North Dakota
Choice Advantage STM

With insurance benefits underwritten by

United States Fire Insurance Company

Billing and Customer Service

MyBenefitsKeeper

STM-70200 - Broch - ND Rev. 03/2022

AH-3667

Non-Insurance Benefits

SingleCare can save you up to 80% on prescriptions, and on average, our prices are 45% lower than retail. In many cases, less than the cost through an insurance plan. You only pay for the prescriptions you need, at the pharmacy of your choice.

Karis360's team of expert Patient Advisors work with members to assist in navigating the confusing and expensive world of healthcare. Karis360 Patient Advisors takes the hassle out of healthcare and saves valuable time and money.

At the Rx Helpline, a team of advocates specializes in finding the lowest cost alternative for prescription medications. The team has helped over one million people navigate the complex system of prescription coverage and save money on their medications. Telephone consulting with Rx Helpline advocates to navigate the options is at your fingertips. The team helps individuals get their medications for the lowest possible cost – and sometimes even for free.

Teladoc is a national network of board-certified doctors providing cross-coverage consultations via phone or video 24/7/365. Teladoc doctors use the member's personal medical record and telephone and/or video consultations to diagnose, recommend treatment, and write short-term prescriptions when appropriate.

Disclaimer: *These are a sampling of non-insurance benefits that members can elect to add to their purchase. These non-insurance benefits can be a great added value for members. Non-Insurance benefits are not insurance and do not provide coverage, they only provide discounts and services. These benefits are not affiliated with United States Fire Insurance Company.*

Insurance Product Summary

Deductible Options	$1,000, $2,500, $5,000, $7,500, $10,000
Coinsurance Options	70/30, 80/20, 100/0
Out-of-Pocket Maximum Options	$2,000, $5,000, $10,000
Coverage Period Maximum Benefit Options	$100,000, $250,000, $750,000, $1,000,000, $1,500,000
Coverage Period	Available for up to 6 months of coverage
Provider	You can choose to be treated by any doctor or hospital facility for covered services and receive the same level of benefits Facility charges: Plan pays up to 150% of Medicare allowable charges
Coverage Effective Date	Next day coverage; later effective date available, but not to exceed 60 days from date of transmission
Age Eligibility	18 - 64 applicant and spouse, dependent children under 26 Child only coverage available for ages 2-17 (adult rates apply to anyone 18 or older)
Free Look Period	10 days
Choice Advantage STM Insurance Plan is great for those who:	• Between jobs or have been laid off • Part-time or temporary employment • Without adequate health insurance • Waiting for employer benefits • Recently graduated

Pre-Existing Conditions Allowance Benefit:

Pre-Existing Conditions Allowance Benefit means, any eligible expenses related to Pre-Existing Conditions will be paid up to and no more than 50% of the Plan's Deductible, per Coverage Period. Deductibles and Coinsurance payments of any eligible plan benefits are applicable to this benefit. However, payment of this benefit does not in any way affect or waive any of the Exclusions or Limitations, including the Pre-Existing Conditions Exclusion. Once the plan has paid the amount of up to 50% of the Plan's Deductible the Insured Person is responsible for all claims related to the Pre-Existing Conditions.

How will consecutive policy terms work?

When an Insure Person applies for consecutive policy terms in one enrollment, they will be issued their initial term of coverage, and subsequent terms will be pended. During the Insured Person's initial enrollment, the Insured Person will complete an application and their initial policy will be issued. Ten days prior to their subsequent policy going into effect, the Insured Person will receive an email with their new monthly rate (if applicable), and they will have the opportunity to opt out at this time. If the Insured Person does not opt out, upon successful payment, the Insured Person will be issued new policy documents, such as, application, policy, and schedule of benefits. The waiting periods on all subsequent terms will be waived if the Insured Person purchased the Waiver of Pre-Existing Conditions Rider during their initial purchase. The limitations on consecutive policy terms varies by state, please see your master policy for complete details.

NOTICE:

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 MASTER POLICY 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, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR MASTER POLICY MIGHT ALSO HAVE 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 AND RIDERS FOR COMPLETE DETAILS.

Insurance Plan Benefits

Benefits	Plan 1	Plan 2	Plan 3
Deductible Options	$1,000, $2,500, $5,000, $7,500	$1,000, $2,500, $5,000, $7,500	$1,000, $2,500, $5,000, $7,500, $10,000
Coinsurance Options	70/30, 80/20, 100/0	70/30, 80/20, 100/0	70/30, 80/20, 100/0
Out-of-Pocket Maximum Options	$2,000, $5,000	$2,000, $5,000	$2,000, $5,000, $10,000
Coverage Period Maximum Benefit Options	$250,000, $750,000, $1,000,000	$100,000, $250,000, $750,000, $1,000,000, $1,500,000	$100,000, $250,000, $750,000, $1,000,000, $1,500,000
Additional Deductibles			
Outpatient Surgery Additional Deductible	No Additional Deductible	No Additional Deductible	$500 per Covered Person per Surgery for Surgery performed in an Outpatient Surgical Facility after which Plan Deductible and Coinsurance will apply. There is a maximum of 3 Outpatient Surgery Deductibles per Covered Person per Coverage Period. Surgeries in excess of the maximum number of Outpatient Surgery Deductibles will remain subject to the Plan Deductible and Coinsurance.
Emergency Room Additional Deductible	No Additional Deductible	No Additional Deductible	$500 per Covered Person per visit for use of emergency room in the event of Sickness or Injury after which the Plan Deductible and Coinsurance will apply. The Emergency Room Deductible is waived if the Covered Person is directly admitted as an Inpatient for further treatment after which the Plan Deductible and Coinsurance will apply.
Advanced Diagnostic Studies Additional Deductible	No Additional Deductible	No Additional Deductible	$500 per Covered Person per occurrence for Advanced Diagnostic Studies in an Outpatient setting, such as PET, MRI, CAT scans, after which the Plan Deductible and Coinsurance will apply.
Copayments			
Doctor's Office Visit or Urgent Care Center Visits	$40 Copayment per Covered Person per visit or consultation, not to exceed a maximum of 3 Doctor's Office or Urgent Care Center Visits Copayments per Covered Person per Coverage Period. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible. Doctor's office or urgent care visits or doctor consultations in excess of the maximum number of Doctor's Office or Urgent Care Center Visits Copayments will be subject to the Plan Deductible and Coinsurance. Any other services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance.	$25 Copayment per Covered Person per visit or consultation Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	$40 Copayment per Covered Person per visit or consultation Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.
Wellness Benefit	$50 Copayment per Covered Person for one annual Routine Physical Exam. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	$50 Copayment per Covered Person for one annual Routine Physical Exam. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	$50 Copayment per Covered Person for one annual Routine Physical Exam. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.
Advanced Diagnostic Studies Copayment	--	$500 Copayment per Covered Person per occurrence for Advanced Diagnostic Studies in an Outpatient setting, such as PET, MRI, CAT scans, not to exceed a maximum of 3 Advanced Diagnostic Studies Copayments per Covered Person per Coverage Period. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible. Occurrences in excess of the maximum number of Advanced Diagnostic Studies Copayment will be subject to the Plan Deductible and Coinsurance.	--

Disclaimer: *All benefits are limited to Usual and Customary Fees. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the master policy for complete details.*

Insurance Plan Benefits (Cont.)

Benefits	Plan 1	Plan 2	Plan 3
Inpatient Hospital Services (Eligible Expenses are subject to Deductibles and Coinsurance)			
Average Standard Room Rate	Not to exceed Average Standard room rate. Eligible Expenses, including nursing services and all miscellaneous medical charges, are limited to $1,000 per day.	Not to exceed Average Standard room rate. Eligible Expenses, including nursing services and all miscellaneous medical charges, are limited to $4,000 per day.	Not to exceed Average Standard room rate.
Intensive Care or Critical Care Unit	Payable for each day of confinement in an Intensive Care or Critical Care Unit. Eligible Expenses, including nursing services and all miscellaneous expenses, are limited to $1,250 per day.	Payable for each day of confinement in an Intensive Care or Critical Care Unit. Eligible Expenses, including nursing services and all miscellaneous expenses, are limited to $4,000 per day.	Payable for each day of confinement in an Intensive Care or Critical Care Unit.
Inpatient Doctor Visits	Not to exceed $50 per day. Eligible Expenses for all Hospital visits during a Hospital stay are limited to $500 per Covered Person per Coverage Period.	Not to exceed $50 per day. Eligible Expenses for all Hospital visits during a Hospital stay are limited to $500 per Covered Person per Coverage Period.	Subject to Deductible and Coinsurance
Emergency Room	Payable for each emergency room visit, including professional and facility services. Eligible Expenses are limited to $250 per visit. (This includes the emergency room physician charge, 24 hours surveillance and all miscellaneous medical charges)	Payable for each emergency room visit, including professional and facility services. Eligible Expenses are limited to $500 per visit. (This includes the emergency room physician charge, 24 hours surveillance and all miscellaneous medical charges)	Subject to Additional Deductible shown above, then subject to Deductible and Coinsurance for each emergency room visit, including professional and facility services. (This includes the emergency room physician charge, 24 hours surveillance and all miscellaneous medical charges)
Outpatient Services (Eligible Expenses are subject to Deductibles and Coinsurance)			
Outpatient Surgical Facility	Payable for each day in an Outpatient Surgical Facility. Eligible Expenses, including all miscellaneous expenses, are limited to $1,250 per Coverage Period.	Payable for each day in an Outpatient Surgical Facility. Eligible Expenses, including all miscellaneous expenses, are limited to $2,500 per Coverage Period.	Subject to Additional Deductible shown above, then subject to Deductible and Coinsurance.
Outpatient Miscellaneous Hospital Expenses	Payable for miscellaneous Outpatient Hospital expenses, excluding Outpatient Surgery. Eligible Expenses are limited to $1,250 per Covered Person per Coverage Period for all Eligible Expenses combined.	Payable for miscellaneous Outpatient Hospital expenses, excluding Outpatient Surgery. Eligible Expenses are limited to $2,500 per Covered Person per Coverage Period for all Eligible Expenses combined.	Payable for miscellaneous Outpatient Hospital expenses, excluding Outpatient Surgery.
Surgery Services (Eligible Expenses are subject to Deductibles and Coinsurance)			
Surgeon	Not to exceed $5,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $10,000 per Covered Person per Coverage Period.	Not to exceed $10,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $20,000 per Covered Person per Coverage Period.	Subject to Deductible and Coinsurance
Surgeon Assistant and Surgical Assistant	Not to exceed $1,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $2,000 per Covered Person per Coverage Period.	Not to exceed $2,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $4,000 per Covered Person per Coverage Period.	Subject to Deductible and Coinsurance
Administration of Anesthetics	Not to exceed $1,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $2,000 per Covered Person per Coverage Period.	Not to exceed $2,000 per surgery, for all Eligible Expenses combined. Eligible Expenses are limited to $4,000 per Covered Person per Coverage Period.	Subject to Deductible and Coinsurance

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Insurance Plan Benefits (Cont.)

Benefits	Plan 1	Plan 2	Plan 3
Other Services (Eligible Expenses are subject to Deductibles and Coinsurance)			
Doctor's Office Visit or Urgent Care Center Visits	After the Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible. Eligible Expenses for any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance. Eligible Expenses for office or urgent care center visits or consultations in excess of the maximum number of Doctor's Office Visit or Urgent Care Center Copayments will be subject to the Plan Deductible and Coinsurance. The office visit maximum for all Doctor's office or urgent care center visits or consultations, including any other covered services or tests performed as part of the office visit, are limited to $2,000 per Covered Person per Coverage Period.	After the Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible. Eligible Expenses for any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance.	After the Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible. Eligible Expenses for any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance.
Routine Child Health Care	Immunizations are not subject to the Plan Deductible.	Immunizations are not subject to the Plan Deductible.	Immunizations are not subject to the Plan Deductible.
Extended Care Facility	Not to exceed $150 per day. There is a maximum limit of 30 days per Covered Person per Coverage Period.	Not to exceed $150 per day. There is a maximum limit of 30 days per Covered Person per Coverage Period.	Not to exceed $150 per day. There is a maximum limit of 30 days per Covered Person per Coverage Period.
Home Health Care	Not to exceed $50 per visit. There is a limit of 1 visit per day not to exceed a maximum 30 Home Health Care visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a limit of 1 visit per day not to exceed a maximum 30 Home Health Care visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a limit of 1 visit per day not to exceed a maximum 30 Home Health Care visits per Covered Person per Coverage Period.
Hospice Care	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.
Ambulance (Injury or Sickness)	Not to exceed $250 per transport.	Not to exceed $500 per transport.	Not to exceed $500 per transport.
Physical, Occupational and Speech Therapy	Not to exceed $50 per day and 20 visits combined per Covered Person per Coverage Period.	Not to exceed $50 per day and 20 visits combined per Covered Person per Coverage Period.	Not to exceed $50 per day and 20 visits combined per Covered Person per Coverage Period.
Organ or Tissue Transplants	Not to exceed $50,000 per Covered Person per Coverage Period.	Not to exceed $50,000 per Covered Person per Coverage Period.	Not to exceed $50,000 per Covered Person per Coverage Period.
Acquired Immune Deficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV)	Not to exceed $10,000 per Covered Person per Coverage Period.	Not to exceed $10,000 per Covered Person per Coverage Period.	Not to exceed $10,000 per Covered Person per Coverage Period.
Temporomandibular Joint Disorder (TMJ)	Not to exceed $3,500 per Covered Person per Coverage Period.	Not to exceed $3,500 per Covered Person per Coverage Period.	Not to exceed $3,500 per Covered Person per Coverage Period.
Kidney Stones	Not to exceed $1,500 per Covered Person per Coverage Period.	Not to exceed $1,500 per Covered Person per Coverage Period.	Not to exceed $1,500 per Covered Person per Coverage Period.
Appendectomy	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.
Joint or Tendon Surgery	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.
Knee Injury or Disorders	Not to exceed $2,500 per Covered Person per Coverage Period for both left knee and right knee.	Not to exceed $2,500 per Covered Person per Coverage Period for both left knee and right knee.	Not to exceed $2,500 per Covered Person per Coverage Period for both left knee and right knee.
Gallbladder Surgery	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.	Not to exceed $2,500 per Covered Person per Coverage Period.

Disclaimer: *All benefits are limited to Usual and Customary Fees. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the master policy for complete details.*

Insurance Plan Benefits (Cont.)

Benefits	Plan 1	Plan 2	Plan 3
Mental Disorders **(Eligible Expenses are subject to Deductibles and Coinsurance)**			
Inpatient	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.
Outpatient	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.
Substance Use **(Eligible Expenses are subject to Deductibles and Coinsurance)**			
Inpatient	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.	Not to exceed $100 per day. There is a maximum limit of 31 days per Covered Person per Coverage Period.
Outpatient	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.	Not to exceed $50 per visit. There is a maximum limit of 10 visits per Covered Person per Coverage Period.

Disclaimer: *All benefits are limited to Usual and Customary Fees. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the master policy for complete details.*

Insurance Pre-Certification Requirements/Limitations & Exclusions

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

Pre-Certification Requirements

All Inpatient Hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-certified.

A. To comply with the pre-certification requirements, the Covered Person must:
   1. Contact the professional review organization at the following telephone number 1-800-650-6497 as soon as possible before the expense is to be incurred; and
   2. Comply with the instructions of the professional review organization and submit any information or documents they require; and
   3. Notify all Doctors, Hospitals and other providers that this insurance contains pre-certification requirements and ask them to fully cooperate with the professional review organization.

B. If the Covered Person complies with the pre-certification requirements, and the expenses are pre-certified, the Company will pay Eligible Expenses subject to all terms, conditions, provisions and exclusions described in this Policy.

C. If the Covered Person does not comply with the pre-certification requirements, or if the expenses are not precertified, Eligible Expenses will be reduced by 50%.

D. Emergency pre-certification: In the event of an emergency Hospital admission, pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.

E. Pre-certification Does Not Guarantee Benefits – The fact that expenses are pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions of this Policy.

F. Concurrent Review – For Inpatient stays of any kind, the professional review organization will pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be pre-certified if a Covered Person receives prior approval.

Limitations & Exclusions

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

1. Pre Existing Conditions:
   a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, within the 24 month period immediately preceding such person's Policy Effective Date of coverage under the Policy.

   This exclusion does not apply to any Eligible Expense payable for Pre-Existing Conditions until the Allowance Benefit maximum shown in the Schedule of Benefits has been reached.

2. Charges during the first 6 months after the Policy Effective Date of coverage for a Covered Person for the following:
   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;
   g. Herniorraphy; or
   h. Cholecystectomy (Gallbladder).

   However, if such condition is a Pre-Existing Condition, any benefit consideration will be in accordance with the Pre-Existing Conditions limitation.

3. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:
   a. Kidney Stones;
   b. Appendectomy;
   c. Joint or tendon Surgery;
   d. Knee Injury or disorder;
   e. Gallbladder Surgery

4. Charges which are not incurred by a Covered Person during his/her Coverage Period.

5. Charges which exceed any limits or limitations specified in this Policy, including the Schedule of Benefits.

6. Charges for services of supplies in excess of the Maximum Allowable Expense.

7. Charges for services or supplies which are not administered by or under the supervision of a Doctor.

8. Mental, emotional or nervous disorders or counseling of any type, unless specifically covered as an Eligible Expense.

9. Marital Counseling or social counseling.

10. Treatment for Substance Abuse, unless specifically covered as an Eligible Expense.

11. Outpatient Prescription Drugs, unless specifically covered as an Eligible Expense. This does not include those administered by a Doctor in an Inpatient or Outpatient setting covered as an Eligible Expense.

Disclaimer: *This is a brief description of Choice Advantage STM plan limitations and exclusions.. Please check the master policy for complete details on benefits, limitations, and exclusions.*

Insurance Limitations & Exclusions (Cont.)

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

12. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

13. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

14. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.

15. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.

16. Cosmetic Treatment, except for reconstructive surgery where expressly covered as an Eligible Expense.

17. Weight modification or surgical treatment of obesity.

18. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.

19. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.

20. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial 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 as an Eligible Expense.

21. Routine pre-natal care, Pregnancy, child birth, and post-natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)

22. Sclerotherapy for veins of the extremities.

23. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.

24. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage. This exclusion does not apply if these treatments are related to a covered Injury.

25. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.

26. Chronic fatigue or pain disorders.

27. Kidney or end stage renal disease.

28. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.

29. Treatment for cataracts.

30. Treatment of sleep disorders.

31. Treatment required as a result of complications or consequences of a treatment or condition not covered under this Policy.

32. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

33. 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.

34. Treatment for or related to any Congenital Condition, except as it relates to a newborn child or newborn adopted child added as a Covered Person pursuant to the terms of this Policy.

35. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.

36. Spinal manipulation or adjustment.

37. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinesiotherapy, unless specifically covered as an Eligible Expense.

38. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and non-medical self-care or self-help programs.

39. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, orthoptics, visual eye training and any examination or fitting related to these devices, and all vision and hearing tests and examinations.

40. Care, treatment or supplies for the feet, and orthopedic prescription devices to be attached to or placed in shoes.

41. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; treatment of corns, calluses or toenails; and orthopedic shoes.

42. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.

Disclaimer: *This is a brief description of Choice Advantage STM plan limitations and exclusions. Please check the master policy for complete details on benefits, limitations, and exclusions.*

Insurance Limitations & Exclusions (Cont.)

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

43. Exercise programs, whether or not prescribed or recommended by a Doctor.

44. Failure to keep a scheduled appointment.

45. Charges for travel or accommodations, except as expressly provided for local ambulance.

46. All charges incurred while confined primarily to receive Custodial or Convalescent Care.

47. Services received or supplies purchased outside the United States, its territories or possessions, or Canada unless specifically covered as an Eligible Expense.

48. Any services or supplies in connection with cigarette smoking cessation.

49. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.

50. Services received for any condition caused by a Covered Person's commission of or attempt to commit an assault, battery, or felony, whether charged or not, or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

51. Services or supplies which are not included as Eligible Expenses as described herein.

52. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by a commercial airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, bungee jumping, scuba diving, sail gliding, parasailing, para kiting, rock or mountain climbing, cave exploration, parkour, racing including stunt show or speed test of any motorized or non-motorized vehicle or rodeo activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.

53. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.

54. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.

55. Charges 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 the Covered Person on a pro-rated basis.

56. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered as an Eligible Expense.

57. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.

58. Charges 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, whether or not application for such benefits have been made.

59. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

Disclaimer: *This is a brief description of coverage provided under Individual Short Term Medical form number STM-70200 - IP-ND, and is subject to the terms, conditions, limitations and exclusions of the policy. Please see the policy for complete details. Plans are underwritten by United States Fire Insurance Company, Eatontown, NJ.*

Provider & Repricing

Practitioner & Ancillary

Insured Person under this plan may choose to be treated within, or out of, the PHCS network and receive the same level of benefits. You can choose to be treated by any provider for covered services; however, the PHCS Practitioner & Ancillary network gives Insured Person access to negotiated rates. Locate providers by visiting www.multiplan.com and selecting the appropriate network.

Facility Charges

Plan pays up to 150% of Medicare allowable charges.

Disclaimer: *The amount of reduction varies by state and type of medical service received. must pay for all services, no portion of any provider's fees will be reimbursed or otherwise paid by MultiPlan PHCS Practitioner & Ancillary Only network. The list of participating providers is subject to change without notice. The MultiPlan PHCS Practitioner & Ancillary Only network is not affiliated with United States Fire Insurance Company and the insurance benefits provided are not dependent on the use of this network. For more information about this network please visit Multiplan.com.*