Nebraska Select STM

Carrier and Underwriter

AMERICAN NATIONAL
Standard Life
AND ACCIDENT INSURANCE COMPANY
AN AMERICAN NATIONAL COMPANY

Association

MSGA
Med-Sense Guaranteed Association

Billing and Customer Service

MyBenefitsKeeper

03/2023

MSGASTM-NE

Association

MSGA
Med-Sense Guaranteed Association

The Med-Sense Guaranteed Association (MSGA) is a Not-For-Profit corporation. Members of the MSGA enjoy discounts on a variety of health and travel services. There are multiple memberships of the association; the following is a brief overview of the benefits offered though not all benefits are included in every membership of the association.

- **Sprint® Cell Phone Service (for New Sprint® Subscribers only)**
- **ID Resolution Identity Theft Service**
- **VSP Individual Vision Plans**
- **24-Hour Nurse Helpline Plan**
- **Gateway Medicard**
- **Easy Hearing-Discount Hearing Service**
- **Travel Assistance Benefits**
- **Customized Web Services – NAC Web Services**
- **UPS™ Express Delivery Services**
- **24-Hour Emergency Roadside Assistance**
- **Office Depot® Office Supplies and Furniture**
- **Hewlett-Packard® Computer and Digital Equipment**
- **Saving Benefits Perks Program**
- **GymAmerica.com**
- **TrueCar Auto Buying Service**
- **ADP® Payroll Processing Service**
- **Swansonvitamins.com - Vitamins and Nutritional Supplements**
- **AVIS®, Budget® and Dollar® Rent A Car - Car Rental Discounts**
- **1800Flowers.com®**
- **Constant Contract®**
- **Grainger® Discount Program Facility, Maintenance, and Operations Product**
- **Magazine Line & Magazine.com® - Magazine Discounts**
- **Cord Moving and Storage Co. - Moving Service**
- **TravelerBonus.com**
- **Point Health**

Disclaimer: *Association membership is not required in all states. MSGA association benefits are not affiliated with Standard Life and Accident Insurance Company. Select STM benefits are not dependent on the use of the association's providers. MSGA 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 MSGA Membership Guide for complete details.*

Product Summary

Plan 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
Overall Coverage Period Maximum Benefit Options	$100,000, $250,000, $750,000, $1,000,000, $1,500,000
Coverage Period Options	Available for up to 364 days of coverage depending upon state regulations
Network	The member can choose to be treated by any doctor or hospital facility for covered services and receive the same level of benefits. Plan allows up to 150% of Medicare allowable charges
Coverage Effective Date	Next day coverage; later effective date available, but not to exceed 45 days from date of processed application
Age Eligibility	18-64 years old and their dependent unmarried children under 26 years old; and can answer "No" to all of the questions in the application for insurance. Child only coverage available for ages 0-25 (adult rates apply to anyone 18 or older)
Waiting Periods	• 5 days for sickness • 6 months for various covered surgeries • 30 days for cancer
Select STM is great for those who are:	• Between jobs or have been laid off • Waiting for employer benefits • Part-time or temporary employees • Recently graduated • Without adequate health insurance

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 does the Waiver of Pre-Existing Conditions Rider work?

If a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, develops during your initial policy term, the Waiver of Pre-Existing Conditions Rider will allow resulting charges to be paid in the consecutive policy term. 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.

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.

Disclaimer:

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, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR 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.

Plan Benefits

Benefits	Plan 1	Plan 2	Plan 3
Plan 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
Overall Coverage Period Maximum Benefit Options	$100,000, $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	**Plan 1**	**Plan 2**	**Plan 3**
Outpatient Surgery 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 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 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.

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Plan Benefits (Cont.)

Copayments (Copayments paid do not apply towards the Plan Deductible or Out-of-Pocket Maximum)	**Plan 1**	**Plan 2**	**Plan 3**
Advanced Diagnostic Studies Copayment	No 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.	No Copayment
Doctor's Office or Urgent Care Center Visits Copayment	$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.	$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 Copayment	$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.
Health Risk Screening Copayment	$50 Copayment per Covered Person for the first visit per Coverage Period. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	$50 Copayment per Covered Person for the first visit per Coverage Period. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	$50 Copayment per Covered Person for the first visit per Coverage Period. Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.

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Plan Benefits (Cont.)

Inpatient Hospital Services (Eligible Expenses are subject to Deductibles and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.	Subject to Deductible and Coinsurance
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)

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Plan Benefits (Cont.)

Outpatient Hospital Services (Eligible Expenses are subject to Deductibles and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.	Subject to Deductible and Coinsurance, excluding Outpatient Surgery
Surgery Services (Eligible Expenses are subject to Deductibles and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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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Plan Benefits (Cont.)

Other Services (Eligible Expenses are subject to Deductibles and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.
Health Risk Screening Benefit	After the Health Risk Screening Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	After the Health Risk Screening Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.	After the Health Risk Screening Copayment shown above, Coinsurance is 100% of Eligible Expenses and is not subject to the Plan Deductible.
Routine Child Heath 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.

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Plan Benefits (Cont.)

Other Services (Eligible Expenses are subject to Deductibles and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.

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Plan Benefits (Cont.)

Mental Disorders (Eligible Expenses are subject to Deductible and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.
Drug Use (Eligible Expenses are subject to Deductible and Coinsurance)	**Plan 1**	**Plan 2**	**Plan 3**
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.
Waiver of Pre-Existing Conditions Rider	**Plan 1**	**Plan 2**	**Plan 3**
	Yes	Yes	Yes

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STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

Home Office: One Moody Plaza, Galveston, Texas, 77550

Nebraska Comparison Summary

	Group Short Term Medical Insurance Plans	ACA Individual Health Insurance Plans
Coverage for Pre-Existing Conditions	Pre-Existing Conditions are not covered.	ACA plans will not deny benefits due to your Pre-Existing Conditions.
Preventive or Wellness Care	Routine pediatric care is covered. Annual adult routine physical exams are covered.	Preventive care is one of the 10 Essential Health Benefits 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	Both Mental Illness and Substance abuse is covered but has maximums on the number of covered days and amount of benefit.	Covered as an essential health benefit.
Prescription drug coverage	Outpatient prescription drugs are not covered.	Covered as an essential health benefit.
Enrollment - Availability of Coverage	Available at any time of the year. Subject to medical underwriting.	Limited to 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, after you apply.	No waiting periods.
Length of Coverage	Coverage duration periods from 30 days to 364 days are available.	Coverage duration available monthly usually for 12 months and renewable subject to new premiums.
Maximum Benefit	**Plan 1:** Maximum benefit per coverage duration period is available from $250,000 to $100,000,000. **Plan 2 or 3:** Maximum benefit per coverage duration period is available from $100,000 to $1,500,000.	**Plan 1:** Unlimited **Plan 2 or 3:** Unlimited
Type of Coverage	Short term medical insurance coverage. Coverage varies by plan, and plans are NOT required to include the 10 essential health benefits required by the ACA.	Comprehensive medical insurance coverage. All plans include the 10 essential health benefits required by the ACA.
Provider Network	Access to any provider; because there is no network, patients may be balanced billed.	Access to a network of providers. When insureds use in-network providers, they are not subject to balance billing.

	Group Short Term Medical Insurance Plans	ACA Individual Health Insurance Plans
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.
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.

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 Certificate Effective Date of coverage under the Policy.
   b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 24 month period immediately prior to the Covered Person's Certificate 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.

This exclusion does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with **PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.**

2. 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 Certificate Effective Date of coverage under the Policy.
   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 Certificate Effective Date of coverage under the Policy.

3. Charges during the first 6 months after the Certificate 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. Herniorrhaphy

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

4. 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. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
   f. Gallbladder Surgery
5. Charges which are not incurred by a Covered Person during his/her Coverage Period.
6. Charges which exceed any limits or limitations specified in this Certificate, including the Schedule of Benefits.
7. Charges for services of supplies in excess of the Maximum Allowable Expense.
8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.
9. Mental, emotional or nervous disorders or counseling of any type, unless specifically covered as an Eligible Expense.
10. Marital counseling or social counseling.
11. Treatment for Drug Abuse, unless specifically covered as an Eligible Expense.
12. 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.
13. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
14. 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.
15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.
16. 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.
17. Cosmetic Treatment, except for reconstructive surgery where expressly covered as an Eligible Expense.
18. Weight modification or surgical treatment of obesity.

Disclaimer: *Select STM plan limitations, exclusions, terms and conditions may differ by state. Please check the policy/certificate provided by Policy Form Series SL-AX20STM-NE for complete details.*

Limitations & Exclusions (Cont.)

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

19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
20. 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.
21. 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, unless specifically covered as an Eligible Expense.
22. Routine pre-natal care, Pregnancy, child birth, and post-natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
23. Sclerotherapy for veins of the extremities.
24. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
25. 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.
26. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
27. Chronic fatigue or pain disorders.
28. Kidney or end stage renal disease.
29. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
30. Treatment for cataracts.
31. Treatment of sleep disorders.
32. Treatment required as a result of complications or consequences of a treatment or condition not covered under this Certificate.
33. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
34. 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.
35. 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 Certificate.
36. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
37. Spinal manipulation or adjustment.
38. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinesiotherapy, unless specifically covered as an Eligible Expense.
39. 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.
40. 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.
41. Care, treatment or supplies for the feet, and orthopedic prescription devices to be attached to or placed in shoes.
42. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions; treatment of corns, calluses or toenails; and orthopedic shoes.
43. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
44. Exercise programs, whether or not prescribed or recommended by a Doctor.
45. Telephone or Internet consultations, except for Telehealth, and/or treatment or failure to keep a scheduled appointment.
46. Charges for travel or accommodations, except as expressly provided for local ambulance.
47. All charges incurred while confined primarily to receive Custodial or Convalescent Care.
48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada unless specifically covered as an Eligible Expense.
49. Any services or supplies in connection with cigarette smoking cessation.

Disclaimer: *Select STM plan limitations, exclusions, terms and conditions may differ by state. Please check the policy/certificate provided by Policy Form Series SL-AX20STM-NE for complete details.*

Limitations & Exclusions (Cont.)

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

50. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.
51. 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.
52. Services or supplies which are not included as Eligible Expenses as described herein.
53. 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, mountain climbing, 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, rodeo activities, or similar hazardous activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.
54. 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.
55. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor.
56. Intentionally self-inflicted Injury or Sickness (whether the Covered Person is sane or insane).
57. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
58. 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.
59. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered as an Eligible Expense.
60. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
61. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.
62. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
63. 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.
64. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

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Network & Repricing

MultiPlan® 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 allows 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 Standard Life and Accident Insurance Company and the insurance benefits provided are not dependent on the use of this network. This plan 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 an 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 consultations, 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 non-insurance benefits are not affiliated with Standard Life and Accident Insurance Company.*