PRECISE CHOICE
Short Term Medical

AWA
Affiliated Workers Association

Precise Choice STM Agent Guide

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Welcome to AWA

Membership to Affiliated Workers Association (AWA) has its advantages. You are now part of a non-profit organization comprised of small business owners, self-employed professionals and entrepreneurs from all across America. AWA is committed to providing education, resources and benefits to help our members save money, time and grow their business.

As an AWA member, you receive valuable resources for information to help you navigate through the complexity of running a business. You also have access to industry-leading benefits to help you and your family stay healthy and reduce expenses in your daily life, like telemedicine, insurance and roadside assistance.

Who We Serve

Our membership is as diverse as our population, ranging from a shop owner in Texas to a freelance web designer in Pennsylvania. Membership is open to small business owners, independent contractors and entrepreneurs ages 18 and over, and can extend to the entire family.

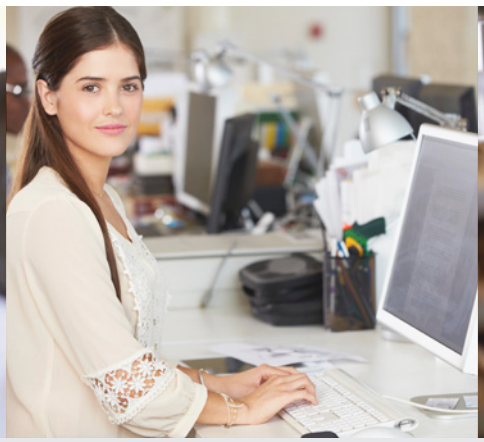
Our Approach

One word that defines our commitment to our members: Empowerment. We work tirelessly to research resources and benefits that will help our members reduce overhead expenses and learn how to succeed in their business endeavors. We know our members work hard for their money, and we work hard for them. Seeking out the best benefit providers and assuring top-quality services is just part of the day-to-day business for the AWA.

Our Partners

SMALL BUSINESS MAJORITY

The AWA is proud to be a strategic partner with a national advocacy group, Small Business Majority, to support our members in small business growth and provide information on issues that impact small businesses, including government, health care reform, clean energy, and other areas.


Health Care Programs & Services

Health Care Programs & Services

Karis360 Patient Advocacy Services

Karis360's team of Advisors offer personalized, caring, expert service helping members navigate the complex and expensive healthcare maze. With services from Healthcare Navigator to Bill Negotiator to Surgery Saver to Chaplaincy, Karis360 will sort through your healthcare paperwork saving you time and money.

- ✓ Karis360 sorts through healthcare needs from start to finish
- ✓ Karis360 saves time and money
- ✓ Karis360 provides unlimited assistance from a Personal Advisor

Healthcare Navigator

Karis360 members never face the healthcare world alone. Each member has access to an expert Advisor to help address healthcare needs and concerns.

Appointment Scheduling
Advisors are happy to schedule primary care and specialist visits, labs, imaging, flu shots and more.

Looking for a Physician or Hospital?
Karis360 Advisors will find quality physicians, specialists and surgeons in the member's area who focus on the member's unique healthcare needs.

Need Alternative Treatments?
Advisors help find alternative care in areas like Chiropractic, Acupuncture, Homeopathic and Naturopathic.

Health Cost Estimates
Cost estimates for various outpatient procedures are provided so members know what to expect.

Medical Records Transfer
Karis360 Advisors organize the seamless transfer of member medical records between providers.

Insurance Policy Assistance
Advisors can help clarify health insurance benefits as well as help resolve issues and expedite solutions.

Elder Care Solutions
Members get help finding assisted living facilities, coordinating home health, Medicare questions, VA benefits, supplemental insurance and more.

Bill Negotiator

With two-thirds of all bankruptcies in America including a medical bill debt component, the Bill Negotiator becomes important as we assist members in avoiding financial hardship and possible bankruptcy.

Medical Bill Negotiation Karis360 Advisors will assign a dedicated Patient Advocate to work directly with a member's healthcare provider (doctor's offices, hospitals, etc.) to help reduce their medical bills. If a member has bills totaling over $2,000 from a single-related medical incident during membership, Advisors will negotiate the medical bills.

Pre-Negotiation Advisors can negotiate potential medical costs before a procedure. Members provide a written estimate stating the bill will likely total over $2,000 and Advisors will pre-negotiate the potential medical bills easing stress and saving money.

Results Karis360 has unparalleled results negotiating discounts. Members can see an average of 40-70% savings after insurance has been applied.

Surgery Saver

Each Karis360 member has access to an experienced Advisor who researches up to five surgical facilities for non-emergency procedures in the member's area with information regarding cost, quality, availability and physician privileges.
Results With Surgery Saver, members see an average savings of $13,000. Advisors have found a 66% difference between the highest and lowest quoted surgery costs between facilities.

Chaplaincy

On-staff Chaplains are available to spend time with members on the phone, listening and providing support. Sustaining, guiding and healing, Chaplains help members find answers and direction.

Note: Karis360 is not insurance and does not provide funds to pay for bills. This is a best-efforts service. Despite Karis360's diligent efforts on member's behalf, some providers refuse to make accommodations to help resolve outstanding medical bills.

Teladoc Telemedicine

Founded in 2002, Teladoc is a national network of physicians who use electronic health records, telephone consultations and online video consultations to diagnose, recommend treatment and write short-term, non-DEA-controlled prescriptions, when appropriate. Teladoc doctors are board-certified in internal medicine, pediatrics and family medicine. Consultations are available 24/7/365 with no fees and no time limit, allowing members to access quality care from wherever they are as opposed to more traditional and expensive settings like the doctor's office, urgent care or emergency room.

From your home, office, hotel room, or vacation campsite, simply make a phone call, and in most cases, speak to a doctor in less than 30 minutes, with an average call back time of less than 10 minutes. When you call Teladoc, you will always speak to a doctor who lives and works in the United States and is licensed to practice medicine in your state. Teladoc is also the only telemedicine provider able to treat children from 0-17[1]. And now available via mobile app, it's health care that fits in the palm of your hand.

95% member satisfaction rate with Teladoc.

92% of Teladoc members resolved their medical issue with Teladoc.

Call Teladoc:

- When your physician is not available
- For non-emergent medical care
- After normal hours of operation
- When on vacation or a business trip
- For second opinions

Teladoc Treats Non-Emergency Medical Issues such as:

- Cold and Flu symptoms
- Bronchitis
- Allergies
- Poison Ivy
- Pink eye
- Urinary tract infection
- Respiratory infection
- Sinus problems
- Ear infection
- and more!

Teladoc is simply a more convenient way for you to resolve many of your medical issues.

[1]Consults for children under the age of 18 must be accompanied by a parent, guardian, or approved consenter.

First consult in AR and DE will be by video, after that it can be phone or video.

VERY IMPORTANT: IN LIFE THREATENING EMERGENCIES, CALL 911 or go directly to the nearest hospital emergency room for treatment. If 911 is not available in your area, call the local police/fire department or go directly to the nearest hospital or emergency room.

Health Care Programs & Services

ScriptSave Prescription Savings Card

The ScriptSave Prescription Savings Card provides you access to discounted prescription drug prices. All household members can use the same card – including pets, if the pet medication is a common drug that is also used by people. There are no limits on how many times members and their family can use the card. Locate participating pharmacies and look up drug pricing at **www.awarxplan.com**.

Features

- Save between 15% to 75%, with average savings of 44% (based on 2014 national program savings data)
- Accepted at over 62,000 participating pharmacies nationwide, including major chains and independent pharmacies
- An open formulary so nearly all medications qualify for discounts
- Discounts on brand and generic medication - no physician referrals needed
- Members will always receive the lowest price available on your prescription purchase

Savings

- **FAMILIES WITH LIMITED OR NO PRESCRIPTION COVERAGE** can reduce out of pocket costs
- **INDIVIDUALS WITH PRESCRIPTION COVERAGE** can reduce the cost of medications that are not covered
- **SENIORS WITH MEDICARE PART D** can save on prescriptions that are EXCLUDED from coverage

Honored at Over 62,000 Participating Pharmacies, Including:

CVS pharmacy · Walmart Save money. Live better. · Kroger · TARGET · RITE AID PHARMACY · duane reade · Walgreens AT THE CORNER OF HAPPY & HEALTHY · kmart pharmacy

Plus Thousands of Additional Chains and Independent Pharmacies Nationwide.

DISCOUNT ONLY - NOT INSURANCE. Discounts are available exclusively through participating pharmacies. The range of the discount will vary depending on the pharmacy or provider chosen and services rendered. The program does not make payments directly to the pharmacies or providers. Members are required to pay for all health care services.

Health Care Programs & Services

IDLife Nutritional Products

No matter what your goals are in life, to look and feel better, lose weight, or get in the best shape of your life, IDLife is your systematic approach to achieving the health and wellness you've always wanted.

IDLife HEALTHY SIMPLIFIED

IDLife products are scientifically formulated to help you by providing therapeutic doses of specific nutrients to:

- Restore nutrients depleted by your Rx program
- Help your body resist Rx side effects
- Improve your overall nutrition status thus optimizing your health

Additionally, they have been pre-screened to avoid drug/nutrient interactions that may be present with your current vitamin program.

ENERGY
Drink & Chew

- Phase I (short term) - The Advantra Z gives you a rapid onset of energy.
- Phase II (mid term) - The caffeine gives you sustained energy, increasing focus, mental clarity metabolism, cognitive function performance and feelings of well-being.
- Phase III (long term) - Theobromine helps with fatigue protection, with no jitters or crash, appetite suppression, elevated mood and helps reduce fluid retention.

MEAL REPLACEMENT
Shake

- A superior low calorie, high-quality shake loaded with nutrients, with only six nutritional and organic ingredients.
- The only shake with 23 grams of cold-filtered whey protein and micro milled Chia.
- Simply the best tasting, most nutritious meal of the day.
- Non-GMO, Casein, Soy and Gluten free.

PRE WORKOUT

- Take your workout further and push through the plateau with Pre Workout from IDLife.
- A balanced complex of targeted amino acids, branched chain amino acids (BCAAs), vitamins, minerals, enzymes and nutrients to assist in maximizing your physical conditioning and mental focus.
- Combine Pre Workout with IDLife Post Workout formula to optimize lean muscle regeneration.

POST WORKOUT

- Reduce inflammation and soreness after exercise while promoting fast muscle repair with Post Workout from IDLife.
- A high quality complex of proteins, vital electrolytes and antioxidants that address post workout recovery.
- Get professional grade nutritional support for your body's muscular and nervous system with Post Workout from IDLife.

APPETITE CONTROL

- Advantra Z Citrus Aurantium boosts metabolism and increases lean muscle mass.
- Promotes thermogenesis and suppresses appetite.
- Increases energy level and mental clarity so you can stay sharp and focused while curbing your hunger.

SLEEP STRIPS

- Uses a complex of nutrients, including Melatonin, L-Theanine and 5HTP.
- Brings your body into balance so you can go to sleep fast, stay asleep, and get restful, restorative, deep sleep.
- Great mint flavored strips melt in your mouth.
- Wake up refreshed, never groggy, and ready to take on whatever the day has in store.

HYDRATE

- About 75% of Americans are dehydrated, which can lead to health complications.
- IDLife Hydrate is a formula of vital electrolytes, antioxidants, minerals and vitamins.
- Hydrate supports cardiovascular, muscular and nervous system functioning to keep you healthy and hydrated.

LEAN

- IDLife Lean is a natural way to boost metabolism, increase thermogenesis, reduce sugar cravings and promote the preservation and development of lean muscle mass.
- Whether your interest is weight management or building lean muscle, choose Lean as a part of your personal nutritional plan.

*These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease. * IDLife does not represent that its products are certified organic under the United States Department of Agriculture rules and regulations.*

Health Care Discounts

Health Care Discounts

The following disclosure is required to ensure you are aware that the following benefits are discount services and not insured benefits: Beltone Hearing Network, Cigna Discount Dental Network, Diabetic Supplies Savings, EyeMed Vision Network, MyMedLab/Pathology Network and One Call Care Radiology Network. While these programs offer valuable discounts and savings over the normal cost to AWA members, members are still required to pay for these services (less discounts) at the time they are purchased. It is vitally important that these services are represented as discount services to your clients rather than insured benefits.

Not available in AK, OK, UT, VT, WA. If you move to one of those states, your discount medical benefits will terminate.

Disclosures for pages 9-10: The discount medical, health, and drug benefits of this Plan (The Plan) are NOT insurance, a health insurance policy, a Medicare Prescription Drug Plan or a qualified health plan under the Affordable Care Act. The Plan provides discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plan. The range of discounts for medical, pharmacy or ancillary services offered under The Plan will vary depending on the type of provider and products or services received. The Plan does not make and is prohibited from making members' payments to providers for products or services received under The Plan. The Plan member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plan, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plan. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P.O. Box 630858, Irving, TX 75063. You may call (800) 269-3563 for more information or visit www.a1healthcare.com/members for a list of providers. The Plan will make available before purchase and upon request, a list of program providers and the providers' city, state and specialty, located in the member's service area. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint. **Note to DE, IL, LA, NE, NH, OH, RI, SD, TX, and WV consumers:** If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00.

Health Care Discounts

MyMedLab

MyMedLab is an efficient, affordable and confidential solution to medical laboratory testing. Using MyMedLab can save members 50%-80% on testing.

Hundreds of tests are available from MyMedLab, and the website provides information on a wide assortment of illnesses and medical testing. When members need a laboratory test, they can go to **https://awa.mymedlab.com/home** and order the test. A MyMedLab doctor will quickly approve the test, then members will receive an email telling them how to get their lab test order. Members just print the test order and go to the nearest lab and have the test done. The results will be available to view on their online personal health record on MyMedLab's website. Members can show the results to their doctor, or call the professionals at MyMedLab to help them understand the results.

MyMedLab is not available in AK, IL, OK, UT, VT, WA.

One Call Care

If the doctor orders radiology tests, members can get high-quality imaging services at reduced rates by using One Call Care. One Call Care combines a national network of highly credentialed radiology providers and unique scheduling services that can help members access radiology testing. When members use One Call Care, they can save 20%-50% on MRIs, PET and CT scans.

The program is voluntary and requires no additional paperwork or enrollment. Before an MRI or a PET or CT scan is scheduled, contact One Call Care. One Call Care can help find the most convenient provider in the member's area and schedule the test for them. One Call Care can also answer questions about the test and help members understand what to expect during the procedure.

Using One Call Care helps stretch the plan benefit dollars further and saves AWA members money.

One Call Care is not available in AK, OK, UT, VT, WA.

Beltone

Hearing health is a critical piece to overall health. Just as it is important to make time for regular eye exams, cholesterol screenings, and dental check-ups, it is important to schedule an annual hearing screening.

Members and their immediate family (parents, grandparents, spouse and children) will receive a free hearing screening and a 15% discount off the retail price of any Beltone hearing instrument at more than 1,500 locations across the country.

Beltone products are developed using only the latest hearing technology and are designed to fit just about any lifestyle and hearing loss. With 70 years of experience, highly trained professionals and friendly service, Beltone is the most trusted brand among adults 50+.

Beltone is not available in AK, OK, UT, VT, WA.

Health Care Discounts

Cigna Discount Dental

Save 15%-50%* on dental work through the Cigna Discount Dental Network. The discount is good at more than 80,000 dentists and specialists around the country. The discount card allows members to pay discounted rates for their dental work. Members just show the card to their dental care provider and pay the discounted rate for the services they receive. There is no limit to the number of times members can use their Cigna discount dental plan.

*Actual costs and savings vary by geographical location. Not available in AK, OK, MT, ND, SD, UT, VT, WA, WY.

Vision Network Savings

Save on eye examinations, eye glasses, contact lenses, lens options and accessories, LASIK and PRK laser vision procedure and frames from leading frame manufacturers.

Members have access to a national network of over 45,000 vision providers in 21,000 locations, including LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney Optical, along with their choice of participating independent optometrists, ophthalmologists and opticians located throughout the country.

Members can use this service as many times as they would like; there is no annual limit.

EyeMed is not available in AK, OK, UT, VT, WA.

Diabetic Supplies Savings

Through this program, AWA members can get diabetic testing supplies shipped directly to their door each month at a savings of 40% to 60% less than the retail drug store prices, including glucose meter, ultra-thin lancets, test strips and carrying case!

Monthly fees are based on the number of testing times per day and the supplies will meet their monthly need. There are no health restrictions and no limit on the number of times a year members can use this service. With eleven years of experience and a 100% satisfaction guarantee, the Diabetic Supplies Savings program provides reliable, affordable testing supplies to the thousands of diabetics who are uninsured or underinsured or have to pay out of pocket.

Diabetic Supplies Savings is not available in AK, IL, OK, UT, VT, WA.

Additional Benefits

AWA Consumer Solutions

- Car Rental Discounts
- GlobalFit Gym Network
- Gym America
- Magazine Discounts
- Massage Envy
- Moving Discounts
- 1-800-flowers
- Retail Benefits
- TrueCar Auto Buying Service

AWA Business Solutions

- ADP Payroll Processing
- Business AdvantEdge Program
- FedEx Shipping
- Hewlett-Packard Computer and Technology Products
- NAC Web Services
- Office Depot-OfficeMax Discount
- Penny Wise Office Supplies
- Sherwin Williams
- Sprint
- UPS Shipping
- and more!

PRECISE CHOICE
Short Term Medical

Plan Benefits

National General Accident & Health

National General Holdings Corp. (NGHC) is a publicly traded company with approximately $2.5 billion in annual revenue. The companies held by NGHC provide personal and commercial automobile insurance, recreational vehicle and motorcycle insurance, homeowner and flood insurance, self-funded business products, life, supplemental health insurance products, Short Term Medical, and other niche insurance products.

National General Accident & Health, a part of NGHC, is focused on providing supplemental and short term coverage options to Individuals, Associations and Groups. Products are underwritten by National Health Insurance Company (incorporated in 1965), Integon National Insurance Company (incorporated in 1987) and Integon Indemnity Corporation (incorporated in 1946). These three companies, together, are authorized to provide health insurance in all 50 states and the District of Columbia and have all been rated as A- (Excellent) by A.M. Best. Each underwriting company is financially responsible for its respective products.

National General
Accident & Health




About Precise Choice STM

The AWA provides members with a variety of value-added benefits including health care programs, services and discounts to help you manage everyday healthcare expenses, as well as consumer and lifestyle discounts and business solutions.

Precise Choice STM provides Short Term Medical insurance for individuals and families who find themselves without major medical coverage for a period of time. Members choose the deductible, coinsurance and term length that best suits their needs. Precise Choice STM is designed to be a temporary solution that can provide members with the confidence they need to safely navigate a time of transition with minimal risk.

Health Care Solutions

AWA's health care solutions span the most commonly needed services to keep members and their families healthy, while minimizing out of pocket expenses. These programs include 24/7 access to U.S.-based, board certified physicians via phone or online video, patient advocacy, savings on lab and imaging services, dental and vision discounts, prescription savings and more.[†]

Small Business Solutions

AWA also offers a variety of programs to help business owners reduce expenses on everyday operating essentials including office supplies and equipment, communications services, website development, payroll processing, printing, shipping and more.

Consumer Discounts

The AWA is committed to providing services and discounts that save members time, enrich their lives and maximize every dollar. Online shopping, car rental and purchase, massage and fitness memberships and magazine subscriptions are just a few of the consumer discounts available to Precise Choice members.

Insured Benefits

Precise Choice STM also provides your customers with short term medical insurance benefits. Precise Choice offers an affordable way for individuals and families to obtain coverage for their health care needs. Some of the advantages of a Precise Choice STM plan include:

- Deductible and coinsurance options allow members to choose the plan that fits their budget and coverage needs
- Standard Issue and Guaranteed Issue plans ensure members will be able to qualify for a plan
- One (1), Two (2) or Three (3) month, less one day term options.
- Aetna Open Choice PPO Network offers pre-negotiated, reduced rates

All the benefits in the AWA Membership and the Precise Choice STM plans work together to provide a complete solution and help members maximize savings! Affiliated Workers Association is pleased to make Precise Choice available to their members to help ease the burden of rising health care costs.

[†] Not all benefits are not available in all states.

About Precise Choice STM

Precise Choice STM Can Be The Perfect Solution When ...

- You missed the last open enrollment period
- You are in between jobs or your employer doesn't offer insurance coverage
- You are a new hire and have a waiting period until you are eligible for your company plan
- You are a student or recent graduate who is no longer eligible to remain on your parent's plan
- You want an alternative to COBRA coverage
- You are waiting for Medicare eligibility

How It Works

Satisfy The Deductible

Individuals choose the deductible option that is best for them. They will pay this amount out of pocket before the insurance coverage begins to pay for covered services.

Pay The Coinsurance Percentage

After individuals have met their deductible amount, the insurance carrier will pay a portion of the charge for covered services and the individual will pay the other portion for covered services.

Full Coverage

After the maximum out-of-pocket amount has been met (deductible and coinsurance), the insurance will pay 100% for covered services up to the lifetime maximum of $100,000 (GI*) or $1,000,000 (SI) per covered person.

* Guaranteed Issue (GI) STM plans are not available in all states.

Covered Medical Expenses

The following is a list of covered services as a result of a covered injury of sickness. Covered services may be subject to copays, deductibles and coinsurance and must be incurred while the coverage is in force. All benefits are subject to the terms, conditions, limitations, exclusions and maximums stated in the certificate. Covered services may vary by state.

Doctor's Office Visits
Urgent Care Facility Visits
Emergency Room Visits
Ambulance Trips
Inpatient Doctor Visits
Diagnostic Testing
Mammography

Hospital Covered Expenses
Outpatient Hospital Surgery
Surgeon
Anesthesia
Dental Care for Injuries
Physical Therapy
Hemodialysis

Organ Transplant and Marrow Reconstitution or Support
Miscellaneous Medical Services and Supplies
Radiation Therapy and Chemotherapy
Skilled Nursing Facility
Home Healthcare
Durable Medical Equipment
Oxygen

Health Eligibility Questions*

Individuals need to answer the questions below for **all family members applying for coverage**.

- Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid?
- Are you or any applicant:
  a. Now pregnant, an expectant father, in process of adoption, or undergoing infertility treatment?
  b. Over 300 pounds if male or over 250 pounds if female?
- Within the last 5 years has any applicant been diagnosed, treated, or taken medication for or experienced signs or symptoms of any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?
- Have you or any applicant been hospitalized for mental illness in the last 5 years or seen a psychiatrist more than 5 times during the last 12 months?
- Within the last 5 years has any applicant been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?
- If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?

* Eligibility Questions vary by state.

If the answer is "YES" to questions 1 through 5 or "NO" to question 6,
Individuals will not qualify for Standard Issue coverage,
but may enroll in a Guaranteed Issue Short Term Medical plan.

Standard Issue and Guaranteed Issue Short Term Medical plans
do not cover any pre-existing conditions. (Not applicable in IL)

Creditable Coverage and Rewrite Questions

Residents in the following states need to answer the questions below for **all family members applying for coverage**.

- **Colorado residents:** Have your or any other person to be insured been covered under two or more non-renewable short-term policies during the past twelve (12) months? (If "yes", then this policy cannot be issued. You must wait six (6) months from the date of you last such policy to apply for a short-term policy.)
- **Connecticut residents:** Have you or any person applying for coverage, had prior Short Term Medical coverage with Us[1]? (You must wait at least 30 days between plans.)
- **Idaho residents:** Have you or any person to be insured had prior Short Term Medical coverage with Us[1] within the last 64 days? (You must wait at least 64 days between plans.)
- **Maine residents:** Including the coverage you are applying for, have you or any person applying for coverage been insured with a Short Term Medical plan where the total number of months of coverage exceeds 24 months (2 years)?
- **Maryland, Missouri & South Dakota residents:** Have you or any person applying for coverage had prior health insurance with any carrier including a Short Term Medical with Us[1]? (If so, you must wait at least 64 days between plans.)
- **Michigan & Nevada residents:** In the last 12 months, have you or any person applying for coverage been insured with a Short Term Medical plan with Us[1] for 185 days (6 months)?
- **North Dakota residents:** Have you or any person applying for coverage, had more than one Short Term Medical plan(s) with Us[1]? (You must wait at least 6 months between plans.)
- **Oregon residents:** Including the coverage you are applying for, have you or any person applying for coverage been insured with a Short Term Medical plan(s) marketed by National General Accident & Health where the total number of months of coverage exceeds 12 continuous months? (If so, you must wait at least 60 days between plans.)
- **Tennessee residents:** Have you or any person applying for coverage been covered under a Short Term Medical plan in the last 30 days? (You must wait at least 30 days between plans.)
- **Wisconsin residents:** Have you or any person to be insured had prior Short Term Medical coverage marketed by National General Accident & Health within the last 64 days? (You must wait at least 64 days between plans.)

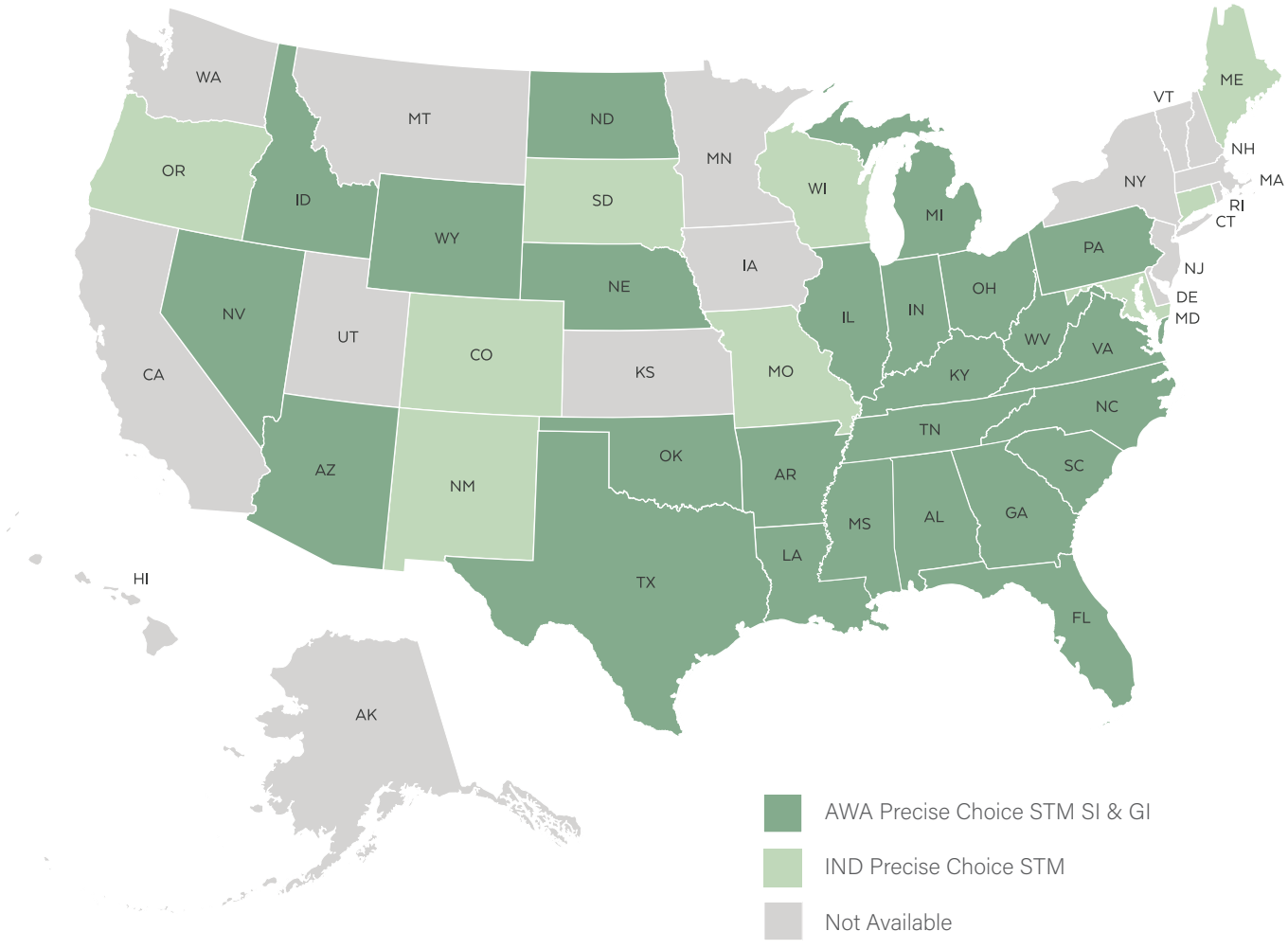
If the answer is "YES" to any question above,
Individuals will not be able to enroll in a Short Term Medical plan.

[1] "Us": National General Accident & Health markets products underwritten by National Health Insurance Company, Time Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation.

Membership & State Availability

Individuals may enroll in a Precise Choice STM plan and AWA membership if they meet the following eligibility requirements:

- Between the ages of eighteen (18) and sixty-four (64) at time of enrollment
- Legal Resident of the United States residing in an available state
- Not eligible for or enrolled in Medicare, Medicaid, Medical Disability or any other Federal or state-funded program
- Not covered under hospital, major medical, group health or other medical insurance coverage
- Not pregnant at the time of application
- Not a full-time member of the armed forces
- Applicants must meet the carrier's underwriting requirements at the time of application
- Legal Spouse and Domestic Partners accepted
- Dependent children age sixty (60) days to twenty-five (25) years



GI Association STM plans are NOT available in IL; GI Individual STM plans are NOT available in CO, CT, ME, MD, NM, OR.

Eligibility Restrictions

State	SHORT TERM MEDICAL RESTRICTIONS
AL	3 month maximum benefit period.
AK	Not available.
AZ	3 month maximum benefit period.
AR	3 month maximum benefit period.
CA	Not available.
CO	3 month maximum benefit period; Maximum of 2 plans with any carrier in 12 months before a 6 month gap is required for additional STM plan.
CT	3 month maximum benefit period; 30 day wait before purchasing another plan.
DE	Not available.
DC	3 month maximum benefit period.
FL	3 month maximum benefit period.
GA	3 month maximum benefit period.
HI	Not available.
ID	3 month maximum benefit period; 64 day wait before purchasing another plan.
IL	3 month maximum benefit period.
IN	3 month maximum benefit period.
IA	Not available.
KS	Not available.
KY	3 month maximum benefit period.
LA	3 month maximum benefit period.
ME	3 month maximum benefit period; Combined total of the new policy and successive policies cannot exceed 24 months.
MD	3 month maximum benefit period; 64 day wait before purchasing another plan.
MA	Not available.
MI	3 month maximum benefit period; Limited to 185 days of Short Term Medical Coverage in any 365 day period.
MN	Not available.
MS	3 month maximum benefit period.
MO	3 month maximum benefit period; 64 day wait before purchasing another plan.
MT	Not available.
NE	3 month maximum benefit period.
NV	3 month maximum benefit period; Limited to 185 days of Short Term Medical Coverage in any 365 day period.
NH	Not available.
NJ	Not available.
NM	3 month maximum benefit period.
NY	Not available.
NC	3 month maximum benefit period.
ND	3 month maximum benefit period; 6 month wait before purchasing another plan.
OH	3 month maximum benefit period.
OK	3 month maximum benefit period.
OR	3 month maximum benefit period; Limited to a maximum of 12 consecutive months of STM before a 60 day gap in coverage is required.
PA	3 month maximum benefit period.
RI	Not available.
SC	3 month maximum benefit period.
SD	3 month maximum benefit period; 64 day wait before purchasing another plan.
TN	3 month maximum benefit period. 30 day separation required between policies. Not more than 2 years total under any short term policy.
TX	3 month maximum benefit period.
UT	Not available.
VT	Not available.
VA	3 month maximum benefit period.
WA	Not available.
WV	3 month maximum benefit period.
WI	3 month maximum benefit period; 64 day wait before purchasing another plan.
WY	3 month maximum benefit period.
Legend	AWA Precise Choice STM SI & GI plans	IND Precise Choice STM plans*

GI Association STM plans are NOT available in IL; GI Individual STM plans are NOT available in CO, CT, ME, MD, NM, OR.

Precise Choice STM Benefits - Standard Issue

STANDARD ISSUE SHORT TERM MEDICAL INSURANCE BENEFITS Underwritten by National Health Insurance Company, Integon National Insurance Company and Integon Indemnity Corporation				
Options - Choose Your Deductible and Coinsurance				
Deductible [1]	$1,000	$2,500	$5,000	$10,000
Coinsurance	80/20%	80/20%	80/20%	100/0%
Out-Of-Pocket Maximum (in addition to Deductible)	$1,500	$1,500	$2,500	$0
Details - All Plans				
Lifetime Maximum Amount	$1,000,000			
Length of Coverage	Choice of 1 month, 2 months, or 3 months, less one day.			
Pre-Existing Conditions Limitation	12 month lookback in most states (6 months in ID, NE, NV, NM, SD). NA in IL.[2]			
Free Look Period	A 10-day period to return your certificate for a full refund.[3]			
Coverage Rewrite	Certificates are non-renewable. Re-applications are allowed, unless otherwise restricted by state regulation (varies by state).			
PPO Network	Aetna Open Choice® PPO			
Benefits				
Hospital Confinement ICU Confinement	Subject to Deductible and Coinsurance; Not to exceed average semi-private room and board rate.			
Inpatient Physician / Surgeon	Subject to Deductible and Coinsurance.			
Assistant Surgeon	Subject to Deductible and Coinsurance; up to 20% Surgeon's Benefit.			
Emergency Room	Unlimited visits; $250 access fee per visit, waived if admitted to hospital. Subject to Deductible and Coinsurance.			
Ambulance	Unlimited trips; plan pays a maximum of $250 per trip.			
Doctor's Office Visits	Subject to Deductible and Coinsurance; Plan will pay $50 for the first office visit per coverage term in CO, FL, MD, NM, OH and OR only.			
Urgent Care	Unlimited visits; $50 copay per visit, then subject to coinsurance.			
Outpatient Anesthesia	Subject to Deductible and Coinsurance; up to 20% Surgeon's Benefit.			
Diagnostic Tests	Subject to Deductible and Coinsurance. Tests include: MRI; CAT Scan; PET Scan; Colonoscopy; Bone Marrow Test; Stress Test, Laboratory Test, Mammography; EEG; X-Ray; Breast Ultrasound; Sigmoidoscopy.			
Physical Therapy	Subject to Deductible and Coinsurance; Maximum benefit of $50 per day.			
Skilled Nursing Facility	Subject to Deductible and Coinsurance. Maximum 50 days per coverage term and maximum of $150 per day.			
Home Healthcare	Subject to Deductible and Coinsurance. Maximum of 60 visits per coverage term; a visit is defined as up to 4 consecutive hours of home healthcare services in a 24 hour period. Maximum of 1 visit per day.			
Transplant	Subject to Deductible and Coinsurance; $100,000 benefit per coverage term.			

[1] Per-person deductible and out-of-pocket amounts capped at 3x the individual amounts for a family greater than three. This means that when three insured family members satisfy their individual deductibles and out-of-pocket amounts, the remaining individual deductibles and out-of-pocket amounts will be deemed as satisfied for the remainder of the coverage term.

[2] Pre-Existing Conditions Limitation does not apply in Illinois.

[3] Certificates returned within the free look period will be terminated back to the effective date and member will forfeit any potential claims in lieu of a full refund including the enrollment fee. After the free look period, cancellations require a minimum 10-day cancellation notice and will not be eligible for refund or any pro-rated fees. We have the right to change the premium we charge. If we plan to make a change, we will send you a notice at least 60 days before we make it. We may change premium rates at any time for reasons which affect the risk assumed, including but not limited to if a change occurs in the plan design, the named insured moves or changes his/her address or a new law or a change in any existing law is enacted which applies to this plan.

Precise Choice STM Benefits - Guaranteed Issue

GUARANTEED ISSUE SHORT TERM MEDICAL INSURANCE BENEFITS Underwritten by National Health Insurance Company, Integon National Insurance Company and Integon Indemnity Corporation		
Options - Choose Your Deductible and Coinsurance		
Deductible[1]	$3,500	$5,000
Coinsurance	80/20%	90/10%
Out-Of-Pocket Maximum (in addition to Deductible)	$6,500	$5,000
Details - All Plans		
Lifetime Maximum Amount	$100,000	
Length of Coverage	Choice of 1 month, 2 months, or 3 months, less one day.	
Pre-Existing Conditions Limitation	12 month lookback in most states (6 months in ID, NE, NV, SD).	
Free Look Period	A 10-day period to return your certificate for a full refund.[2]	
Coverage Rewrite	Certificates are non-renewable. Re-applications are allowed, unless otherwise restricted by state regulation (varies by state).	
PPO Network	Aetna Open Choice® PPO	
Benefits		
Hospital Confinement ICU Confinement	Subject to Deductible and Coinsurance; Not to exceed average semi-private room and board rate.	
Inpatient Physician / Surgeon	Subject to Deductible and Coinsurance.	
Assistant Surgeon	Subject to Deductible and Coinsurance; up to 20% Surgeon's Benefit.	
Emergency Room	Unlimited visits; $250 access fee per visit, waived if admitted to hospital. Subject to Deductible and Coinsurance.	
Ambulance	Unlimited trips; plan pays a maximum of $250 per trip.	
Doctor's Office Visits	Subject to Deductible and Coinsurance; Plan will pay $50 for the first office visit per coverage term in FL and OH only.	
Urgent Care	Unlimited visits; $50 copay per visit, then subject to coinsurance.	
Outpatient Anesthesia	Subject to Deductible and Coinsurance; up to 20% Surgeon's Benefit.	
Diagnostic Tests	Subject to Deductible and Coinsurance. Tests include: MRI; CAT Scan; PET Scan; Colonoscopy; Bone Marrow Test; Stress Test, Laboratory Test, Mammography; EEG; X-Ray; Breast Ultrasound; Sigmoidoscopy.	
Physical Therapy	Subject to Deductible and Coinsurance; Maximum benefit of $50 per day.	
Skilled Nursing Facility	Subject to Deductible and Coinsurance. Maximum 50 days per coverage term and maximum of $150 per day.	
Home Healthcare	Subject to Deductible and Coinsurance. Maximum of 60 visits per coverage term; a visit is defined as up to 4 consecutive hours of home healthcare services in a 24 hour period. Maximum of 1 visit per day.	
Transplant	Subject to Deductible and Coinsurance; $100,000 benefit per coverage term.	

[1] Per-person deductible and out-of-pocket amounts capped at 3x the individual amounts for a family greater than three. This means that when three insured family members satisfy their individual deductibles and out-of-pocket amounts, the remaining individual deductibles and out-of-pocket amounts will be deemed as satisfied for the remainder of the coverage term

[2] Certificates returned within the free look period will be terminated back to the effective date and member will forfeit any potential claims in lieu of a full refund including the enrollment fee. After the free look period, cancellations require a minimum 10-day cancellation notice and will not be eligible for refund or any pro-rated fees. We have the right to change the premium we charge. If we plan to make a change, we will send you a notice at least 60 days before we make it. We may change premium rates at any time for reasons which affect the risk assumed, including but not limited to if a change occurs in the plan design, the named insured moves or changes his/her address or a new law or a change in any existing law is enacted which applies to this plan.

Pre-Authorization Notice

Persons insured under a Short Term Medical plan are required to notify us of all hospital admissions, outpatient surgeries and certain other services. The notification process must be followed in its entirety to receive maximum benefits, the full list of services that require pre-authorization are listed in the insureds certificate/policy. Benefits for unauthorized services of otherwise Covered Expenses will be reduced.

Each Short Term Medical identification card includes the phone number to call for authorizations.
Refer to the state specific contract for detailed information regarding which services require notification.

Reduction of Payment

These authorization requirements are included to assist a covered person in obtaining the most appropriate medical care. Follow the requirements described above so you can receive the full benefits of coverage under the policy. If you do not obtain authorization for the services listed above or if the course of treatment is not performed in the manner authorized, your benefits will be reduced for otherwise Covered Expenses by the amount shown on the Benefit Schedule. The reduced amount, or any portion thereof, will not be applied to any deductible or out-of-pocket maximum determination.

In addition, NO benefits will be paid for expenses:

1. That are not for medically necessary services; or
2. That are otherwise not considered a covered expense; or
3. For organ transplant or marrow reconstitution or support if the procedure was not authorized prior to the beginning of the transplant evaluation, testing, preparative treatment or donor search.

AN AUTHORIZATION IS NOT THE SAME AS "VERIFICATION OF BENEFITS" AND DOES NOT GUARANTEE THAT BENEFITS WILL BE PAID. AUTHORIZATION ADDRESSES ONLY THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE CARE TO BE RECEIVED, INCLUDING THE TYPE OF TREATMENT AND FACILITY. PAYMENT OF BENEFITS IS SUBJECT TO ALL THE TERMS, LIMITS, AND CONDITIONS IN THE POLICY, CERTIFICATE AND BENEFIT SCHEDULE.

THE REVIEW PROCESS MUST BE REPEATED IF TREATMENT IS RECEIVED MORE THAN 30 DAYS AFTER OUR REVIEW OR IF THE TYPE OF TREATMENT, ADMITTING DOCTOR OR FACILITY DIFFERS FROM WHAT WE AUTHORIZED.

Limitations & Exclusions

Limitations and exclusions may vary by state. Please check your policy certificate for a full list of limitations and exclusions. This plan will not pay benefits for Sickness or Injuries that are caused by or expenses incurred for:

LIMITATIONS & EXCLUSIONS

1. Intentionally self-inflicted Sickness or Injury, whether sane or insane.
2. Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.
3. Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
4. Treatment of Sickness or Injury caused by or contributed to by war or any act of war; or participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.
5. Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the Policy is in force.
6. Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
7. Normal pregnancy or childbirth; routine well baby care including Hospital nursery charges at birth; or abortion, except as provided in the complications arising from pregnancy provision in the Benefits section.
8. Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization.
9. Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
10. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
11. Treatment and medication to stimulate growth and growth hormones for any purpose.
12. Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
13. Sterilization and drugs or devices used directly or indirectly to promote or prevent conception.
14. Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
15. All treatments for varicose veins.
16. Therapy or treatment for learning disorders or disabilities or developmental delays.
17. Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
18. Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section.
19. Treatment of Mental Health Conditions or substance abuse; and outpatient treatment of mental and nervous disorders, except as specifically covered.
20. Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.
21. Treatment or services required due to accidental Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Covered Person is charged with any violation in connection with the accident.
22. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
23. Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
24. Treatment or services required due to Injury sustained while participating in any interscholastic or inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
25. Treatment or services required for Sickness or Injury resulting from being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Sickness or Injury took place.
26. Expense incurred due to Sickness or Injury of which a contributing cause was the Covered Person's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person's being under the influence of illegal narcotics or non-prescribed controlled substances.
27. Custodial Care; respite care; rest care; or supportive care.
28. Expenses incurred outside of the United States or its possessions or Canada.
29. Expenses incurred for Experimental or Investigational Treatment, subject to the Pre-Authorization section.
30. Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.
31. Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section.
32. Reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis, except as provided in the Benefits section.
33. Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.
34. Treatment, services or supplies rendered or received when coverage under the Policy is not in effect, except as provided under the Extension of Benefits provision.
35. Any amount in excess of the Usual, Reasonable and Customary Amount, as determined by Us under this Policy.
36. Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
37. Treatment, services or supplies that are not Medically Necessary as determined by Us under this Policy.

Insurance Products Underwritten by National Health Insurance Company in: AL, AZ, AR, DC, GA, ID, IL, IN, KY, LA, ME, MD, MI, MS, MO, NE, NV, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, VA, WV, WI, WY; Integon National Insurance Co in: CO, CT; and Integon Indemnity Corporation in FL.

Limitations & Exclusions

LIMITATIONS & EXCLUSIONS (CONTINUED)

38. Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Covered Person or Doctor.
39. Treatment, services or supplies not described in the Benefits section.
40. Expenses for marital counseling or social counseling.
41. Outpatient Prescription 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 except as provided in the Benefits section for diabetes.
42. Treatment, services or supplies provided at no cost to the Covered Person.
43. Telephone consultations or failure to keep a scheduled appointment.
44. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk. 45. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
46. Treatment for cataracts.
47. Treatment of the temporomandibular joint unless Medically Necessary and caused by a congenital or developmental deformity, Sickness or Injury and except as specifically covered.
48. Biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy, except as provided in the Benefits section for acquired brain injury.
49. Orthoptics and visual eye training.
50. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and nonmedical self-care or self-help programs.
51. Any services or supplies in connection with cigarette smoking cessation.
52. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
53. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this Policy and as provided in the Benefits section for reconstructive surgery for craniofacial abnormalities and temporomandibular joint disorder.
54. Spinal manipulation or adjustment.
55. Sclerotherapy for veins of the extremities.
56. Chronic fatigue or pain disorders; or immunodeficiency disorders.
57. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
58. Kidney or end stage renal disease.
59. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
60. Hospice care.
61. Costs of 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, except as specifically covered.
62. Expenses for surgery during the first 6 months after the Effective Date of Coverage for a Covered Person for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis or carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-Existing Conditions exclusion); tonsillectomy, adenoidectomy, repair of deviated nasal septum or any type of surgery involving the sinus, myringotomy, tympanotomy, herniorraphy, or cholecystectomies.

PRE-EXISTING CONDITION EXCLUSION

Charges resulting directly from a pre-existing condition are excluded from coverage. Pre-existing conditions are referred to as conditions for which medical advice, diagnosis, care, or treatment (including services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 12 months immediately preceding the effective date, unless a lesser period is required by state regulation. Pre-existing Condition Exclusion does not apply in IL.

SHORT TERM MEDICAL IS NONRENEWABLE

This Short Term Medical policy is nonrenewable, and plan termination is not considered a qualifying life event for purposed of enrolling in a major medical plan. Therefore, depending on the length of your coverage term, you may have a gap in insurance coverage until you can begin coverage with a new Short Term Medical or other health plan.

If you choose to purchase a new Short Term Medical plan, you must submit a new application. Any illness or conditions that developed and was covered under your previous plan is considered a pre-existing condition and will not be covered by subsequent Short Term Medical plans. Reapplication may not be available in all states. Pre-existing Condition Exclusion does not apply in IL.

SHORT TERM MEDICAL DOES NOT MEET MINIMUM ESSENTIAL COVERAGE AS MANDATED BY THE AFFORDABLE CARE ACT

Short Term, limited duration plans are not subject to certain provisions of federal health care reform, including the provisions related to Essential Health Benefits, lifetime limits, preventive care, guaranteed renewability, and pre-existing conditions. The pre-existing condition exclusion for Short Term Medical plans will apply for all insureds, including those under the age of 19. Know your plan. Short Term Medical plans offer affordable medical coverage, but are medically underwritten (so you can be declined) and do not provide Minimum Essential Coverage.

What does this mean for the applicant? They may have to pay a tax penalty, depending on their income level and the cost of plans available. Examples of the claims Short Term Medical plans do not cover are for most preventive care, maternity, mental health and treatment related to medical conditions they had prior to the plan's effective date. Because these plans are not guaranteed renewable, the applicant may not be eligible for another short-term plan after the plan's termination date; and the pre-existing condition exclusion will apply to any conditions that arose during any prior short term plans.

DEPENDENT DEFINITIONS

Spouse: Your lawful spouse, common law spouse, or domestic partner, on the day we issue your certificate.

Dependent Children: Any natural children, step-children, legally adopted children, children placed into your custody for adoption including children for whom you are a party in a suit in which the adoption of the child is being sought or grandchildren if your grandchildren are dependents of yours for federal income tax purposes at the time of application for coverage of the grandchildren are made; and who are under 26 years of age.

Insurance Products Underwritten by National Health Insurance Company in: AL, AZ, AR, DC, GA, ID, IL, IN, KY, LA, ME, MD, MI, MS, MO, NE, NV, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, VA, WV, WI, WY; Integon National Insurance Co in: CO, CT; and Integon Indemnity Corporation in FL.

Nationwide PPO Network

Aetna Open Choice® PPO Network

Aetna Open Choice® PPO Network is a Preferred Provider Organization (PPO), or network of doctors and healthcare facilities that agree to provide services at a pre-negotiated, reduced rate. Containing more than 850,000 participating physicians and ancillary providers and 6,900 hospitals, Aetna's network provides services with strong, negotiated rates, helping you to save on the cost of healthcare.

MERITAIN℠ HEALTH
An Aetna Company

Aetna's Added Healthcare Services

Aetna's network provides our members with the benefit of Aetna's specialty programs, including dialysis, lab services and transplant services.

Locate Preferred Providers

With Aetna's comprehensive provider participation, many of your preferred doctors may already be in the Aetna network. To verify whether or not a doctor or healthcare facility participates, visit **www.aetna.com/docfind/custom/mymeritain.**

Important Steps to Remember

Members need to show their ID card when they visit a doctor or facility and they should request that a copy is placed in their file. Their ID card identifies Aetna as their PPO network. This can help to ensure they receive all applicable network discounts.

For any questions regarding the Aetna Open Choice® PPO Network, contact **Meritain Health customer service at (866) 596-5817.**

Frequently Asked Questions

Q. What will my effective date be?

A. You choose the start date of your plan. Effective dates are available on the 1st and 15th of each month.

Q. How are my plan rates determined?

A. Monthly rates are based on the deductible and coinsurance you choose, as well as your age, gender and zip code. The online rating tool will display the options when your agent enters the above information.

Q. When will I be billed?

A. Your initial payment is due at the time of your application. Following the initial payment, recurring payments will be automatically drafted from your bank account or credit card on the same day each month, based on your effective date. We offer a 30-day grace period for declined payments.

Q. Will I receive ID cards?

A. You will be mailed an ID card for your Short Term Medical Insurance plan with your PPO Network information on it. You need to present your STM ID card to your provider any time you receive services. If applicable, you will also be mailed a separate ID card for your Association benefits. You need to present your Association Membership card to your pharmacist any time you have a prescription filled. **Please be careful to use the correct card when you go to the doctor and pharmacy - the cards are not interchangeable.**

Q. Where do I get information about my plan?

A. You will receive an email from the insurance carrier with instructions on how to access your STM documents online. Your STM ID cards will be mailed to you. You will also receive a welcome email regarding how to access your benefits guides online. If you have any questions about your materials, please call **Member Services** at **(800) 269-3563**.

Q. Can I make changes to my plan?

A. You may only make changes to your plan if you experience a Qualifying Life Event.

Q. What is a Qualifying Change?

A. The Qualifying Life Events that allow you to make changes to your plan are:

- **Change in legal marital status** – death or divorce of a spouse
- **Change in dependent children** – birth or death of a child

To make changes to your membership due to a Qualifying Event, call Member Services at (800) 269-3563.

Q. My term is up and I still need coverage; can I reapply?

A. Short Term Medical plans are issued for a period of time designated in advance. If your insurance needs extend beyond this time frame, you may be eligible for another plan. This will require a new application and will not be considered an extension of your current plan. Any illness or condition that develops while covered by your current plan will be considered a pre-existing condition and will not be covered by subsequent Short Term Medical plans. (Pre-existing Condition Exclusion does not apply in IL.)

Q. What is the process for cancellations?

A. There is a 10-day free look period following the coverage start date. Cancellations received within the 10-day free look period will be eligible for a full refund, including the enrollment fee. Following the free look period a 10-day minimum cancellation notice is required. Cancellations will be effective at the end of the paid through date, no sooner than 10 days following the date the cancellation request is received.

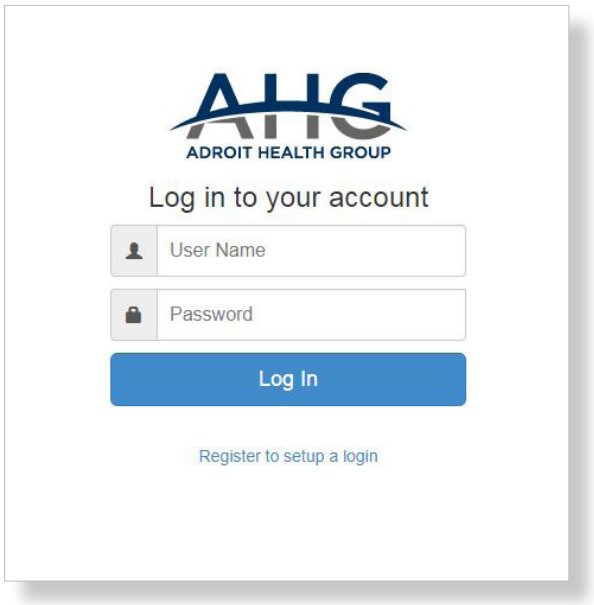
Cancellations must be received in a written format via email or mail:

Mail:
Adroit Health Group
P.O. Box 310
McKinney, TX 75070

Email:
csr@a1healthcare.com

Online Membership Access

Member Portal



All memberships include exclusive access to our online Member Portal, a secure, convenient website that helps members to manage their membership.

Visit: www.a1healthcare.com/members

Through quick and easy access, members can:

- Review their benefit information, association benefits and account information
- Access benefit partner websites for valuable health care savings
- Download and print Member materials
- Update contact information
- Add a new form of payment

Important Agent Note:
Initial access to Member Portal requires a valid email address. Be sure to capture at time of enrollment.

Enrollment Form

AWA Precise Choice Enrollment Form

AWA STM plans are available in the following states: AL, AZ, AR, DC, FL, GA, IL, IN, KY, LA, MI, MS, NE, NV, NC, ND, OH, OK, PA, SC, TN, TX, VA, WV, WY.

* Fields are required.

GROUP OR ASSOCIATION Affiliated Workers Association Requested Effective Date / /

Company Contact Contact Phone Number

Enrollee Name * Enrollee Address *

City * State * Zip * Daytime Phone Number *

Date of Birth * E-mail Address * Gender: ☐ Male ☐ Female

MEMBERSHIP LEVELS

☒ AWA Membership

STM PLAN OPTIONS

Standard Issue	☐ $1,000-80/20%	☐ $2,500-80/20%	☐ $5,000-80/20%	☐ $10,000-100/0%
Guaranteed Issue	☐ $3,500-80/20%	☐ $5,000-90/10%		
Coverage	☐ Member	☐ Member + Spouse	☐ Member + Child(ren)	☐ Member + Family

SPOUSE & DEPENDENT INFORMATION

(Write spouse's name below if you are applying for Enrollee and Spouse or Enrollee and Family coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

Spouse Name Date of Birth * Gender (M/F)

Dependent Name Date of Birth * Gender (M/F)

Dependent Name Date of Birth * Gender (M/F)

Dependent Name Date of Birth * Gender (M/F)

Beneficiary * (Please print full name) Relationship

(The enrollee will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.)

I hereby enroll as a member of the Affiliated Workers Association (the "Association"). I appoint the Secretary of the Association in office at any particular time as my proxy to receive notice of and attend all meetings of the members and vote on my behalf and to otherwise act for me in the same manner and with the same effect as if I were personally present. This proxy shall be valid until revoked at any time prior to voting at any meeting by executing and delivering a written notice of revocation to the Secretary of the Association, by executing and delivering a subsequently dated proxy to the Secretary of the Association or by voting in person.

By signing below, I and the individuals named herein are eligible for membership. I understand that the insurance benefits included with my membership are short term medical insurance plans issued to the Affiliated Workers Association and are neither "essential health benefit plans" under the ACA, traditional major medical insurance plans, nor Workers Compensation plans under state law and are not intended as a substitute for basic health insurance or medical coverage. Individuals who enroll in this membership are subject to the ACA's "shared responsibility payment". Membership will not begin until the effective date shown on the Member ID Card. I authorize Affiliated Workers Association to collect any and all fees and dues for this membership. By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of membership as they have been presented to me.

CREDIT CARD OR AUTOMATIC BANK DRAFT

Credit Card Type Card Number Expiration Date Security Code

Bank Name Routing Number Account Number

Applicant Signature Date

Enrollee Signature Date

IND Precise Choice Enrollment Form

Individual STM plans are available in the following states: (SI & GI): MO, SD, WI; (SI Only): CO, CT, ME, MD, NM, OR.

* Fields are required.

Requested Effective Date / /

Company Contact | Contact Phone Number

Enrollee Name * | Enrollee Address *

City * | State * | Zip * | Daytime Phone Number *

Date of Birth * | E-mail Address * | Gender: ☐ Male ☐ Female

STM PLAN OPTIONS

Standard Issue	☐ $1,000-80/20%	☐ $2,500-80/20%	☐ $5,000-80/20%	☐ $10,000-100/0%
Guaranteed Issue	☐ $3,500-80/20%	☐ $5,000-90/10%		
Coverage	☐ Member	☐ Member + Spouse	☐ Member + Child(ren)	☐ Member + Family

SPOUSE & DEPENDENT INFORMATION

(Write spouse's name below if you are applying for Enrollee and Spouse or Enrollee and Family coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

Spouse Name | Date of Birth * | Gender (M/F)

Dependent Name | Date of Birth * | Gender (M/F)

Dependent Name | Date of Birth * | Gender (M/F)

Dependent Name | Date of Birth * | Gender (M/F)

Beneficiary * (Please print full name) | Relationship

(The enrollee will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.)

By signing below, I and the individuals named herein are eligible for plan.. I understand that the insurance benefits are short term medical insurance plans and are neither "essential health benefit plans" under the ACA, traditional major medical insurance plans, nor Workers Compensation plans under state law and are not intended as a substitute for basic health insurance or medical coverage. Individuals who enroll in this plan are subject to the ACA's "shared responsibility payment". Coverage will not begin until the effective date shown on the ID Card. I authorize Premier Health Solutions to collect any and all fees for this plan. By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of plan as they have been presented to me.

CREDIT CARD OR AUTOMATIC BANK DRAFT

Credit Card Type | Card Number | Expiration Date | Security Code

Bank Name | Routing Number | Account Number

Applicant Signature | Date

Enrollee Signature | Date

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