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Community Flex™

For Individuals & Families

Benefit Chart

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	
Family Deductible is 2 times the individual deductible, met collectively by 2 or more persons. Non-Network deductible is 2 times the Network deductible.				
Flex 100 Non-Network Benefit Percentage is 70%* *75% in Arkansas	$5,000	0%	$5,000	
	$7,500		$7,500	
	$10,000		$10,000	
			20% of $10,000	20% of $20,000
Flex 80 Non-Network Benefit Percentage is 50%* *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
Flex 60 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.[1]

Lifetime Policy Maximum	$5 million per person

Type of Service	Flex (100%, 80% or 60%)	Gold Benefits Option
Office Visits/Urgent Care Centers • Office Visit/Urgent Care Center evaluation and management services • X-Ray and Laboratory performed on site	**Network:** Deductible and benefit percentage **Non-network:** Non-network deductible and benefit percentage	**Network: Copay** per visit then we pay **100%** **Non-network:** 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
• Injections • Diagnostic Services • Surgical Procedures • Chemotherapy and radiation therapy	**Network:** Deductible and benefit percentage **Non-network:** Non-network deductible and benefit percentage	

[1]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.

Please refer to the brochure, state variations page, or the policy/certificate for additional information on limited benefits and plan exclusions.

Community Flex™

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Benefit Chart

Type of Service	Flex (100%, 80% or 60%)	Gold Benefits Option
Preventive Care • HPV Immunizations • Bone Density Test • Colorectal Cancer Screening • Lab work sent to an independent lab	**Network:** Deductible and benefit percentage **Non-network:** 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 Mammograms (Screening)	**Network:** Deductible and benefit percentage **Non-network:** Not covered	**Network:** Office visit copay and **100%** **Non-network:** Not covered
Allergy Treatment (12-month waiting period) Injections	**Network:** Deductible and benefit percentage **Non-network:** Non-network deductible and benefit percentage	**Network:** 100% **Non-network:** Non-network deductible and benefit percentage
Testing and Serums $500 Calendar Year Maximum per Family Member	**Network:** Deductible and benefit percentage **Non-network:** Non-network deductible and benefit percentage	
Emergency Room Sickness and Injury. Non-emergency not covered.	**Network and Non-network:** $250 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours.	**Network and Non-network:** $150 copay and network deductible and benefit percentage. Copay waived if admitted within 24 hours.
Accident Benefit	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.	
Hospital Emergency admissions	**Network and Non-network:** Network deductible and benefit percentage	
Non-Emergency admissions Outpatient Surgery	**Network:** Deductible and benefit percentage **Non-network:** $500 copay, then Non-network deductible and benefit percentage	
In-Hospital Services	**Network:** Deductible and benefit percentage **Non-network:** Non-network deductible and benefit percentage	
Maternity Benefit for policyholder or spouse only, if spouse is covered under the policy (not available in Arkansas, Missouri, or Texas)	**Advantage:** Network discounts apply when network providers are used. **Coverage:** $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.	
Prescription Drugs	Value discount drug card for preferred pricing on select generic and brand name prescription drugs at network retail outlets.	

Prescription Drug Options	Retail 31-day supply	Mail Order 90-day supply
Option 1 - Generic Only	20% copayment, $15 minimum	20% copayment, $35 minimum
Option 2 - Four-Tier Option	$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	

Dental Option (not available in Tennessee)

Dental Benefit	
Dental Benefit $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%

Please refer to the brochure, state variations page, or the policy/certificate for additional information on limited benefits and plan exclusions.

Waiting Period

Treatment for the following conditions are not covered during the first 12 months the coverage is in force: tonsils, adenoids, bunions, hemorrhoids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy (unless the condition is life-threatening), carpal tunnel surgery, joint replacement, myringotomy, nasal repair (including rhinoplasty and septoplasty), retained hardware removal, amenorrhea, cataracts, cystocele, dysmenorrhea, enterocele, rectocele, urethrocele, and uterine prolapse. This list of conditions may vary by state, see the Community Flex State Variations page for details.

Medicare Coordination, Insurance with Other Insurers, Third Party Reimbursement, Subrogation and Coordination of Benefits

Community Flex contains certain provisions that may reduce benefits under the plan, as allowed by law; a full description is contained in the policy.

Simplified Underwriting

Underwriting of new business is performed on a "whole group" basis. When submitting a new group, all full-time, eligible employees must submit an application. Information contained in both the employer and employee applications will be used to determine the risk and the rates to be used for the group as a whole. If the group meets the eligibility requirements, all eligible applicants will be covered. Proposed rates and actual rates may differ if the enrollment census changes from the proposal census or due to additional medical risk disclosed at enrollment. All groups are classified by industry based on the Standard Industrial Classification. Certain industries are considered unstable, hazardous or high risk and will require an additional premium.

General Exclusions and Limitations

The following list of exclusions varies by state, see the Community Flex State Variations page for details. Some of the services that Community Flex does NOT cover include:

Pre-existing conditions for the 2 year period starting on the effective date of coverage. Benefits will be paid for a sickness, injury or condition that existed prior to the effective date of the policy/ certificate, if approved, only if such sickness, injury, or condition is fully disclosed on the application and is not excluded from coverage by a rider or policy/ certificate exclusion.; Charges in excess of the usual, customary, and reasonable charges for non-network services and supplies; Charges for services that are experimental, investigational, unproven or for research; Charges arising from war, commission of a felony, or participation in a riot or insurrection; Any sickness contracted or injury received while a member of the military; Charges for sickness or injury that are covered by workers' compensation insurance or similar laws; Treatment given in a hospital emergency room for a non-emergency sickness or injury; Prescription Drugs, unless the prescription drug benefit is purchased; Vitamins, supplements ; Services and supplies related to alternative and complementary medicine; Breast reductions; Treatment, testing, and surgical intervention of sleep disorders (e.g., sleep apnea); Learning disabilities, Attention Deficit Hyperactivity Disorders; Charges for dental services or supplies, unless the dental benefit rider is purchased; Cosmetic treatment, except as provided in the policy; Care covered under a government program; Eyeglasses, contact lenses, eye surgery; Artificial hearing devices, cochlear implants; Contraceptives, sterilization, voluntary abortion, infertility treatment; Treatment for hair loss restoration or removal; Treatment of acne; Treatment for mental or nervous disorders, or emotional conditions; Treatment for substance abuse; Examination, diagnosis, appliances or treatment of malocclusion, misalignment, dysfunction, deformity, defect of the jaw or TMJ; Charges for services that are not medically necessary; Services performed by volunteers or relatives; Services or supplies for comfort, convenience maintenance, custodial care, or non-medical expenses; Replacement, maintenance or repair of prosthetics or durable medical equipment; Suicide or attempted suicide; Gender reassignment, sexual function or dysfunction; Treatment of eating disorders or services and supplies for weight loss; Charges for smoking cessation; Genetic testing; Growth hormones; Charges for routine foot care; shoes, shoe accessories, or orthotics; Treatment for an injury received while engaging in a hazardous occupation or activity for which compensation is received; Charges due to an injury received while operating a motorized vehicle with a blood alcohol level above the legal limit; Charges for which benefits are not provided in the policy; Charges for travel or lodging expenses.

Community Flex™
State Variations

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This document is an addition to the Community Flex brochure.

Arizona

- ✓ Pre-existing condition is a medical condition for which medical advice or treatment was received or symptoms existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment within 60 months before effective date.
- ✓ There is no limit on Outpatient Spinal Manipulation
- ✓ Amino Acid Based Formula: $20,000 maximum per person per calendar year: Deductible then 75%
- ✓ Medical Foods: $5,000 maximum per person per calendar year: Deductible then 50%
- ✓ Patient costs in connection with a Cancer Clinical Trial are covered
- ✓ Preventive Care benefits are covered at a non-network provider
- ✓ There is no limit on Home Health Care

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).

Arkansas Continued

- ✓ 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
- ✓ 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
- ✓ Appliances or dental treatment of malocclusion, misalignment, dysfunction, deformity, defect of the jaw or TMJ are not 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

Illinois Continued

- ✓ 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

Indiana

- ✓ Pre-existing conditions are not covered for 12 months
- ✓ Pre-existing condition is a medical condition for which medical advice, diagnosis, care or treatment was recommended or received or symptoms existed that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within 12 months before effective date.
- ✓ The 12-month pre-existing condition waiting period may be reduced for the family member if covered by qualifying prior coverage
- ✓ Spinal Manipulations are not covered
- ✓ PSA Testing is not subject to the $1,000 preventive care maximum

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
- ✓ 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

Ohio Continued

- ✓ 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, dysmenorrheal, entherocele, 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

Oklahoma Continued

  - (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
- ✓ 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, hemorroids, varicose veins, inguinal hernia (other than a strangulated or incarcerated hernia), elective hysterectomy, amenorrhea, cystocele, dysmenorrheal, enterocele, rectocele, urethrocele, uterine prolapse

Texas Continued

- ✓ 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.

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