North Dakota
Preferred Short Term Medical

Issued by

PAN AMERICAN LIFE INSURANCE COMPANY

Association

Association for Entrepreneurship U.S.A.

Billing and Customer Service

MyBenefitsKeeper

Association

Association for Entrepreneurship U.S.A.

AFEUSA strives to bring the member the most current information on business, technology, and related processes to help the member grow the confidence needed to succeed. Entrepreneurship takes a much different shape today than in the past. In fact, the member may have a business and not even know it.

The member might be selling goods on eBay, repairing old cars and posting ads online, might be a grandmother who babysits kids, or an Uber or Lyft driver. We are always eager to chat with our members. We are here for you! With AFEUSA it's success by association.

- ACI Legal and Financial Services/Childcare
- BurnAlong
- NeedyMeds
- AmericanTM Hearing Benefits (AHB)
- Avis® and Budget® Car Rental Discounts
- SkyMed
- SkyMed Travel
- CARCHEX®
- TrueCarTM
- Costco®
- Benefit Hub
- Home Chef
- Long-Term Care Resources
- Griswold ® Home Care
- Gusto
- Take Charge America®
- The Credit Clinic
- EJ Pro Lease
- First American
- Eric'sJobs.com
- Trapp Technology
- UPS
- Office Depot® and OfficeMax® Discounts
- E6 Agency
- The Newsletter Pro
- Genius Network®
- Big Results Academy
- GoSmallBiz.com
- The Messinger Institute
- SocialCore Marketing
- Joe Weldon Consultant and Executive Speech Coach
- Empowered Couples University
- InfoArmor®
- LegalShield℠
- IDShield℠

Disclaimer: *Association membership is not required in all states. AFEUSA association benefits are not affiliated with Pan-American Life Insurance Company. Preferred STM benefits are not dependent on the use of the association's providers. AFEUSA membership is available without purchasing this plan. The benefits listed 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 AFEUSA Membership brochure for complete details.*

Product Summary

Deductible Options	$500, $1,000, $2,500, $5,000, $7,500, $10,000
Coinsurance Percentage Options	50/50, 70/30, 80/20, 100/0
***Coinsurance Maximum Options** (*Deductibles, Copayments, Pre-Authorization penalties, amounts in excess of the Usual, Reasonable and Customary charge and amounts in excess of the Maximum Benefit amounts do not apply towards the Coinsurance Maximum.)	$2,000, $5,000, $10,000, $20,000
Coverage Period Maximum Options	$25,000, $50,000, $100,000, $250,000, $750,000, $1,000,000, $2,000,000
Network	• **PHCS Practitioner & Ancillary Only Network** giving members access to in-network negotiated rates • 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	Members and spouse between ages 18 - 64 Dependent unmarried children up to age 25 Child only coverage between ages 1 - 17 (One child allowed per child only policy)
Waiting Periods	5 days for sickness, 30 days for cancer, 6 months for various covered surgeries
This plan requires Pre-Authorization by a pre-authorization service prior to a Hospitalization or surgery. A Covered Person must call the pre-authorization service:	1. For elective or non-Emergency Hospitalization or surgery, as soon as possible before the expense is to be incurred; 2. Within 48-hours of an Emergency admission; or 3. Within 48-hours of delivery for complicated childbirth.

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 member is responsible for all claims related to the Pre-Existing Conditions.

How will consecutive policy terms work?
When a member 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 member's initial enrollment, the member will complete an application and their initial policy and certificate will be issued. Ten days prior to their subsequent policy going into effect, the member 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 member does not opt out, upon successful payment, the member will be issued new policy documents, such as, application, policy, certificate, and schedule of benefits. The waiting periods on all subsequent terms will be waived if the member purchased the Waiver of Pre-Existing Conditions Rider during their initial purchase. The limitations on consecutive policy terms varies by state*, please see your certificate or master policy for complete details.

*North Dakota residents may elect to renew coverage for one additional consecutive coverage period, not to exceed a total of 12 months, without underwriting.

What is MyBenefitsKeeper?
All the plans featured on our platforms offer access to MyBenefitsKeeper.com. MyBenefitsKeeper was designed with a user-friendly desktop and mobile device layout. Members can print ID cards, get notifications when action is required, review or edit billing information, review current available benefits, and purchase more coverage.

Plan Benefits

Benefits	Plan 1	Plan 2	Plan 3
Deductible Options	$500, $1,000, $2,500, $5,000, $7,500, $10,000	$500, $1,000, $2,500, $5,000, $7,500, $10,000	$500, $1,000, $2,500, $5,000, $7,500, $10,000
Coinsurance Options	50/50, 70/30, 80/20, 100/0	50/50, 70/30, 80/20, 100/0	50/50, 70/30, 80/20, 100/0
***Coinsurance Maximum Options**	$2,000, $5,000, $10,000, $20,000	$2,000, $5,000, $10,000, $20,000	$2,000, $5,000, $10,000, $20,000
Coverage Period Maximum Options	$25,000, $50,000, $100,000, $250,000, $750,000, $1,000,000	$25,000, $50,000, $100,000, $250,000, $750,000, $1,000,000	$250,000, $750,000, $1,000,000, $2,000,000
Pre-Existing Conditions Allowance	Up to 50% of the Deductible for Covered Expenses incurred for a Pre-Existing Condition	Up to 50% of the Deductible for Covered Expenses incurred for a Pre-Existing Condition	Up to 50% of the Deductible for Covered Expenses incurred for a Pre-Existing Condition
After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses will not exceed a maximum benefit listed below per Coverage Period, unless otherwise specified.			
Benefits	**Plan 1**	**Plan 2**	**Plan 3**
Part A: Hospital Covered Expenses			
In Hospital Regular Care	Not to exceed the Average Standard Room Rate charged by the Hospital, including all Inpatient Miscellaneous Medical Expenses, maximum $1,250 per day	Not to exceed the Average Standard Room Rate charged by the Hospital, including all Inpatient Miscellaneous Medical Expenses, maximum $5,000 per day	Not to exceed the Average Standard Room Rate
In Hospital Intensive or Critical Care	Not to exceed 3 times the Average Standard Room Rate for each day in an Intensive Care, including all Inpatient Miscellaneous Medical Expenses, maximum $3,750 per day	Not to exceed 3 times the Average Standard Room Rate for each day in an Intensive Care, including all Inpatient Miscellaneous Medical Expenses, maximum $15,000 per day	Not to exceed 3 times the Average Standard Room Rate for each day in an Intensive Care, including all Inpatient Miscellaneous Medical Expenses, Subject to Deductible and Coinsurance
Emergency Room Treatment	Payable for Emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses incurred during the emergency room visit, maximum $250 per visit	Payable for Emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses incurred during the emergency room visit, maximum $1,000 per visit	Payable for Emergency room Doctor charge, 24 hour observation and all miscellaneous medical expenses incurred during the emergency room visit, Subject to Deductible and Coinsurance
Inpatient Doctor Visits	Not to exceed $500 per In-Hospital Confinement	Not to exceed $1,000 per In-Hospital Confinement	Subject to Deductible and Coinsurance
Inpatient Mental Illness	Not to exceed $100 per day, maximum of 30 days, per Coverage Period	Not to exceed $100 per day, maximum of 30 days, per Coverage Period	Not to exceed $100 per day, maximum of 30 days, per Coverage Period
Inpatient Substance Abuse	Not to exceed $100 per visit, maximum of 30 visits per Coverage Period	Not to exceed $100 per visit, maximum of 30 visits per Coverage Period	Not to exceed $100 per visit, maximum of 30 visits per Coverage Period

Disclaimer: *All benefits are limited to Usual, Reasonable and Customary Fees. Benefits may vary by state. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the product certificate or master policy for complete details. *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.*

Plan Benefits (Cont.)

After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses will not exceed a maximum benefit listed below per Coverage Period, unless otherwise specified.			
Benefits	**Plan 1**	**Plan 2**	**Plan 3**
Part B: Covered Expenses for Treatment, Services or Supplies			
Doctor Office or Urgent Care Center Visits	After a $25 Copayment for the first 2 visits, the Company will pay 100% of the Coinsurance Percentage for Covered Expenses and the Deductible will not apply. After the first 2 visits, Covered Expenses will be subject to Deductible and Coinsurance. Covered Expenses for any other covered services or tests performed as part of the visit will be subject to the Deductible and Coinsurance. Not to exceed $1,000 per Coverage Period, including all additional services or test performed during the Office Visit. (This maximum will not apply to any services or tests that fall under another Benefit)	After a $25 Copayment for the first 3 visits, the Company will pay 100% of the Coinsurance Percentage for Covered Expenses and the Deductible will not apply. After the first 3 visits, Covered Expenses will be subject to Deductible and Coinsurance. Covered Expenses for any other covered services or tests performed as part of the visit will be subject to the Deductible and Coinsurance. Not to exceed $1,000 per Coverage Period, including all additional services or test performed during the Office Visit. (This maximum will not apply to any services or tests that fall under another Benefit)	After a $25 Copayment the Company will pay 100% of the Coinsurance Percentage for Covered Expenses and the Deductible will not apply. Covered Expenses for any other covered services or tests performed as part of the visit will be subject to the Deductible and Coinsurance.
Ambulatory Surgical Center or Outpatient Hospital Facility	Not to exceed $1,000 per day	Not to exceed $2,500 per day	Subject to Deductible and Coinsurance
Surgeon Services	Not to exceed $2,500 per surgery, maximum of $5,000 per Coverage Period	Not to exceed $10,000 per surgery, maximum of $20,000 per Coverage Period	Subject to Deductible and Coinsurance
Anesthesia Services	Not to exceed 20% of the Surgeon Services' benefit	Not to exceed 20% of the Surgeon Services' benefit	Not to exceed 20% of the Surgeon Services' benefit
Assistant Surgeon	Not exceed 20% of the Surgeon Services' benefit	Not exceed 20% of the Surgeon Services' benefit	Not exceed 20% of the Surgeon Services' benefit
Surgeon's Assistant	Not to exceed 20% of the Surgeon Services' benefit	Not to exceed 20% of the Surgeon Services' benefit	Not to exceed 20% of the Surgeon Services' benefit
Ambulance (Ground or Air)	Not to exceed $250 per incident	Not to exceed $500 per incident	Not to exceed $1,000 per incident
Therapy Services	Not to exceed $50 per day, maximum number of days for all therapies combined is 20 days per Coverage Period	Not to exceed $100 per day, maximum number of days for all therapies combined is 20 days per Coverage Period	Not to exceed $100 per day, maximum number of days for all therapies combined is 20 days per Coverage Period
Mammography, Pap Smear and Prostate Antigen Tests	The Company will pay the Coinsurance Percentage for all Covered Expenses. The Deductible will not apply.	The Company will pay the Coinsurance Percentage for all Covered Expenses. The Deductible will not apply.	The Company will pay the Coinsurance Percentage for all Covered Expenses. The Deductible will not apply.
Annual Routine Physical Exam	$50 Copayment, Coinsurance is 100% of Eligible Expenses, Deducible will not apply. This benefit is payable one time per 12 month period.	$50 Copayment, Coinsurance is 100% of Eligible Expenses, Deducible will not apply. This benefit is payable one time per 12 month period.	$50 Copayment, Coinsurance is 100% of Eligible Expenses, Deducible will not apply. This benefit is payable one time per 12 month period.

Disclaimer: *All benefits are limited to Usual, Reasonable and Customary Fees. Benefits may vary by state. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the product certificate or master policy for complete details.*

Plan Benefits (Cont.)

After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses will not exceed a maximum benefit listed below per Coverage Period, unless otherwise specified.			
Benefits	**Plan 1**	**Plan 2**	**Plan 3**
Part B: Covered Expenses for Treatment, Services or Supplies (Cont.)			
Routine Child Health Care	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.	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.	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.
Outpatient Mental Illness	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period
Outpatient Substance Abuse	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period	Not to exceed $100 per visit, maximum of 10 visits per Coverage Period
Extended Care Facility	Not to exceed $150 per day, maximum of 30 days per Coverage Period	Not to exceed $150 per day, maximum of 30 days per Coverage Period	Not to exceed $150 per day, maximum of 30 days per Coverage Period
Home Health Care	Not to exceed $50 per visit, maximum of 30 visits per Coverage Period	Not to exceed $50 per visit, maximum of 30 visits per Coverage Period	Not to exceed $50 per visit, maximum of 30 visits per Coverage Period
Hospice Care	Not to exceed $5,000 per Coverage Period	Not to exceed $5,000 per Coverage Period	Not to exceed $5,000 per Coverage Period
Organ or Tissue Transplants	Not to exceed $50,000 per Coverage Period	Not to exceed $50,000 per Coverage Period	Not to exceed $50,000 per Coverage Period
Acquired Immune Deficiency Syndrome (AIDS)	Not to exceed $10,000 per Coverage Period	Not to exceed $10,000 per Coverage Period	Not to exceed $10,000 per Coverage Period
Knee Injury or Disorder Surgery	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period for both left and right knees	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period for both left and right knees	Subject to Deductible and Coinsurance
Gallbladder Surgery	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Subject to Deductible and Coinsurance
Temporomandibular Joint Disorder (TMJ)	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Subject to Deductible and Coinsurance
Kidney Stones	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Subject to Deductible and Coinsurance
Appendectomy	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Subject to Deductible and Coinsurance

Disclaimer: *All benefits are limited to Usual, Reasonable and Customary Fees. Benefits may vary by state. Coverage is not limited to the benefits listed; any eligible expenses are subject to plan limitations. Please check the product certificate or master policy for complete details.*

Plan Benefits (Cont.)

After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses will not exceed a maximum benefit listed below per Coverage Period, unless otherwise specified.			
Benefits	**Plan 1**	**Plan 2**	**Plan 3**
Part B: Covered Expenses for Treatment, Services or Supplies (Cont.)			
Joint or Tendon Surgery	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Covered Expenses will be limited by all other applicable maximum benefit amounts not to exceed $2,500 per Coverage Period	Subject to Deductible and Coinsurance
After the Deductible has been satisfied, the Company will pay the Coinsurance Percentage for all Covered Expenses. Covered Expenses will not exceed a maximum benefit listed below per Coverage Period, unless otherwise specified.			
Benefits	**Plan 1**	**Plan 2**	**Plan 3**
Part C: Outpatient Miscellaneous Medical Expense Services			
Outpatient Miscellaneous Medical Expense Services	Not to exceed $1,250 per Coverage Period for all Covered Expenses listed in Part C combined	Not to exceed $5,000 per Coverage Period for all Covered Expenses listed in Part C combined	Subject to Deductible and Coinsurance

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NOTICE TO ILLINOIS RESIDENTS:

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.

Coverage cannot exceed 180 days and is non-renewable.

Limitations & Exclusions

We will not pay for loss or expense caused by or resulting from any of the following:

PRE-EXISTING CONDITIONS LIMITATION

We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. "Preexisting Conditions" means any medical condition or Sickness for which medical advice, treatment or diagnosis was received from a Doctor within the 24 months immediately prior to a Covered Person's Effective Date of coverage.

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 has been reached.

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision.
2. 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.
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy.
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment.
5. Amounts in excess of the Maximum Allowable Expense for covered services or supplies.
6. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
7. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.
8. Expenses for purposes determined by Us to be educational.
9. 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, whether or not application for such benefits has been made.
10. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).
11. 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.
12. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
13. Expenses incurred while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony or assault.
14. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy.
15. Expenses for voluntary termination of normal pregnancy or elective cesarean section.
16. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth.
17. 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.
18. Expenses for sterilization or reversal of sterilization.
19. 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.
20. Expenses for sex transformation or penile implants or sex dysfunction or inadequacies.
21. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered.
22. Expenses for prophylactic treatment, including surgery or diagnostic testing, except as specifically covered.
23. 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; unless it is specifically covered.
24. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction; unless it is specifically covered.

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

Limitations & Exclusions (Cont.)

25. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation.
26. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered.
27. 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.
28. 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 eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts.
29. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids.
30. Expenses for cosmetic or reconstructive procedures, services or supplies; except as specifically covered.
31. Expenses for breast reduction or augmentation or complications arising from these procedures; except as specifically covered.
32. 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.
33. Expenses incurred in connection with any drug or other item used to treat hair loss.
34. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corms, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person.
35. Expenses incurred in the treatment of acne, or varicose veins.
36. Expenses of weight loss programs or diets.
37. Transportation Expenses, except as specifically covered.
38. 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, unless it is specifically covered.
39. All charges incurred while confined primarily to receive custodial or convalescent care, unless it is specifically covered.
40. 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.
41. Expenses for services or supplies furnished or provided by a member of Your Immediate Family.
42. Expenses for diagnosis or treatment of a sleeping disorder.
43. 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; or participation in rodeo contests.
44. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator).
45. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits.
46. Expenses 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).
47. Expenses for participating in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.
48. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions, unless specifically covered.

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Limitations & Exclusions (Cont.)

49. Expenses for private duty nursing services.50. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment.
51. 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.
52. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas.
53. 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.
54. Expenses for marital counseling or social counseling.
55. Expenses for acupuncture.
56. 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.
57. Expenses for replacement of artificial limbs or eyes.
58. Expenses for removal of breast implants when not Medically Necessary.
59. Chronic fatigue or pain disorders.
60. Kidney or end stage renal disease.
61. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
62. Biofeedback, acupuncture, recreational, sleep or mist therapy, holistic care of any nature, massage and kinestherapy, excepted as provided for under Home Health Care.
63. 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.
64. Failure to keep a scheduled appointment.
65. 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.
66. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

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Network & Repricing

MultiPlan® PHCS Practitioner & Ancillary Only

PHCS
Practitioner &
Ancillary Only

Members 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 members 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. Members 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. Per our Compliant Sales Guidelines, members must be made aware the MultiPlan PHCS Practitioner & Ancillary Only network is not affiliated with Pan-American Life Insurance Company and the insurance benefits provided are not dependent on the use of this network. This plant should not be referred to as PPO or PPO plan. For more information about this network please visit Multiplan.com.*

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.

The expert healthcare navigators listen to the member's needs, then find the best care for them at a low price. Also, when a member faces and unexpected or unreasonably high medical bill, a dedicated Point Health patient advocate works on their behalf to negotiate a reduction.

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.

DialCare Physician Access is a modern, easy-to-use telemedicine solution for non-emergency illnesses and general care. Members and their families have direct access to state-licensed and fully credentialed doctors, via phone or video consultation, to receive treatment and advice for common ailments, including colds, the flu, rashes and more.

Disclaimer: *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.*