Pennsylvania Select STM

Carrier and Underwriter

Billing and Customer Service

06/2022

STM-PA

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
Providers	You can choose to be treated by any provider for covered services; however, the PHCS network gives insureds access to negotiated rates. Plan pays up to 150% of Medicare allowable charges
Coverage Effective Date	Next day coverage; later effective date available, but not to exceed 45 days from 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	• 15 days for sickness and cancer • 6 months for various covered surgeries
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 insured 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 insured purchased the Waiver of Pre-Existing Conditions Rider during their initial purchase.

How will consecutive policy terms work?

Coverage under this plan is provided on a short term basis and is not renewable. Although the plan may be rewritten for a new separate coverage period (as long as you meet eligibility criteria), the coverage does not continue from one certificate to another. A new enrollment form must be submitted with a new effective date. Any medical condition which occurred or existed under the previous certificate will be treated as a Pre-Existing Condition under the new one.

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. 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.

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 policy provided by Policy Form Series SL-AX20STMI-P-PA for complete details.*

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.	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)

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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.	Payable for miscellaneous Outpatient Hospital expenses, 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.
Substance 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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Limitations & Exclusions

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

Pre-Existing Conditions: Pre-Existing Conditions mean a condition for which medical advice or treatment was recommended by a Doctor or received by a Doctor 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.

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: Covered Persons will only be entitled to receive benefits for Sicknesses or cancer, that begin, by occurrence of symptoms and/or receipt of treatment, more than 15 days following the Covered Person's Policy 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 Substance 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.
19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.

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Limitations & Exclusions (Cont.)

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

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. 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 Certificate.
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 Certificate.
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.
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.

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Limitations & Exclusions (Cont.)

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

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, 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.
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. 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.
55. Intentionally self-inflicted Injury or Sickness
56. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
57. 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.
58. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered as an Eligible Expense.
59. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
60. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.
61. 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.
62. 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.
63. 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

PHCS Network (Private Healthcare Systems)

Insureds under this plan receive access to the PHCS network, and may choose to be treated in or out of this network. This network entitles insureds access to doctors and hospital facilities who are contracted with PHCS to provide specific medical care at negotiated rates. Insurance benefits provided are not dependant on the use of this network.

- Locate providers at www.multiplan.com
- Approximately 900,000 healthcare providers under contract
- Estimated 57 million members accessing the network products
- Nearly 110 million claims processed through the network each year

Facility Charges

Plan pays up to 150% of Medicare allowable charges.

Disclaimer: *The amount of reduction varies and type of medical service received. Insureds must pay for all services, no portion of any provider's fees will be reimbursed or otherwise paid by MultiPlan PHCS network. MultiPlan PHCS does not process claims, they only provide a network of providers who have agreed to accept negotiated rates. The list of participating providers is subject to change without notice. Insureds under this plan receive access to the PHCS network, and may choose to be treated in or out of this network. The PHCS 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. For more information about this network please visit www.multiplan.com.*