EXPLORE INSURANCE OPTIONS FOR YOUR **SHORT TERM NEEDS**

PAN AMERICAN
ACCIDENT & HEALTH

Short Term Medical Insurance issued by:
Pan-American Life Insurance Company

Billing, Fulfillment and Customer Service
administered by the Third-Party Administrator

H A Partners, Inc. and HealthyAmerica
409 W Vickery Blvd
Ft Worth, TX 76104
866-438-4274

SHORT TERM MEDICAL INSURANCE

BROCHURE

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WHAT IS SHORT TERM MEDICAL INSURANCE

Short Term Medical Insurance is designed for the temporary times when you are in-between traditional health insurance coverage.

Short term plans are medically underwritten and generally do not cover preexisting conditions. Short Term Medical Insurance coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. When enrolling in a Short Term Medical Insurance plan, be sure to check your policy/certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Short Term Medical Insurance policies/certificates might also have lifetime and/or annual dollar limits on health benefits. If this type of coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Short Term Medical Insurance is not Minimum Essential coverage as defined in the Affordable Care Act and may not cover all Essential Health Benefits in your state.

STUDENT COMING OFF PARENT OR COLLEGE PLAN

When a student graduates or is coming off their parents' plan and is in-between open-enrollments, Short Term Medical Insurance is a great fit to help continue coverage until employment group coverage or traditional insurance can be enrolled.

IN-BETWEEN JOB START DATES

When in-between coverage start dates for a new job, Short Term Medical Insurance can help with the gap in coverage until the new group insurance coverage begins. It can also be a temporary alternative to expensive COBRA coverage after leaving a job.

EXAMPLES

OF REASONS YOU MIGHT BE IN-BETWEEN COVERAGE

BETWEEN OPEN ENROLLMENTS

ACA Enrollments only occur during a select time each year. Short Term Medical Insurance is perfect for in-between open enrollment windows when Special Enrollment qualifications do not apply.

EARLY RETIREMENT

When healthy and retiring early and are in need of a short bridge before you are able to enroll in Medicare, Short Term Medical Insurance can be budget-friendly option.

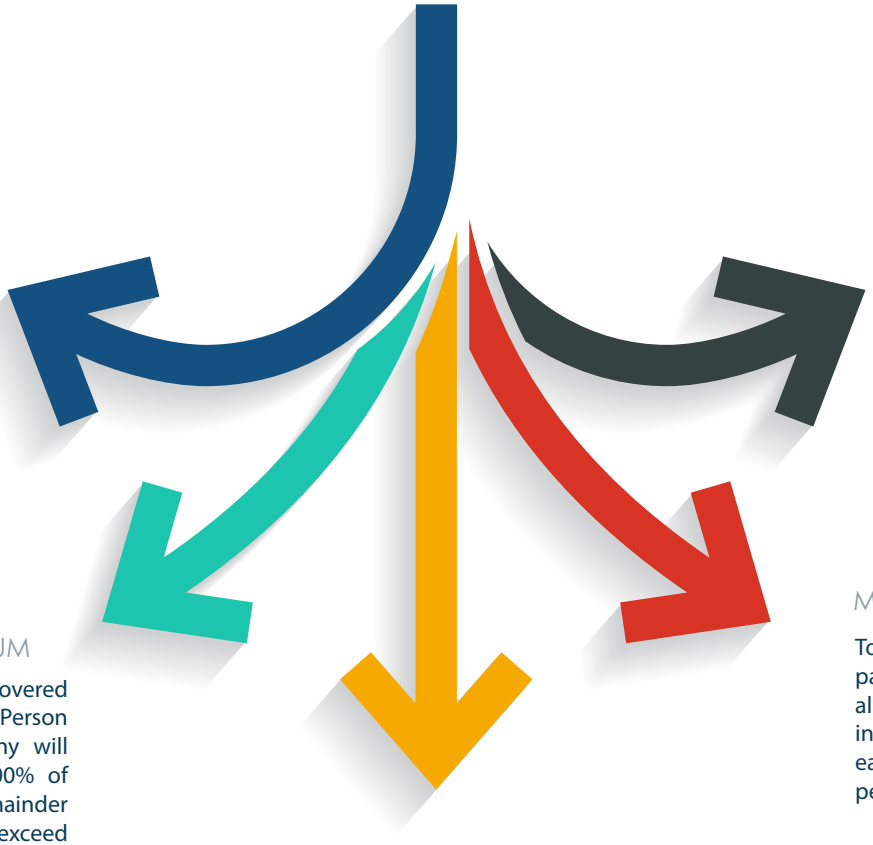
HOW DOES ACA COMPARE TO SHORT TERM MEDICAL INSURANCE

	Group Short Term Medical Insurance Plans†	ACA Individual Health Insurance Plans
Coverage for preexisting conditions	Generally preexisting conditions are not covered.*	ACA plans will not deny benefits due to your preexisting conditions.
Prescription Drug Coverage	Outpatient prescription drugs are not covered.	Covered as an essential health benefit.
Enrollment Availability of Coverage	Buy at any time of the year. Subject to medical underwriting.	Limited to Annual Open Enrollment (or during a Special Enrollment with a qualifying event).
Waiting Period	Coverage as early as the next day for injuries, 5 days for sickness, 30 days for cancer from effective date.	No waiting periods.
Length of Coverage	Coverage duration periods from 30 days to 364 days are available. (Coverage terms could vary depending on state)	Coverage duration available monthly usually for 12 months and renewable subject to new premiums.
Maximum Benefit	Maximum benefit per coverage duration period is $1,000,000. ($2,000,000 in Indiana)	Unlimited
Type of Coverage	Short Term medical insurance coverage. Plans are not required to include the 10 essential health benefits required by the ACA. Benefits will vary by plan and by state.	Comprehensive medical insurance coverage. All plans include the 10 essential health benefits required by the ACA.
Provider Network	Coverage does not include in-network providers and because there is no network patients may be balanced billed.	When insureds use in-network providers, they are not subject to balance billing.
Deductible and Coinsurance	Generally, you must pay all of the costs from providers up to the deductible amount you elected before the plan begins to pay. The coinsurance percentage is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. This will vary based on the plan you pick.	Generally, you must pay all of the costs from providers up to the deductible amount you elected before the plan begins to pay. The coinsurance percentage is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. This will vary based on the plan you pick.
Preventive or Wellness Care	Mammography, Pap Smear and Prostate Antigen Tests, Routine Physical Exams, and Routine Child Health Care are covered. Other preventive coverage is not included*. *(unless specifically stated in the Policy, Certificate and any applicable State Riders)	Preventive care is required in all ACA health plans.
Maternity Coverage	Maternity coverage is not available.	Covered as an essential health benefit.
Mental Illness and Substance Abuse Treatment	Mental Illness and Drug Abuse is covered but has maximums on the number of covered days and amount of benefit. Treatment for alcoholism is covered but has maximums on the number of covered days.	Covered as an essential health benefit.
Rehabilitative and Habilitative Services	Physical, Occupational and Speech Therapy are covered but have maximums on the number of covered days and amount of benefit.	Covered as an essential health benefit.

*PALIC Short Term Medical plans provide some limited benefits for preexisting conditions up to 50% of the Deductible for Covered Expenses. See page 8 for details.

†This description of Group Short Term Medical Insurance is only a broad description of the differences between ACA and Short Term Medical Insurance and may not be specific to the short term medical insurance issued by Pan-American Life Insurance Company (PALIC) and covered in this brochure. Coverage for Short Term Medical Insurance may vary or may not be available in all states.

SOME HELPFUL INSURANCE TERMS



DEDUCTIBLE

The amount of Covered Expenses, up to the Maximum Allowable Expense that each Covered Person must pay before benefits will be payable. The Deductible does not include any Copayment amounts. The Deductible does not apply towards the Coinsurance Maximum.

COVERAGE PERIOD

The length of time coverage is in force under the Certificate shown in the Schedule of Benefits.

COINSURANCE MAXIMUM

The maximum amount of Covered Expenses that the Covered Person will pay before the Company will begin paying benefits at 100% of Covered Expenses for the remainder of the Coverage Period, not to exceed the Coverage Period Maximum Benefit amount and any applicable maximum benefit amounts. The Coinsurance Maximum does not include Deductibles, Copayments, Pre-Authorization penalties, amounts in excess of the Maximum Allowable Expense and amount in excess of the maximum benefit amounts.

COVERAGE PERIOD MAXIMUM BENEFIT AMOUNT

Total aggregate amount of benefits payable under the Certificate for all Covered Expenses which are incurred for Sickness or Injury by each Covered Person during such person's Coverage Period.

COINSURANCE PERCENTAGE

The applicable percentage amount the Company will pay for Covered Expenses incurred by the Covered Person after satisfaction of the Deductible and any Copayments have been met.

USUAL, REASONABLE AND CUSTOMARY means:

1. With respect to fees or charges, fees for medical services or supplies which are: (a) usually charged by the provider for the service or supply given; and (b) the average charged for the service or supply in the locality in which the service or supply is received; whichever is less, or
2. With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.

In reaching a determination as to what amount should be considered as Usual, Reasonable and Customary for services and supplies, We may use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The database used reflects the amounts charged by providers for healthcare services based on geographic zip code areas generating a statistically credible charge distribution. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the database.

[1]This is a very brief description of the Short Term Medical plan issued by Pan-American Life Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. All benefits are limited to Usual, Reasonable and Customary Fees. Coverage is not limited to the benefits listed and eligible expenses are subject to plan limitations.

SHORT TERM MEDICAL OPTIONS

Choose a term period and an effective date that is right for you. Coverage Term Period options could vary based on state. See below for all options available with this Group Short Term Medical Insurance Plan issued by Pan-American Life Insurance Company.

3 MONTHS, 6 MONTHS, OR 12 MONTHS† TERM
Choose Your Term*

1ST OR 15TH EFFECTIVE DATE OPTIONS
Choose Your Effective Date

†12 month term option is 364 days and not 365 days.

* DE & VA only have the term option of 3 months.
IL, LA & NV only has the term options of 3 months or 6 months.
SC only has the term options of 3 months, 6 months or 11 months.

There is no continuous coverage. It is not renewable. Although this short-term plan may be rewritten for new and completely separate Coverage Periods (depending on state laws). If another coverage period is desired, a new enrollment form must be completely separate Coverage Periods (as long as eligibility criteria is met). Coverage does not continue from one Certificate to another. This means that a new enrollment Form must be submitted, a new Certificate date is given, and a new Pre-Existing Condition exclusion period begins. Any medical condition which may have occurred and /or existed under a prior Certificate will be treated as a Pre-Existing Condition under the new Certificate. Some states vary in allowing re-enrollments. Check below for some state conditions that apply to re-enrollment in this group short term insurance plan. The following states have provisions as to re-enrollments:

DE: Coverage is limited to no more than 3 months of coverage in a 365 day period.
IL: Coverage is limited to 6 months; must have a 60 day break in coverage before reapplication.
NV: Coverage is limited to no more than 6 months of coverage in a 365 day period.
SC: Coverage cannot exceed 33 consecutive months.
VA: Coverage is limited to 3 months. No more than 6 months in a 365 day period.
WI: Coverage cannot exceed 18 months. There must be a 63 day break in coverage between new enrollments.

ELIGIBILITY

Looking for coverage for you, your dependents or your entire family? Find out the eligibility requirements for enrollment in the Short Term Medical Insurance plan issued by Pan-American Life Insurance Company.

PRIMARY MEMBER

Ages 1 to under 65 years of age

Not covered as dependent under Group Policy

Not Pregnant at the time of application

Lived in U.S. for 12 consecutive months

Not an active member of the armed forces

Stand-alone Child Policy: coverage ages 1-17; one policy per stand-alone child.

ELIGIBLE DEPENDENTS

Spouse: Under 65 at time of application

All references to spouse shall include Domestic Partner (and in Illinois it includes Civil Union Partner)

Dependent Children^: Unmarried and under 26

(Eligible if required to provide insurance under medical support order or an order enforceable by a court.)

Children means natural children, step children, legally-adopted children, children placed with You for the purpose of adoption, and children subject to legal guardianship

Both Spouse & Dependent Children:

Not pregnant at time of application

Not an active member of the armed forces

Lived in U.S. for 12 consecutive months

^Dependent Children State Variations are listed below:

In Indiana, *remove the term "unmarried". Also includes children subject to legal guardianship who haven't yet reached age 26.*

In Illinois, *"Children" also includes children who are military veteran dependents under age 30 if the military veterans: (a) are Illinois residents; (b) are not married; (c) have served in the active or reserve components of the U.S. Armed Forces (which includes the National Guard); and (d) have received a release or discharge other than a dishonorable discharge.*

In Louisiana, *"Children" means natural children, stepchildren, legally-adopted children, children placed with You for the purpose of adoption, children who are placed in Your home following execution of an act of voluntary surrender in Your favor and children or grandchildren subject to Your legal guardianship.*

In Texas, *"Children" means natural children, stepchildren, legally-adopted children, children placed with You for the purpose of adoption, children for whom You are in a party in a suit which the adoption of such child by You is being sought and children subject to Your legal guardianship, including grandchildren who, at the time of application, can be claimed as a dependent on Your federal tax return. Coverage for a grandchild may not be terminated solely because he or she is no longer Your Dependent for federal tax purposes.*

Both member and eligible dependents must submit a written application for insurance and evidence of insurability, if evidence is required. and meet the enrollment and underwriting requirements.

HIGHLIGHTS[1] OF THE SCHEDULE OF BENEFITS	LIMITS FOR COVERED EXPENSES
Deductible Options When 3 insured individuals in a family satisfy their Deductibles, the Deductibles for any remaining insured individual in the insured family are deemed satisfied for the remainder of the Coverage Period.	**$5,000 or $10,000** per Covered Person, per Coverage Period
Coinsurance Percentage the Company Pays (Per Covered Person)	**80%** of Covered Expenses, after the Deductible has been satisfied. The Company will pay 100% of Covered Expenses per Coverage Period once the Coinsurance Maximum has been met.
Coinsurance Maximum (Per Covered Person)	**$10,000** of Covered Expenses per Coverage Period. Deductibles, Copayments, Pre-Authorization penalties, amounts in excess of the Maximum Allowable Expense charge and any amounts in excess of the maximum benefit amounts do not apply towards the Coinsurance Maximum.
Coverage Period Maximum Benefit Amount	**$1,000,000** per Covered Person ($2,000,000 in Indiana)
Pre-Existing Conditions Allowance Maximum Benefit	**Up to 50%** of the Deductible of Covered Expenses incurred for a Pre-Existing Condition. Payment of any benefits, including application to the Deductibles and Coinsurance under this Allowance does not waive, or in any manner whatsoever affect, any of the Covered Person's Exclusions or Limitations, including the Pre-Existing Conditions exclusion.
Annual Routine Physical Exam (Maximum Benefit Per Covered Person)	**$50 Copayment** After a $50 Copayment, the Company will pay 100% of the Coinsurance Percentage for all Covered Expenses. **The Deductible will not apply**. This benefit is payable one time per 12 month period.
Doctor Office or Urgent Care Center Visits (Maximum Benefit Per Covered Person - Covered Expenses for any other Covered services or tests performed as part of the visit will be subject to the Deductible and Coinsurance.)	**$40 Copayment** After $40 Copayment, the Company will pay 100% of the Coinsurance Percentage for Covered Expenses and the **Deductible will not apply**.
Mammography, Pap Smear and Prostate Antigen Tests (Maximum Benefit Per Covered Person)	The Company will pay the Coinsurance percentage for all Covered Expenses. **The Deductible will not apply.**
Routine Child Health Care (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. **The Deductible will not apply to immunizations.** **Covered Expenses for any other covered services or tests performed as part of the visit will be subject to the Deductible and Coinsurance.**
In Hospital Regular Care (Maximum Benefit Per Covered Person)	After the Deductible is satisfied, the Company will pay the Coinsurance Percentage **not to exceed the average standard room rate charged by the Hospital, including all Inpatient Miscellaneous Medical Expenses charged or billed by the Hospital for that day**. Covered Expenses are subject to the Deductible and Coinsurance.
In Hospital Intensive or Critical Care Emergency Room Treatment (Maximum Benefit Per Covered Person)	After the Deductible is satisfied, the Company will pay the Coinsurance Percentage **not to exceed 3 times the average standard room rate for each day in an Intensive Care Unit, including all Inpatient Miscellaneous Medical Expenses charged or billed by the Hospital for that day.** Covered Expenses are subject to the Deductible and Coinsurance.
Ambulance Air or Ground (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum benefit of $1,000 per incident.**

[1]This is a very brief description of the Short Term Medical plan and Covered Expenses issued by Pan-American Life Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states**. Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. All benefits are limited to Usual, Reasonable and Customary Fees. Coverage is not limited to the benefits listed and eligible expenses are subject to plan limitations. If there are any discrepancies between this brochure and the Certificate, the Certificate will govern.

HIGHLIGHTS[1] OF THE SCHEDULE OF BENEFITS	LIMITS FOR COVERED EXPENSES
Inpatient Doctor Visits, Ambulatory Surgical Center or Outpatient Hospital Facility, Surgeon Services, Knee Injury or Disorder Surgery, Gallbladder Surgery, Temporomandibular Joint Disorder (TMJ), Kidney Stones, Appendectomy, Joint or Tendon Surgery, Outpatient Miscellaneous Medical Expense Services.	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. **Covered Expenses are subject to the Deductible and Coinsurance**.
Organ or Tissue Transplant (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $50,000 per Coverage Period**.
Hospice Care (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $5,000 per Coverage Period**.
Acquired Immune Deficiency Syndrome (AIDS) (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $10,000 per Coverage Period** **AZ, FL, GA, IN, KY, TN & TX:** The maximum of $10,000 per Coverage Period is not applicable.
Anesthesia Services, Assistant Surgeon, Surgeon's Assistant (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum benefit of 20% of the Surgeon Services' benefit.**
Inpatient Mental Illness, Inpatient Substance Abuse (Maximum Benefit Per Covered Person) (In TX it is Inpatient Chemical Dependency and not Inpatient Substance Abuse and in NE it is Inpatient Drug Abuse instead of Inpatient Substance Abuse.)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $100 per day, and will not exceed a maximum of 30 days, per Coverage Period**. **KY & TX**: Limit of $100 per day and maximum of 30 days is not applicable. **NV:** replaces the limit above to: Covered Expenses will not exceed a maximum of $9,000 per calendar year per Coverage Period.
Outpatient Mental Illness Outpatient Substance Abuse (Maximum Benefit Per Covered Person) (In TX it is Outpatient Chemical Dependency and not Outpatient Substance Abuse and in NE it is Outpatient Drug Abuse instead of Outpatient Substance Abuse.)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $100 per visit, and will not exceed a maximum of 10 visits, per Coverage Period**. **KY & TX:** Limit of $100 per visit and maximum of 10 visits is not applicable. **NV:** replaces the limit above to: Covered Expenses will not exceed a maximum of $1,500 per calendar year for the treatment of withdrawal and a maximum of $2,500 per calendar year for counseling when not admitted to a facility.
Therapy Services (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum benefit of $100 per day. The maximum number of days for all therapies combined is 20 days per Coverage Period.** **TX:** These limits do not apply to the Autism Spectrum Benefit or the Acquired Brain Injury Benefit
Extended Care Facility (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $150 per day, and will not exceed a maximum of 30 days, per Coverage Period**.
Home Health Care (Maximum Benefit Per Covered Person)	After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses are subject to the Deductible and Coinsurance. **Covered Expenses will not exceed a maximum of $50 per visit, and will not exceed a maximum of 30 visits, per Coverage Period**. **KY & TX** have a maximum of 60 visits not 30 visits.
Waiting Period	5 days for Sickness, 30 days for cancer from Eeffective date. 6 months for various covered surgeries.

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COVERED EXPENSES

The following Covered Expenses will be paid which are prescribed or provided by a Doctor for a covered Injury or Sickness. Covered Expenses for the same treatment or service that are applicable to more than one benefit limitation shown in the Schedule of Benefits on the Certificate of Insurance will be applied toward all applicable limitations. Covered Expenses do not include Expenses which are in excess of any maximum amounts shown in the Schedule of Benefits. Expenses in excess of any maximum amounts shown in the Schedule of Benefits do not apply to the Deductible or the Coinsurance Maximum.

For full state-specific details and descriptions of each of the Covered Expenses, review the Certificate of insurance, Policy and any applicable State Riders. Certain state mandates are subject to change as required by state law.

- Hospital Room, Board, General Nursing Care
- Intensive or Critical Care Unit
- Emergency Room Treatment
- Inpatient Doctor Visits
- Inpatient Mental Illness
- Inpatient Substance Abuse
- Doctor Office Visits
- Annual Routine Physical Exam
- Routine Child Health Care
- Ambulatory Surgical Center or Outpatient Hospital Facility
- Surgeon's Services
- Anesthesia Services
- Assistant Surgeon
- Surgeon's Assistant
- Complications of Pregnancy
- Cosmetic or Reconstructive Surgery
- Breast Reconstructive Surgery
- Ambulance Services
- Prescriptions or Legend Drugs
- Dental Treatment
- Therapy Treatment
- Mammography, Pap Smear and Prostate Antigen Test
- Outpatient Mental Illness
- Outpatient Substance Abuse
- Extended Care Facility
- Hospice Care and Services
- Organ or Tissue Transplants
- Acquired Immune Deficiency Disorder (AIDS)
- Knee Injury or Disorder Surgery
- Gallbladder Surgery
- Temporomandibular Joint Disorder (TMJ)
- Kidney Stones
- Appendectomy
- Joint and Tendons Surgery
- Blood or Blood Plasma
- Artificial limbs or eyes
- Casts
- Equipment Rental
- Diagnostic Testing Services
- Radiation Therapy and Chemotherapy Services

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ADDITIONAL OR VARIATIONS OF COVERED EXPENSES:

For full state-specific details and descriptions of each of the Covered Expenses, review the Certificate of Insurance, Policy and any applicable State Riders.

Below are a list of Covered Expenses that are either ● in addition to the Covered Expenses shown in the Certificate or ● have variations in the language from the Certificate based on the State Rider to the Certificate.

ARIZONA
- ● Telehealth Services
- ● AIDS
- ● Home Health Care

ARKANSAS
- ● Colorectal Cancer Screening
- ● Speech or Hearing
- ● Craniofacial Anomaly Corrective Surgery
- ● Orthotic & Prosthetic Devices
- ● Telemedicine
- ● Diabetes
- ● Amino Acid Metabolism
- ● Gastric Pacemakers
- ● Autism Spectrum Disorders
- ● Intravenous Immunoglobulin
- ● Breast Reconstructive Surgery
- ● Routine Child Health Care
- ● Mammography, Pap Smear & Prostate Antigen Test

DELAWARE
- ● Colorectal Cancer Screening
- ● Ovarian Cancer
- ● Lead Poison Test
- ● Scalp Hair Prosthesis
- ● Medical Formulas & Foods
- ● Biologically-Based Mental Illness
- ● Mammography, Pap Smear & Prostate Antigen Test

FLORIDA
- ● Cleft Lip & Cleft Palate
- ● Osteoporosis
- ● AIDS
- ● Anesthesia Services
- ● Breast Reconstructive Surgery
- ● Mammography, Pap Smear & Prostate Antigen Test

GEORGIA
- ● AIDS

ILLINOIS
- ● Inpatient Alcoholism
- ● Dental Anesthesia
- ● Colorectal Cancer Screening & Fecal Occult Blood Testing
- ● Clinical Breast Examination
- ● Vaccinations
- ● Amino Acid-Based Elemental Formulas
- ● Diabetes
- ● Breast Reconstructive Surgery
- ● Mammography, Pap Smear & Prostate Antigen Test

INDIANA
- ● Telehealth Services
- ● AIDS

KENTUCKY
- ● Breast Cancer
- ● Inpatient Mental Illness
- ● Outpatient Mental Illness
- ● AIDS
- ● Temporomandibular Joint Disorder
- ● Mammography, Pap Smear & Prostate Antigen Testing (PSA)

MISSISSIPPI
- ● Autism Spectrum Disorder
- ● TMJ & Craniomandibular Disorder

NEBRASKA
- ● Autism
- ● Diabetes
- ● Primary Treatment or Outpatient Treatment for Alcoholism
- ● Colorectal Cancer (>6 month term required)
- ● Telehealth
- ● Drug Abuse (replaces term Substance Abuse)
- ● Routine Child Health Care
- ● Screening Mammogram, Pap Smear, & Prostate Antigen Testing (PSA)
- ● Radiation Therapy & Chemotherapy
- ● TMJ & Craniomandibular Disorder

NEVADA
- ● Colorectal Cancer Screening
- ● Human Papillomavirus Vaccine (HPV)
- ● Outpatient Health Care
- ● Women's Health Benefits
- ● Severe Mental Illness
- ● Clinical Trial
- ● Inherited Metabolic Disease
- ● Diabetes
- ● Telehealth
- ● Contraceptive for Female Covered Persons
- ● Inpatient & Outpatient Substance Abuse
- ● Breast Reconstructive Surgery
- ● Mammography, Pap Smear & Prostate Antigen Test

OHIO
- ● Alcoholism
- ● Autism Spectrum Disorder
- ● Mammography, Pap Smear & Prostate Antigen Test
- ● Routine Child Health Care
- ● Radiation Therapy & Chemotherapy Services

SOUTH CAROLINA
- ● Diabetes
- ● Cleft Lip or Cleft Palate
- ● Mammography, Pap Smear & Prostate Antigen Test
- ● Breast Reconstructive Surgery

TENNESSEE
- ● Hearing Aids
- ● Treatment of Phenylketonurias
- ● Telehealth Services
- ● Diabetes
- ● AIDS
- ● Breast Reconstructive Surgery

TEXAS
- ● Screening for Hearing Loss
- ● Screening for Dependent Child for Autism Spectrum Disorder
- ● Hearing Aids or Cochlear Implants
- ● Treatment of Phenylketournia (PKU)
- ● Cardiovascular Screening
- ● Diabetes
- ● Acquired Brain Injury
- ● Clinical Trials
- ● Bone Mass Measurement
- ● Telemedicine
- ● Colorectal Cancer Screening
- ● Prosthetic Device & Orthotic Device
- ● Inpatient & Outpatient Mental Illness
- ● Inpatient & Outpatient Chemical Dependency (replaces term Substance Abuse)
- ● Breast Reconstructive Surgery
- ● TMJ
- ● Radiation & Chemotherapy Services
- ● Therapy Services
- ● Routine Child Health Care
- ● AIDS
- ● Mammography, Pap Smear & Prostate Antigen Tests (PSA)

WEST VIRGINIA
- ● Rehabilitative Services
- ● Diabetic Equipment & Supplies
- ● Colorectal Cancer Examination & Laboratory
- ● Recognized Chronic Pain Treatment Alternatives
- ● Mammography, Pap Smear & Prostate Antigen Test
- ● TMJ & Craniomandibular Disorder

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LIMITATIONS & EXCLUSIONS

Benefits will not be paid for loss or expense caused by or resulting from any of the following:

1. Expenses for the treatment of Pre-existing Conditions, as defined in the Pre-existing Conditions Limitation provision.
2. Expenses incurred during the waiting period:
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Effective Date of coverage under the Certificate.
   (**TX #2a** exclusion replaces this exclusion with the following: a. Covered Persons will only be entitled to receive benefits for Sicknesses 5 days following the Covered Person's Effective Date of coverage under the Certificate.)
   b. Covered persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person's Effective Date of coverage under the Certificate.
   (**TX #2b** exclusion replaces this exclusion with the following: b. Covered Persons will only be entitled to receive benefits for Cancer 30 days following the Covered Person's Effective Date of coverage under the Certificate.)
3. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision.
4. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Group Policy.
5. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
   (**TN #5** exclusion replaces this exclusion with the following: Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment. Clinical trials will not be the sole basis for denial of coverage.)
   (**TX #5** exclusion replaces this exclusion with the following: Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment. The Covered Person has a right to contact an independent review organization for any denials of Experimental Treatment.)
6. Amounts in excess of the Maximum Allowable Expense for covered services or supplies.
7. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
   (**TN #7** exclusion replaces this exclusion with the following: Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed. This does not apply to charges for services rendered by a non-governmental charitable research hospital because it bills patients for services rendered, but does not enforce by judicial proceedings collection from individual patients in the absence of insurance coverage.)
8. Expenses that do not meet the definition of or are not specifically identified under the Group Policy as Covered Expenses.
9. Expenses for purposes determined by Us to be educational.
   (**TN #9** exclusion replaces this exclusion with the following: Expenses for purposes determined by Us to be educational. This does not apply for Covered Expenses under the Diabetes benefit.)
   (**TX #9** exclusion replaces this exclusion with the following: Expenses for purposes determined by Us to be educational, except as specifically covered.)
10. Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.
    (**OH #10** exclusion replaces this exclusion with the following: Expenses to the extent that they are paid or payable under another group insurance or medical prepayment plan.)
    (**This #10 Exclusion is not applicable in TN or VA**.)
11. Charges that are eligible for payment by Medicare or any other government program except Medicaid.
12. Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
    (**TX #12** exclusion replaces this exclusion with the following: Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care. The Company will not exclude expenses of a non indigent patient incurred in a hospital facility that: (a) is owned or controlled by the state or by a unit of local government; and (b) regularly and customarily demands and collects from non indigent persons payment for those expenses.)
13. Expenses related to Injury or Sickness a rising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or worker's compensation insurance pursuant to applicable state or federal law, whether or not application for such benefits has been made.
    (**KY #13** exclusion replaces this exclusion with the following: Expenses related to Injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or workers' compensation insurance pursuant to applicable state or federal law, which such benefits are paid.)

14. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).
    (**This #14 Exlusion is not applicable in VA**.)
15. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to You on a pro-rated basis.
16. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
17. Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault.
    (**LA #17** exclusion replaces this exclusion with the following: Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault. This does not apply while detained in a correctional facility and the Covered Person has not been adjudicated or convicted of a criminal offense.)
    (**NV #17** exclusion replaces this exclusion with the following: Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault. This is not applicable to Expenses sustained solely due to an act of domestic violence, regardless of whether the Covered Person contributed to any loss or Injury.)
18. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy.
19. Expenses for voluntary termination of normal pregnancy or elective cesarean section.
    (**KY #19** exclusion replaces this exclusion with the following: Expenses for elective abortion. "Elective Abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.)
20. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth.
    (**NV #20** exclusion replaces this exclusion with the following: Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or child birth, except as specifically covered.)
21. Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, in vitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate.
    (**KY #21** exclusion replaces this exclusion with the following: Expenses for the diagnosis and treatment of infertility, any attempt to induce fertilization by any method in vitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate.
22. Expenses for sterilization or reversal of sterilization.
    (**NV #22** exclusion replaces this exclusion with the following: Expenses for male sterilization or reversal of male sterilization.)
23. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness or Sickness or Injury sustained during or after birth, and except as state mandates.
24. Expenses for sex transformation or penile implants or sex dysfunction or inadequacies.
25. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.
26. Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered.
27. Expenses for the treatment of mental illness or nervous disorders, including but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind; except as specifically covered.
    (**GA #27** exclusions replaces this exclusion with the following: Expenses for the treatment of mental illness or nervous disorders, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, hyperactivity, or mental or emotional disease or disorder of any kind.)
    (**TN #27** exclusion replaces this exclusion with the following: Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, hyperactivity, or mental or emotional disease or disorder of any kind; unless it is specifically covered.)
    (**TX #27** exclusion replaces this exclusion with the following: Expenses for the treatment of mental illness ,except as specifically covered.)

28. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; except as specifically covered.
    (**GA #28** exclusion replaces this exclusion with the following: Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addition.
    (**This #28 exclusion is not in the exclusions in the Texas Certificate and not applicable in TX**.)
29. Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor. Intoxication shall be established conclusively by a blood alcohol level o f.10 or the legal limit in the state where the incident occurred, whichever is less.
    (**NV #29** exclusion replaces this exclusion with the following: Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic, unless administered on the advice of a Doctor, which a contributing cause to the Injury was the Covered Person's commission of or attempt to commit a felony. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less.)
    (**IL #29** exclusion adds the following statement to this exclusion: Emergency Expenses are covered.)
    (**This exclusion is the same as TX #28 exclusion.)**
30. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation.
    (**NV #30** exclusion replaces this exclusion with the following: Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation, except as specifically covered.)
    (**This exclusion is the same as TX #29 exclusion**.)
31. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane.
    (**NV #31** exclusion replaces this exclusion with the following: Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane. Self-inflicted Injury or Sickness caused by or related to a severe mental illness will be covered.)
    (**This exclusion is the same as TX #30 exclusion**.)
32. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered. (**This exclusion is the same as TX #31 exclusion**.)
33. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered.
    (**This exclusion is the same as TX #32 exclusion**.)
34. Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription glasses or contact lenses, the purchase, fitting or adjustments of eyeglasses or contact lenses, or treatment of cataracts. (**This exclusion is the same as TX #33 exclusion**.)
35. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids.
    (**AR & TN #35** exclusions & **TX #34** exclusion replace this exclusion with the following: Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids, except as specifically covered.)
36. Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered.
    (**This exclusion is the same as TX #35 exclusion**.)
37. Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered.
    (**This exclusion is the same as TX #36 exclusion**.)
38. Outpatient Prescription or Legend Drugs, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the counter medicines, whether or not ordered by a Doctor, unless it is specifically included as a Covered Expense. This does not include Prescription or Legend drugs administered by a Doctor in an inpatient or outpatient setting in conjunction with a Covered Expense, unless they are drugs that can be self-administered. (**This exclusion is the same as TX #37 exclusion**.)
39. Expenses incurred in conjunction with any drug or other item used to treat hair loss.
    (**This exclusion is the same as TX #38 exclusion**.)

40. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or the prompt repair of an Injury sustained while coverage is in force for the Covered Person.
    (**This exclusion is the same as TX #39 exclusion**.)
41. Expenses incurred in the treatment of acne, or varicose veins. (**This exclusion is the same as TX #40 exclusion**.)
42. Expenses of weight loss programs or diets. (**This exclusion is the same as TX #41 exclusion**.)
43. Transportation Expenses, except as specifically covered. (**This exclusion is the same as TX #42 exclusion**.)
44. Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Extended Care Facility, or home for the aged, whether or not part of a Hospital, except as specifically covered. (**This exclusion is the same as TX # 43 exclusion**.)
45. All charges incurred while confined primarily to receive custodial or convalescent care, unless it is specifically covered.
    (**This exclusion is the same as TX #44 exclusion**.)
46. Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops.
    (**KY #46** exclusion replaces this exclusion with the following: Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops.)
    (**This exclusion is the same as TX #45 exclusion**.)
47. Expenses for services or supplies furnished or provided by a member of Your Immediate Family.
    (**This #47 Exclusion is not applicable in AZ**.)
    (**This exclusion is the same as TX #46 exclusion but replaces the exclusion language with the following**: Expenses for services or supplies furnished or provided by a member of Your Immediate Family, except a dentist.)
48. Expenses for diagnosis or treatment of a sleeping disorder. (**This exclusion is the same as TX #47 exclusion**.)
49. Expenses incurred in the treatment of Injury or Sickness resulting from participation, instructing, demonstrating, guiding, or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by an airline; extreme sports: hot-air ballooning; skydiving, scuba diving, hang or ultra-light gliding, base jumping, rock or mountain climbing, bungee jumping, sail gliding, parasailing, para kiting, cave exploration, parkour; riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart; racing with a motorcycle, boat or any form of aircraft; racing including stunt show or speed test of any motorized or non-motorized vehicle; any participation in sports for pay or profit; participation in rodeo contests; or similar hazardous activities.
    (**This exclusion is the same as TX #48 exclusion, however TX removes** mountain climbing in its exclusion language.)
50. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator).
    (**This exclusion is the same as TX #49 exclusion**.)
51. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifies, air conditioners, allergenic mattresses, and blood pressure kits. (**This exclusion is the same as TX #50 exclusion**.)
52. Expenses during the first 6-months after the Effective Date of coverage for a Covered person for: (a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; or (g) herniorraphy; (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion).
    (**KY #52** exclusion replaces this exclusion with the following: Expenses during the first 6-months after the Effective Date of coverage for a Covered Person for: (a) total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; (b) tonsillectomy; (c) adenoidectomy; (d) repair of deviated nasal septum or any type of surgery involving the sinus; (e) myringotomy; (f) tympanotomy; or (g) herniorraphy; (subject to all other coverage provisions, including the Pre-existing Conditions exclusion).)
    (**IL #52** exclusion removes this statement from the first sentence: during the first 6 months after the Effective Date of Coverage Period.)
    (**This exclusion is the same as TX #51 exclusion**.)

53. Expenses for participating in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities. (**This exclusion is the same as TX #52 exclusion**.)
54. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions.
    (**IL & IN #54** exclusions replace this exclusion with the following exclusion: Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions, unless specifically covered.)
    (**This exclusion is the same as TX #53 exclusion, however the language in the exclusion is replaced with the following**: Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions, unless specifically covered. This does not include Emergency Care Services.)
55. Expenses for private duty nursing services. (**This exclusion is the same as TX #54 exclusion**.)
56. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment.
    (**This exclusion is the same as TX #55 exclusion**.)
57. Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace.
    (**AR & WV #57** exclusion replaces this exclusion with the following: Expenses for orthotics (except as specifically covered), special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace.)
    (**TN #57** exclusion replaces this exclusion with the following: Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace. This does not apply for Covered Expenses under the Diabetes benefit.
    (**This exclusion is the same as TX #56 exclusion, however the language of the exclusion is replaced with the following**: Expenses for orthotics (except as specifically covered), special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace.)
58. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas.
    (NV #58 exclusion replaces this exclusion with the following: Expenses incurred in connection with the voluntary taking of a poison or inhaling gas, unless caused by or related to severe mental illness.)
    (**This exclusion is the same as TX #57 exclusion**.)
59. Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight. (**This exclusion is the same as TX #58 exclusion**.)
60. Expenses for marital counseling or social counseling. (**This exclusion is the same as TX #59 exclusion**.)
61. Expenses for acupuncture. (**This exclusion is the same as TX #60 exclusion**.)
62. Expenses for a service or supply whose primary purpose is to provide a Covered Person with: (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored.
    (**This exclusion is the same as TX #61 exclusion, however the language for the exclusion is replaced with the following**: Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored, except as specifically covered.)
63. Expenses for replacement of artificial limbs or eyes. (**This exclusion is the same as TX #62 exclusion**.)
64. Expenses for removal of breast implants. (**This exclusion is the same as TX #63 exclusion**.)
65. Chronic fatigue or pain disorders.
    (**WV #65** exclusion replaces this exclusion with the following: Chronic fatigue or pain disorders, except as specifically covered.)
    (**This exclusion is the same as TX #64 exclusion**.)

66. Kidney or end stage renal disease.
    (**This #66 Exclusion is not applicable in TN.**)
    (**This exclusion is the same as TX #65 exclusion**.)
67. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
    (**This exclusion is the same as TX #66 exclusion**.)
68. Biofeedback, acupuncture, recreational, sleep or mist therapy, holistic care of any nature, massage and kinestherapy, except as provided for under Home Health Care.
    (**LA #68** exclusion replaces this exclusion with the following: Biofeedback, acupuncture, recreational, sleep or mist therapy, holistic care or any nature, massage (except chiropractic care) and kinestherapy, excepted as provided for under Home Health Care.)
    (**This is the same as TX #67 exclusion**.)
69. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and biofeedback and non-medical self-care or self-help programs. (**This is the same as TX #68 exclusion**.)
70. Failure to keep a scheduled appointment. (**This is the same as TX #69 exclusion**.)
71. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus. (**This is the same as TX #70 exclusion**.)
72. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
    (**KY #72** exclusion replaces this exclusion with the following: Treatment incurred as a result of the Covered Person being directly involved in the release of non-medical nuclear radiation and/or radioactive material(s).)
    (**This is the same as TX #71 exclusion**.)

FL Additional Exclusion:
Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or related immunodeficiency disorders will be excluded if, in the opinion of a legally qualified Doctor, the Covered Person first exhibited, prior to the end the end of the Covered Person's Coverage Period, objective manifestations of AIDS or ARC, as defined by the Centers for Disease Control and Prevention, which objective manifestations are attributable to no other cause or was diagnosed as having AIDS or ARC.

PRE-EXISTING CONDITIONS & SHORT TERM

Short Term plans are medically underwritten and generally do not cover pre-existing conditions. Look below for the Pre-Existing Condition Limitation[1] with the Short Term Medical Insurance issued by Pan-American Life Insurance Company.

PRE-EXISTING CONDITION LIMITATION

Benefits will not be provided for any loss caused by, or resulting from, a Pre-existing Condition.

"Pre-existing Condition" means any medical condition or sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the 24 months (6 months for GA, MS & WY) (12 months for IN, SC & TX) immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the 24 months (6 months for MS) (12 months for IN & SC) immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment. *(This statement is removed in NE, TX, WI, & WY.)*

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit. This limitation does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with Eligibility provision.

This limitation does not apply to any Covered Expense payable for Pre-existing Conditions until the Pre-existing Allowance Maximum benefit shown in the Schedule of Benefits of the Certificate of Insurance has been reached.

STATE VARIATIONS OF PRE-EXISTING CONDITION

FL *adds the following statement* *to Pre-existing Conditions Limitation: Routine follow-up care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow-up care.*

GA *adds the following statement to #1* *of the Pre-Existing Conditions Limitation: The condition at issue must be the ultimate condition for which medical advice or treatment was recommended by or received from a provider of health care services and excludes any preventive services. "Preventive Services" means screening tests, counseling, and preventive medicines, or treatments provided or conducted to prevent medical illness or condition prior to symptoms or physical manifestations of such medical illness or conditions; or.*

SC *Pre-existing Condition Limitation has variances which* ***removes the last paragraph that starts with "This limitation does not apply", and replaces it with****: A Covered Person will be given credit for satisfaction of the pre-existing condition period already satisfied under qualifying prior coverage if that person applies for coverage under the Group Policy when first eligible and the coverage is continuous to a date note more than 30 days prior to the Covered Person's Effective Date of coverage under the Group Policy.*

NE, TX & WI *Pre-existing Condition Limitation* ***removes #2****.*

WY *Pre-existing Condition Limitation has variances. WY #1 is 6 months and not 24 months.* ***WY #2 replaces #2 with****: A pregnancy existing on the Effective Date.)*

[1]This is a very brief description of the Short Term Medical plan issued by Pan-American Life Insurance Company. **For full details, limitations, exclusions, and terms of coverage, review the Policy, Certificate of Insurance and/or Riders in your state. Coverage and benefits may vary or may not be available in all states.** Definitions of each Covered Expense is provided in the Certificate of Insurance. Please review for full details. All benefits are limited to Usual, Reasonable and Customary Fees. Coverage is not limited to the benefits listed and eligible expenses are subject to plan limitations.

 STM limitations, exclusions, terms and conditions may vary by state law. Please check the product certificate or master policy for complete details.

IMPORTANT DISCLOSURES

Review the state-specific Certificate of Insurance for all disclosures, disclaimers, terms, conditions, definitions, claim provisions, and premium provisions specific to your state.

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK THE CERTIFICATE CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PRE-EXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOSPITALIZATION, EMERGENCY SERVICES, MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS, MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER SERVICES). THIS COVERAGE ALSO HAS LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. THIS INFORMATION IS A BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF THIS INSURANCE PLAN. COVERAGE MAY NOT BE AVAILABLE IN ALL STATES OR CERTAIN TERMS MAY BE DIFFERENT WHERE REQUIRED BY STATE LAW. PRE-EXISTING CONDITIONS ARE NOT COVERED, AND BENEFITS ARE SUBJECT TO THE POLICY LIMITATIONS AND EXCLUSIONS. REFER TO THE POLICY, CERTIFICATE AND RIDERS FOR COMPLETE DETAILS. IF FOR ANY REASON YOU ARE NOT SATISFIED WITH THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 10 DAYS (30 DAYS FOR INDIANA & LOUISIANA) AFTER YOU RECEIVE IT. WE WILL REFUND ANY PREMIUM PAID AND YOUR COVERAGE ISSUED UNDER THE GROUP POLICY WILL BE DEEMED VOID, JUST AS THOUGH COVERAGE HAD NOT BEEN ISSUED. GROUP SHORT TERM LIMITED DURATION POLICY IS ISSUED BY PAN-AMERICAN LIFE INSURANCE COMPANY ON FORM NUMBER STM-POL-19-IL AND CERTIFICATE FORM NUMBER STM-CRT-19.

STATE SPECIFIC DISCLOSURES

Unless specifically changed in the Certificate or a State Rider, the following applies.

The Certificate is a part of, and is governed by, a Group Policy that has been issued in the state of: Illinois

ARIZONA ADDITIONAL DISCLOSURE:

The benefits providing Your coverage are governed primarily by the laws of a state other than Arizona.

ARKANSAS ADDITIONAL DISCLOSURE:

Any Certificates issued in Arkansas will be governed by the State of Arkansas.

Policyholder Service Office of Company:
409 W Vickery Blvd, Fort Worth, TX 76104
Toll-Free Telephone Number: 866-438-4274

If we fail to provide you with reasonable and adequate service, you should feel free to contact:
Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102, Little Rock, Arkansas 72202
Telephone: (501) 371-2640 or Toll-Free: 800-852-5494

DELAWARE ADDITIONAL DISCLOSURE:

- This coverage is NOT required to comply with certain federal market requirements for health insurance, principally those contained in the AFFORDABLE CARE ACT.
- Be sure to check your Certificate carefully to make sure you are aware of any EXCLUSIONS or LIMITATIONS regarding coverage of PREEXISTING CONDITIONS or HEALTH BENEFITS (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services).
- Be sure to check Your Certificate carefully to make sure you are aware of any LIFETIME and/or ANNUAL DOLLAR LIMITS on health benefits.
- If this coverage expires or you lose eligibility for this coverage, YOU MIGHT HAVE TO WAIT until an open enrollment period to get other health insurance coverage.
- This coverage is NOT "MINIMUM ESSENTIAL COVERAGE." If you don't have minimum essential coverage for any month in 2019 or thereafter and the penalty for not having minimum essential coverage is more than the 2018 amount of $0, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

The total Coverage Period will not exceed 3 months within a 365 day period.

FLORIDA ADDITIONAL DISCLOSURE:

The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

ILLINOIS ADDITIONAL DISCLOSURE:

NOTICE: THE SHORT-TERM, LIMITED-DURATION INSURANCE BENEFITS UNDER THIS COVERAGE DO NOT MEET ALL FEDERAL REQUIREMENTS TO QUALIFY AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT. THIS PLAN OF COVERAGE DOES NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS AS REQUIRED BY THE AFFORDABLE CARE ACT. PREEXISTING CONDITIONS ARE NOT COVERED UNDER THIS PLAN OF COVERAGE. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOES NOT COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. YOU MAY BE ABLE TO GET LONGER TERM INSURANCE THAT QUALIFIES AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT NOW AND HELP TO PAY FOR IT AT WWW.HEALTHCARE.GOV.

INDIANA ADDITIONAL DISCLOSURE:

The short term insurance plan does not include coverage for the ten (10) essential health benefits required under Patient Protection and Affordable Care Act (PPACA) and does not provide the coverage that is required under PPACA. Enrollment in health coverage that provides the coverage that is required under PPACA may be done during the next PPACA open enrollment period. The dates of the next PPACA open enrollment period during which you may enroll in coverage is November 1st to December 15th or as indicated by the Secretary of Health and Human Services.

LOUISIANA ADDITIONAL DISCLOSURE:

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

NEBRASKA ADDITIONAL DISCLOSURE:

Benefits are not provided for outpatient prescription drug coverage.

NEVADA ADDITIONAL DISCLOSURE:

YOU MAY BE ELIGIBLE FOR A SUBSIDY IF PURCHASING A "QUALIFIED HEALTH PLAN" WHICH PROVIDES MORE COVERAGE AT POSSIBLE A LOWER COST. FOR MORE INFORMATION PLEASE CHECK: https://www.nevadahealthlink.com/

The total Coverage Period will not exceed 185 days within a 365 day period

THE CERTIFICATE ONLY PROVIDES COVERAGE FOR DRUGS PRESCRIBED WHILE HOSPITAL CONFINED.

OHIO ADDITIONAL DISCLOSURE:

Notice to Ohio Residents: Holders of Certificates furnished by any insurer to a resident of Ohio in connection with, or pursuant to any provisions of, any group sickness and accident policy which insures residents of Ohio are entitled to all the protections afforded them under Ohio law, including without limitation, Title XXXIX of the Ohio Revised Code.

NOTICE: If a Covered Person is covered by more than one health care plan, he or she may not be able to collect benefits from both plans. Each plan may require the Covered Person to follow its rules or use specific Doctor and Hospitals, and it may be impossible to comply with both plans at the same time. All of the rules should be read very carefully, including the Coordination of Benefits section, for comparison of them with the rules of any other plan that covers the Covered Person.

This Certificate is not a Medicare supplement certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

TENNESSEE ADDITIONAL DISCLOSURE:

This Certificate is a limited benefit short term medical plan and is not a comprehensive major medical plan. The plan is intended to provide you, and your covered dependents, with basic insurance coverage. Some conditions are capped at specific amounts for Covered Expenses as outlined in the Schedule of Benefits. Read your Certificate carefully.

TEXAS ADDITIONAL DISCLOSURE:

THE INSURANCE POLICY UNDER WHICH THE CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKER'S COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

The Certificate is a part of, and is governed by, a Group Policy that has been issued in the state of: Illinois. Texas laws will govern any Certificate issued to Texas residents.

WISCONSIN ADDITIONAL DISCLOSURE:

We settle claims based on a specific methodology and that the eligible amount of a claim, as determined by the specific methodology, may be less than the provider's billed charge. You may be responsible for the difference. You may call the Administrator at 1-866-438-4274 to describe the specific methodology before the procedure is performed.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM FOR YOUR INSURANCE

Please read the copy of the enrollment form attached to Your Certificate or which has been otherwise previously delivered to You by the Company. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to the Company within 10 days if any information shown on the form is not correct and complete or if any requested medical history has not been included. The insurance coverage was issued on the basis that the answers to all questions and any other material information shown on the enrollment form are correct and complete.

WYOMING ADDITIONAL DISCLOSURE:

THE CERTIFICATE DOES CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY LAW (see page 5 of the Certificate).

CLAIMS

PRE-NOTIFICATION
1-800-650-6497

FIND A NETWORK PROVIDER
primehealthpon.primehealthservices.com/Search

CLAIMS ADMINISTRATOR:

Insurance Benefit System
Administrators c/o Zellis PO BOX 247
Alpharatta, GA 30009-0247

All other claims information:
Insurance Benefit Systems Administrators
PO BOX 1917
Shawnee Mission, KS 66201-1317

BENEFITS, CLAIMS SERVICES
1-888-716-2988
clientservices@ibsadmin.com

- NO CLAIMS FORMS REQUIRED
- Facility Charge: Plan pays up to 150% of Medicare Allowable charge.

PRIME HEALTH SERVICES

The Prime Health Services network is not affiliated with Pan-American Life Insurance Company and the insurance benefits provided are not dependent on the use of this network. For more information about this network please visit: primehealthpon.primehealthservices.com/Search.

PRE-AUTHORIZATION

Surgery, Hospital admissions and lengths of stay are subject to authorization by the pre-authorization service, as stated below.

1. You must notify the pre-authorization service on behalf of a Covered Person:
   a. as soon as possible before the expense is to be incurred for an elective or non-elective or non-Emergency Hospitalization or surgery;
   b. Within 48 hours following an Emergency admission of the Covered Person to a Hospital, or as soon thereafter as is reasonably possible; or
   c. Within 48 hours of delivery for complicated births.
2. The pre-authorization service, after reviewing the applicable information, will authorize:
   a. if the Hospital admission is Medically Necessary;
   b. The appropriate length of stay; and
   c. Appropriate extensions beyond the initially-authorized length of stay.
3. Reduction of Benefits - If Covered Expenses are not authorized by the pre-authorization service, We will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact Us as soon as possible. No benefits will be payable in the event such surgery or Hospital admission, length of stay or extension of stay is not Medically Necessary or Experimental or Investigational.
4. Not a Guarantee of Benefits - Pre-Authorization does not guarantee that benefits will be paid. Payment of benefits will be determined by Us in accordance with and subject to all terms, conditions, limitations and exclusions of the Certificate.

GA Members: The Pre-Authorization provision is **changed with the following**:

The Item #3 for Emergency admissions above is removed for GA.

IL Members: The Pre-Authorization provision is **changed with the following**:

The Item #3, Reduction of Benefits, above **replaces** the first sentence in IL with the following: If Covered Expenses are not authorized by the pre-authorization service, We will only pay 50% or $1,000 whichever is less of the benefits which would otherwise have been payable for Covered Expenses, unless the Covered Person is incapacitated and unable to contact us.

OH Members: The Pre-Authorization provision is **changed with the addition of the following**:

The penalty for non-compliance with Pre-Authorization requirements **will not exceed $2,500**.

A provider can access a Pre-Authorization form through an electronic software system and file a request through a secure electronic transmission (other than a facsimile). We will send an electronic receipt to the provider acknowledging that the request was received. We will respond to all Pre-Certification request within forty-eight hours for Urgent Care services, or ten calendar days for any Pre-Certification request that is not for an Urgent Care service, of the time the request is received by Us. Urgent Care means medical care or other service for a condition where application of the time frame for making routine or life-threatening care determinations is either of the following: (1) could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or (2) in the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is subject to the request.

We will permit a retrospective review for a claim that is submitted for a service where Pre-Authorization was required but not obtained if the service in question meets all of the following:

1. The service is directly related to another service for which Pre-Authorization has already been obtained and that has already been performed.
2. The new service was not known to be needed at the time the original prior authorized service was performed.
3. The need for the new service was revealed at the time the original authorized service was performed.

Once the written request and all necessary information is received, We will review the claim for coverage and Medical Necessity. We will not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

TN Members: The Pre-Authorization penalty under the Pre-Authorization Certification notice under the Schedule of Benefits is **replaced** with the following:

Non-compliance with the Pre-Authorization procedure will **result in a reduction in benefits of 50% or $2,500**, **whichever is less,** unless the Covered Person is incapacitated and unable to contact us.

TX Members: The Pre-Authorization Certification notice under the Schedule of Benefits **adds** the following in TX:

5. Pre-authorization Renewal - Renewal of an existing pre-authorization must be requested by a Doctor or provider at least 60 days before the date the pre-authorization expires. The professional review organization will review the request and issue a determination indicating whether the service is pre-authorized before the existing pre-authorization expires.

#3 Reduction of Benefits from the top of the page is **replaced with the following in TX**: 3. Reduction of Benefits - If Covered Expenses are not authorized by the pre-authorization service, the benefits which would otherwise have been payable for Covered Expenses, **will be reduced 50% or $500**, whichever is less, unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact Us as soon as possible. No benefits will be payable in the event such surgery or Hospital admission, length of stay or extension of stay is not Medically Necessary or Experimental or Investigational.

WHO IS HAA.

Healthy America Association (HAA)

Membership in Healthy America Association (HAA) gives you access to health and lifestyle benefits and services like Patient Advocacy, Labs & Imaging Discounts, Online Fitness, Safety App and more.

As a member in HAA, you also have access to enhance your membership and enroll in any of the optional supplemental a la carte health and wellness Benefit Boost Subscription products like Virtual Urgent Care, Talk Therapy, and Primary Care Visits through Walmart Health Virtual Care, Dental Discounts powered by Aetna Dental Access Network, free multi-vitamins and more.

Members of HAA will have the option to further enhance their membership by adding any of the optional supplemental group insurance membership products issued to the Healthy America Association or individual insurance products endorsed by HAA. Various insurance companies have issued group insurance policies to the Healthy America Association as the group master policyholder. Product features, additional product and availability may vary by state.

You do not have to purchase any additional insurance coverage or non-insurance subscription product on the enrollment application in order to join the Healthy America Association.

Why is it called Group Insurance?

The master policy is issued to the Healthy America Association and as a member of the Healthy America Association group, you have access to add any available optional group insurance to your HAA Membership as a way to enhance your overall membership and to add additional health benefits.

Do I have to be a member to enroll in a Group Insurance Plan issued to HAA?

YES, you must be a member of the Healthy America Association in order to enroll in or add any additional optional supplemental HAA Membership Product that includes group insurance to your HAA Membership. If you are not a member, you cannot enroll in these additional HAA group insurance plans.

Membership is not required for any of the a la carte health and wellness non-insurance Benefit Boost Subscription Products or any individual insurance supplemental plan or short term medical insurance program endorsed by HAA.

Free Look Period, Cancellations and Refunds.

Most states allow a 10-day free-look period (30 days for Indiana & Louisiana) for the Short Term Medical Insurance provided no claims have been filed. To cancel or for any billing related questions, you would need to contact the billing TPA:

H A Partners, Inc or Healthy America (depending on state)
409 W Vickery Blvd, Fort Worth, TX 76014
Toll Free Number: 1-866-438-4274
Email: info@healthyamericaassociation.com
Website: https://healthyamericaassociation.com
Member Portal: https://members.haahub.com

Healthy America Association (HAA) association benefits are not affiliated with Pan-American Life Insurance Company. Short Term Medical benefits are not dependent on the use of the association's providers. Healthy America Association is available without purchasing this plan. The benefits listed for Healthy America Association are not insurance and do not provide coverage, they only provide discounts and services. Benefit discounts and services vary by state. Please refer to the Healthy America Association Membership Guide for complete details on membership.

NON-INSURANCE HAA MEMBERSHIP BENEFIT & SERVICES HIGHLIGHTS

ABENITY MEMBER
PERKS PROGRAM

ALOE CARE HEALTH
MEDICAL ALERT SYSTEM

CAR RENTAL DISCOUNTS
BUDGET & AVIS

CHIROPRACTIC SAVINGS

GATEWAY MEDICARD

IMAGING SERVICE
DISCOUNTS

POINT HEALTH
PATIENT ADVOCACY

LABORATORY SERVICE
DISCOUNTS

LENOVO DISCOUNTS

NOONLIGHT
SAFETY APP

ODP BUSINESS SOLUTIONS
OFFICE SUPPLY DISCOUNTS

PODIATRY DISCOUNTS

PRIORITIZE WELLNESS
ONLINE FITNESS

ROADSIDE ASSISTANCE

SAFELITE AUTOGLASS
DISCOUNTS

TRAVNOW
TRAVEL DISCOUNTS

HEARING AID DISCOUNTS

Stay Healthy for Life.

Membership dues for HAA is $15 a month for the entire family. The $15 HAA Membership dues are in addition to the Short Term Medical Insurance premiums.

Non-Insurance benefits are not insurance and do not provide coverage, they only provide discounts and services. These benefits are not affiliated with Pan-American Life Insurance Company.

Enhance Your HAA Membership & Add the A La Carte Health & Wellness Non-Insurance Benefit Boost Subscription Products.

YOU CAN ENHANCE YOUR MEMBERSHIP WITH

BENEFIT BOOST SUBSCRIPTION PRODUCTS

- Walmart Health Virtual Care Visits (Virtual Urgent Care & Virtual Talk Therapy Visits)
- Walmart Health Virtual Care's Virtual PCP Solution
  (Virtual Urgent Care, Virtual Talk Therapy and Virtual Primary Care Visits including wellness labs)*
- SML Dental Discount powered by the Aetna Dental Access® Network
- Paramount RX® Retail Prescription & Pet RX Discounts
- Benefit Boost 1.0
  (includes Walmart Health Virtual Care Visits (Virtual Urgent Care & Virtual Talk Therapy Visits), Dental Discounts powered by the Aetna Dental Access® network, Retail Prescription & Pet RX Discounts powered by Paramount RX®, Free Gummy Multi-Vitamins, and Identity Theft discounts through LifeLock®.)
- Benefit Boost 2.0
  (includes Walmart Health Virtual Care's Virtual PCP Solution (Virtual Urgent Care, Virtual Talk Therapy, and Virtual Primary Care Visits including wellness labs), Dental Discounts powered by the Aetna Dental Access® network, Retail Prescription & Pet RX Discounts powered by Paramount RX®, Free Gummy Multi-Vitamins, and Identity Theft discounts through LifeLock®.)*

All Benefit Boost Subscription Products are a la carte health and wellness non-insurance membership services and can be sold on a stand-alone basis. Stand-alone Benefit Boost non-insurance subscription product costs are in addition to any Short Term Medical Insurance premiums and the $15 per month HAA Membership dues.

Benefit Boost Subscription non-insurance benefits are not affiliated with Pan-American Life Insurance Company. Healthy America Association is available without purchasing this plan or any of the Benefit Boost non-insurance subscription products. The benefits listed for the Benefit Boost products (listed above) are not insurance and do not provide coverage, they only provide discounts and services. Benefit discounts and services vary by state. Please refer to the Benefit Boost Subscription Product Membership Guide(s) for complete details on membership.

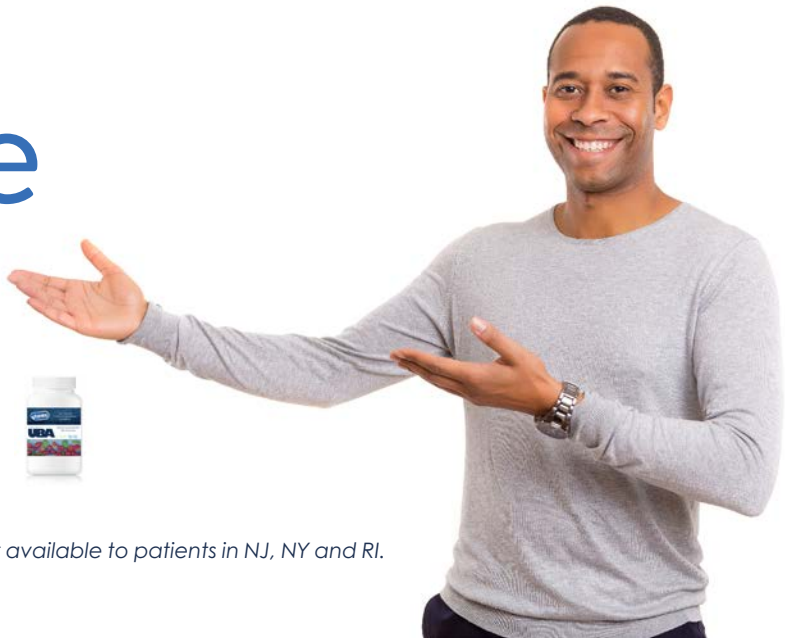
Walmart Health

Virtual Care

Aetna Dental Access®

PARAMOUNT Rx

LifeLock



*Wellness Lab tests are paid for by HealthyAmerica and not by you. Not available to patients in NJ, NY and RI.

CALL WHEN YOU NEED CUSTOMER SERVICE

866-438-4274

We Care.

HAA Offers Knowledgeable & Caring Customer Service.

Our customer service department is always willing to go the extra mile to help a customer understand the HAA Membership and the services and discounts provided in their membership along with any additional optional supplemental membership products the member has added. We value our members and our experienced staff will provide members understanding of their membership and any optional supplemental HAA Membership Products or optional Benefit Boost Subscription Products. We can help with billing issues, cancellations, address or email changes and much more. Healthy America Association provides a Member Portal for the member to be able to access their product information including the following:

1. Member Guides for all plans in which Member is enrolled
2. Certificates of Insurance for any group insurance benefits (if applicable) including any State Riders or additional state-specific documents.
3. E-signed Enrollment Forms including any additional state-specific enrollment documents and disclosures.
4. Digital ID cards for all plans in which Member is enrolled
5. How to Use section that explains how to use the non-insurance HAA or Benefit Boost (if applicable) membership services and discounts including links to services.

Member Portal:

https://members.haahub.com

Call 866-438-4274

for any item listed above or any other questions today. We will be happy to assist you in finding what you are looking for.

GET A QUOTE TODAY! https://healthyamericaassociation.com

This product is for use with out of state association groups and provides the association members and their dependents with medical coverage for a short term, limited duration.

This brochure is a brief description of the group short term medical insurance issued to the Healthy America Association by Pan-American Life Insurance Company in the following states:

AL, AZ, AR, DE, FL, GA. IL, IN, KY, LA, MS, NE, NV, OH, SC, TN, TX, VA, WV, WI, & WY

These states use the following Certificate: STM-CRT-19. **The states that also have an additional State Riders are color-coded in green below.** Please make sure to review the Certificate of Insurance along with any applicable State Riders, additional disclosures or forms in order to review all coverage details, terms, conditions, limitations and exclusions **prior to enrolling in this plan**.

AL, **AZ**, **AR**, **DE**, **FL**, **GA**, **KY**, **LA**, **MS**, **NE**, **NV**, **OH**, **SC**, **TN**, **VA**, **WV**, **WI**, & **WY**

These states have state specific Certificates of Insurance: **IL, IN and TX**. **Indiana** and **Texas** also have additional State Riders. Please make sure to review the Certificate of Insurance along with any applicable State Riders, Outline of Coverage, additional disclosures or forms in order to review all coverage details, terms, conditions, limitations and exclusions **prior to enrolling in this plan**.

Healthy America Association | 409 W Vickery Blvd Fort Worth, TX 76104 | 866.438.4274 | info@healthyamericaassociation.com | healthyamericaassociation.com