum per person per calendar year.
- ✓ Contraceptive drugs and devices are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Vision Exam benefit is not available

## Nebraska

- ✓ Childhood Immunizations: Birth through age 5 covered at 100% in network

### Prescription Drug Coverage

- ✓ Four-Tier Option: Retail maximum day supply is 30 days. Mail Order minimum copay for Generic is \$45; Select Brand: \$90; Additional Brand: \$180

## Ohio

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ The 12-month pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Outpatient mental health services covered for up to \$550 per person per calendar year
- ✓ Biologically based Mental Illness is covered
- ✓ Maternity benefits apply to all females covered under the policy
- ✓ Alcoholism treatment is covered up to a \$550 maximum per person per calendar year
- ✓ Pap Smears are not subject to the Preventive Care maximum
- ✓ Well Child Care benefits provided for birth through age 9, including coverage for hearing screening are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Preventive Care is covered at a non-network provider

## Oklahoma

- ✓ PSA testing and exams are subject to a \$65 maximum reimbursement amount per service, however they are not subject to the Deductible or Preventive Care maximum
- ✓ Preventive care benefits are covered at a non-network provider
- ✓ Pre-existing conditions are not covered for 2 years
- ✓ Bone Density Test is subject to a \$150 maximum reimbursement amount per service
- ✓ Immunizations for ages 0 through 18 are covered at 100%
- ✓ Mammogram maximum benefit is \$115 per service
- ✓ The 12-month waiting period for allergy treatment does not apply
- ✓ Exclusion for foot care does not apply to medically necessary charges
- ✓ There is no separate maximum for non-designated transplant facilities. These charges are subject to the combined lifetime maximum of \$1,000,000
- ✓ 6-month waiting period for the following when received on a non-emergency basis: varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, uterine prolapse
- ✓ A \$1,000 lifetime maximum applies to the following:
  - (1) Weight loss surgery, including complications of surgery.
  - (2) Charges for treatment of TMJ (temporomandibular joint dysfunction).
  - (3) Charges for growth hormone therapy.
  - (4) Charges for breast reduction (other than those due to a mastectomy).
- ✓ Hospital or Free Standing Outpatient Surgery Center charges incurred, including anesthetics, for dental care provided if the Family Member:
  - (1) Is severely disabled; or
  - (2) Is a child under the age of 8 years old and has a medical or emotional condition that requires hospitalization or general anesthesia for dental care.

## Tennessee

- ✓ Bone Density Tests, Colorectal Cancer Exams, Chlamydia Screening, PSA Testing & Exam, Newborn Hearing Screening are not subject to the Preventive Care maximum
- ✓ Treatment for Autism Spectrum Disorder for children under 12 years of age is covered
- ✓ Optional Dental benefit is not available
- ✓ Newborn hearing screening is covered
- ✓ Treatment of PKU Medical Services is covered including special dietary formulas

## Tennessee Continued

- ✓ General Anesthesia for Dental treatment in a hospital for children 8 years old and younger is covered
- ✓ Audiology and Speech Language Pathology—subject to the Speech Therapy calendar year maximum is covered
- ✓ Bone Mass Measurement for diagnosis and treatment of osteoporosis is covered
- ✓ Outpatient spinal manipulation is not subject to the \$500 maximum
- ✓ Treatment of TMJ is covered (limited to Phase I treatment and surgery)
- ✓ Maternity benefits apply to all females covered under the policy

## Texas

- ✓ The 2-year pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Maternity is not a covered benefit, except for complications
- ✓ PSA Testing, Pap Smears and newborn hearing screening are not subject to Preventive Care maximum
- ✓ Immunizations up to age 6 are covered at 100%
- ✓ Newborn Hearing Screening is covered
- ✓ Preventive Care is covered at a non-network provider
- ✓ Telehealth/Telemedicine is covered
- ✓ Organic Brain Disease is covered
- ✓ Developmental Delays limited to children less than 3 years of age are covered (not subject to policy maximums)
- ✓ Reconstructive surgery for craniofacial abnormalities under age 18 is covered
- ✓ 6-month waiting period for treatment of the following when received on a non-emergency basis: tonsils, adenoids, hemorrhoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, uterine prolapse
- ✓ Transplant services at a non-designated transplant facility are covered up to \$700,000
- ✓ The 12-month waiting period for allergy benefits does not apply
- ✓ Contraceptives drugs and devices are covered
- ✓ Prescription Drug benefits are payable if obtained from a participating or non-participating pharmacy
- ✓ Vision Exam benefit is not included

## Wisconsin

- ✓ Home Health Care is limited to 40 visits per person per calendar year
- ✓ Lead Poisoning Screening is covered for children under age 6
- ✓ Dental Anesthesia is covered if the person:
  - (1) Is a child under age 5;
  - (2) has a chronic disability; or
  - (3) has a medical condition that requires hospitalization or general anesthesia for dental care
- ✓ Routine patient care associated with a person's participation in a Cancer Clinical Trial is covered
- ✓ Surgical treatment of TMJ is covered. Diagnosis and non-surgical treatment is covered up to \$1,250 per calendar year.